STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(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 275	Continued From Page 20	T 275		
T 275	12 VAC 5-412-280 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, policies and interview the agency staff failed to ensure that medications were not expired, were dated and/or contained within its original container when opened and/or used. The findings include: 1. On May 30, 2012 a facility tour was conducted between 12:30 PM and 2:00 PM in the facility. During the tour the following was identified: a) Tylenol/Codeine Phosphate with 100 tablets in an unopened bottle with expiration dated 04/2012. b) Lidocaine bottle 10 units/ml in a 10 ml bottle opened with no date when the bottle was opened. c) A plastic bottle labeled ultrasound gel but contained thin brown liquid (not gel) in the bottle. 2. On May 30, 2012 between 12:30 PM and 2:00 PM an interview was conducted with the Administrator in the Procedure Room. The Administrator confirmed that the plastic bottle labeled ultra sound gel contained brown Betadine liquid. The Administrator confirmed that an open bottle of Lidocaine failed to be dated once opened. An interview was conducted with the Administrator in the Recovery Room. The Administrator confirmed that the Tylenol/Codeine Phosphate 100 tablets in an unopened bottle had an	T 275	T 275 Tylenol with codeine has been discarded. Lidocaine that had not been marked with the opening date has been discarded. Plastic bottle with betadine has been discarded. 4 oz bottles of betadine have been purchased. Policies indicate that any opened items must have the date and initials of person who opened item. When setting up for procedures, items are to be checked and any item not properly labeled is to be discarded. Expiration log is to be completed monthly by the medical assistant. Her job description reflects this duty Completion date July 12, 2012	

Tag 285

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: Pharmaceutical Services	**Policy Description:** Disposition of Expired Drugs
Page: 1 of 1	**Replaces Policy Dated:**
Effective Date: 06/12	**Reference Number:** 12VAC5-412-260
Approved:	

Scope:	All medical and nursing personnel
Purpose:	To monitor the disposal of expired drugs
Policy:	RMCW will handle and dispose of expired drugs in the following manner:
Procedure:	The procedure for disposition and handling of non-scheduled drugs will be as follows: 1. Nursing Personnel will be responsible for routinely checking for out-dated/expired drugs. 2. Out-dated drugs will be removed from the shelf or cart and discarded appropriately. 3. Unopened bottles will be returned to the Richmond Medical Center for Women exchange by the Nurse Manager or her designee. 4. If drugs are not exchangeable or returnable they will be destroyed by licensed personnel. The procedure for disposition and handling of scheduled/controlled drugs will be as follows: 1. The nurse will be responsible for routinely checking controlled medications for expiration dates. 2. If there are out-dated/expired drugs present, the Nurse Manager will dispose of the drugs in the required manner and the disposal of controlled substances shall be recorded on the narcotics record for that day.
Reference:	**12VAC5-412-260**

Revised: Date & Initial	06/14/99	05/12/00	4/5/10							
Reviewed: Date & Initial	09/01/03	12/06/04	12/14/05	12/19/06	10/09/07	12/31/08	11/09/09			

Tab 285

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: Pharmaceutical Services	**Policy Description:** Use of Multidose Vials
Page: 1 of 1	**Replaces Policy Dated:**
Effective Date: 6/12	**Reference Number:** 12VAC5-412-260
Approved:	

Scope:	All nursing, allied health and medical staff.
Purpose:	To determine the procedures for multi-dose vials.
Policy:	The following guidelines shall be followed with regard to the use of multi-dose vials at the Center.
Procedure:	Guidelines: A) Multi-dose vials are to be opened/penetrated using strict aseptic technique. B) Unless contamination of a multi-dose vial is apparent or suspected, the vial may be used for 30 days for opened or entered vials unless otherwise specified by the manufacturer. C) All multi-dose vials will be dated and initialed when opened. If a vial is found to be opened and not dated and initialed, it is to be discarded. D) Single use vials are opened and discarded after one time use. E) Recommended discard times for: 1) IV tubing — 24 hours 2) IV sets — 24 hours 3) Irrigating solutions — 24 hours
Reference:	12VAC5-412-260

Revised: Date & Initial										
Reviewed: Date & Initial										

	Meet the waiting family members and explain the situation. Meet ambulance personnel and direct. Make a copy of the chart to accompany patient to the hospital. The physician, nurse, or administrator may accompany patient to the hospital at the direction of the physician.
Reference:	**12VAC5-412-150**

Revised: Date & Initial:										
Reviewed: Date & Initial										

Tag 35

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 & Environment	**Policy Description:** Emergency Care Guidelines
Page: 1 of 2	**Replaces Policy Dated:**
Effective Date: 7/12	**Reference Number: 12VAC5-412-150**
Approved:	

Scope:	All staff rendering emergency care
Purpose:	Providing emergency care when indicated.
Policy:	Patient care during emergencies will be given by qualified personnel in a manner consistent with the orders of the physician.
Procedure:	The crash cart will be maintained by the administrator (See policy titled Emergency Supplies and Equipment) The AED will be taken to the other centers when the physician is seeing patients there. It will be checked in by the administrator at each location. The physician determines that an emergency exist. The physician will direct the management of the emergency. In the absence of a physician, an R.N. certified in ACLS will implement emergency care. These guidelines may only be altered at physician discretion. The procedure assistant will get the Recovery Room Nurse or the Nurse Practitioner. That person will assist in emergency care at the direction of the physician. The counselor in the procedure room will act as the recorder of actions and times. The utility person or the recovery room aide will notify the administrator. She will notify other counselors and staff that an emergency exists. Staff remaining in the area will only be those needed for the management of the emergency. They will remain nearby so that they can be assigned duties as needed. The situation will be explained to the other patients as best as possible maintaining privacy of the patient involved in the emergency. The stretcher/wheel chair will be brought to the scene of the emergency. If the physician determines that the patient must be transported to the hospital, he will decide the method of transportation. If necessary, the nurse will phone for an ambulance. Pertinent information about the patient's condition will be as determined by the physician. Notify personnel to clear hallways and other areas as needed to clear the exit route. Doors off the exit route should be closed.

Revised: Date & Initial										
Reviewed: Date & Initial										

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	14758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(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

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	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	19756 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(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 29 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. The Findings Include: An initial tour of the facility was conducted with the Administrator and facility consultant on May 30, 2012 beginning at about 1:00 P.M. During the tour it was noted that the facility had no provision for a separate collection, storage or disposal of soiled materials, 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, had no evidence of maintenance or performance testing on the facility's suction equipment stored in the attic, doorways where not grade level and were not 5 foot wide, hallway was less than 5 feet in areas where patients would have access, failed to have sinks that could be used without hands, 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 Administrator stated during the tour that the facility had contacted a firm who would assist the facility in complying with the regulations.	T 400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10750 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(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 380	Continued From Page 28 Administrator's office. There was no preventive maintenance policy. 3. On May 30, 2012 during the facility tour the Administrator was interviewed between 12:30 PM and 2:00 PM. The Administrator acknowledged there was no evidence of preventive maintenance safety checks on the following: two (2) exam lights, one (1) lab refrigerator, one (1) centrifuge and one (1) suction machine.	T 380		
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 observations, document review and	T 400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-002	A. BUILDING _____ B. Wing _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	16758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 360	Continued From Page 27 stated that the facility failed to have the MSDS form for the Clorox wipes.	T 360		
T 380	12 VAC 5-412-360 B Maintenance B. When patient monitoring equipment is utilized, a written preventative maintenance program shall be developed and implemented. This equipment shall be checked and/or tested in accordance with manufacturer's specifications at periodic intervals, no less than annually, to ensure proper operation and a state of good repair. After repairs and/or alterations are made to any equipment, the equipment shall be thoroughly tested for proper operation before it is returned to service. Records shall be maintained on each piece of equipment to indicate its history of testing and maintenance. This RULE is not met as evidenced by: Based on observations, review of facility policies and interview the facility staff failed to maintain a preventative maintenance program at least annually on all equipment. Specifically no preventative and or safety checks were documented for two (2) exam lights, one (1) lab, refrigerator, one (1) centrifuge and one (1) suction machine. The findings include: 1. On May 30, 2012 a facility tour was conducted between 12:30 PM and 2:00 PM. The preventive maintenance failed to be documented at least annually for safety on the following: two (2) exam lights, one (1) lab refrigerator, one (1) centrifuge and one (1) suction machine. 2. On May 30, 2012 the facility policies were reviewed between 2:00 PM and 5:00 PM in the	T 380	T 380 Preventive maintenance has been done exam light, refrigerator, centrifuge and suction machine. Preventive maintenance manual to be kept up to date by the administrator. Preventive maintenance visits to be scheduled annually. Completion date July 12, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	16758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 360	Continued From Page 28 PM a facility tour was conducted. During the tour a sharps container was noted in the Procedure Room on the floor and in the Recovery Room on top of the nurses desk. Both containers were not secure to any surface and had an open area at the top in which needles were inserted. According to The Center for Disease Control, Selecting, Evaluating and Using Sharps Disposal Containers article January 1996, reads in part: "Disposal opening-the disposal opening should prevent spills of the contents. Security may be a concern in some areas of facilities, the facility should consider selecting containers with guards to prevent hands or fingers from entering the containers. Stability-containers should be stable when place in a horizontal surface." During the facility tour there were Clorox wipes noted in the Ultrasound and Procedure Rooms. The Administrator stated that the Clorox wipes were used to clean the exam table surface between patients. A request was made for the Material Safety Data Sheet (MSDS) sheet to review for what organisms the the wipes kill. 2. On May 30, 2012 between 12:30 PM and 1:30 PM an interview was conducted with the Administrator during the facility tour. The Administrator acknowledged that the sharps container in the Procedure and Recovery Rooms were easily accessible through the unsecured opening on top of the containers. 3. On May 31, 2012 between 10:00 AM and 11:00 AM the cleaning of the exam table between patient's use were observed being wipe down with the use of Clorox wipes between patient use. 4. On May 31, 2012 between 9:30 AM and 11:00 AM an interview was conducted with the Administrator in the facility. The Administrator	T 360	T 360 Sharps containers which are wall mounted and have the mail slot type opening have been installed. A rack for the procedure room sharps container has been set up to make the container stable. Clorox wipes have been replaced with wipes indicated for medical setting. MSDS sheet in the MSDS manual. Completion date July 5, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 320	Continued From Page 25 complaint resolution; infections, complications and other adverse events; and staff concerns regarding patient care. 2. On May 33, 2012 between 3:00 PM and 6:00 PM an interview was conducted with the Administrator and the facilities nurse consultant in the Administrator's office. Both acknowledged that there was there was no QA policy or program that will evaluate the above concerns.	T 320		
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 observation, interview and policies/procedures of the facility the 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 and to use cleaning products that kill organisms between patient use of exam table. The findings include:	T 360		
	1. On May 30, 2012 between 12:30 PM and 1:30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-062	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 300	Continued From Page 24 in the event of an emergency. The Administrator stated, "We will have the tubing tomorrow. I did not think we needed oxygen."	T 300		
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 document review and interview the facility staff failed to have a quality assurance program that will evaluate the following aspects: Staffing patterns and performance; supervision appropriate to the level of service; patient records; patient satisfaction; complaint resolution; infections, complications and other adverse events; and staff concerns regarding patient care. The findings include: 1. On May 30, 2012 between 1:00 PM to 5:00 PM the agency's policies were reviewed in the Administrator's office. The facility failed to have a quality assurance policy that will evaluate the following aspects: Staffing patterns and performance; supervision appropriate to the level of service; patient records; patient satisfaction;	T 320	T 320 Quality Assurance policy is in place. Policy manual to be reviewed annually by administrator Completion date June 29, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 290	Continued From Page 23 On May 30, 2012 at approximately 3:30 P.M. during the comprehensive tour of the facility with the Administrator and facility consultant there was no evidence of oxygen being available should a patient require oxygen. Also during the tour the emergency cart was checked with the facility consultant. The cart did not contain any IV (intravenous) tubing to connect IV fluids to the needles for administration in the event of an emergency. The Administrator stated, "We will have the tubing tomorrow. I did not think we needed oxygen."	T 290	T 290 IV tubing has been stocked. Oxygen has been stocked. Log for checking supplies has been written. The supplies are checked and the log is maintained by the administrator. Completion date July 12, 2012	
T 300	12 VAC 5-412-290 A Emergency services A. An abortion facility shall provide ongoing urgent or emergent care and maintain on the premises adequate monitoring equipment, suction apparatus, oxygen and related items for resuscitation and control of hemorrhage and other complications. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure the necessary medical equipment and supplies were available to care for patients in the event of an emergency. The Findings Include: On May 30, 2012 during the comprehensive tour of the facility with the Administrator and facility consultant there was no evidence of oxygen being available should a patient require oxygen and no evidence of suction other than the suction used in a procedure. On May 30, 2012 the emergency cart was checked with the facility consultant. The cart did not contain any IV (intravenous) tubing to connect IV fluids to the needles for administration	T 300	T 300 Oxygen has been stocked. Gomco suction for airway has been obtained. IV tubing has been stocked. Completion date July 12, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(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 285	Continued From Page 22 the agency's Administrator was interviewed in the Administrator's office. The Administrator acknowledged that there was no mediation dispensing policy. 3. On May 31, 2012 between 9:30 am and 10:30 am a second interview was conducted with the Administrator and the facilities nurse consultant in the Administrator's office. Both acknowledged that there was no medication dispensing policy.	T 285		
T 290	12 VAC 5-412-270 Equipment and supplies An abortion facility shall maintain medical equipment and supplies appropriate and adequate to care for patients based on the level, scope and intensity of services provided, to include: 1. A bed or recliner suitable for recovery; 2. Oxygen with flow meters and masks or equivalent; 3. Mechanical suction; 4. Resuscitation equipment to include; as a minimum, resuscitation bags and oral airways; 5. Emergency medications, intravenous fluids, and related supplies and equipment; 6. Sterile suturing equipment and supplies; 7. Adjustable examination light; 8. Containers for soiled linen and waste materials with covers; and 9. Refrigerator. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure the necessary medical equipment and supplies were available to care for patients. The Findings Include:	T 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-062	A. BUILDING _____ B. WING _____	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	15768 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(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 210	Continued From Page 19	T 210		
T 210	12 VAC 5-412-240 D Medical testing, patient counseling and labor D. All tissues removed resulting from the abortion procedure shall be examined 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 for further pathologic examination and the patient alerted to the possibility of an ectopic pregnancy, and referred appropriately. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure they had a process and equipment available to have tissue specimens sent to a lab when the physician could not be certain the villi or fetal parts were present. The Findings Include: On May 30, 2012 a comprehensive tour of the facility was performed. There was no evidence of containers being available to transport tissue specimens to a lab for further testing. On May 31, 2012 at approximately 11:30 A.M. the facility physician and Administrator was interviewed. The physician stated, "I check each specimen to make sure villi and or fetal parts are present. When I can't be sure the specimen is sent to the lab. The specimens are transported the day of the procedure to the lab. They are transported in a specimen cup with saline." The Administrator stated, "We don't have any specimen cups. I will order them."	T 210	T 210 Specimen cups had in the past been brought by procedure assistant. That is why administrator did not have specimen cups on hand. Specimen cups are now stocked in the lab at the facility. Completion date July 6, 2012	

T 275	Continued From Page 20	T 275		
T 275	12 VAC 5-412-260 C Administration, storage and dispensing of drug 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, policies and interview the agency staff failed to ensure that medications were not expired, were dated and/or contained within its original container when opened and/or used. The findings include: 1. On May 30, 2012 a facility tour was conducted between 12:30 PM and 2:00 PM in the facility. During the tour the following was identified: a) Tylenol/Codeine Phosphate with 100 tablets in an unopened bottle with expiration dated 04/2012. b) Lidocaine bottle 10 units/ml in a 10 ml bottle opened with no date when the bottle was opened. c) A plastic bottle labeled ultrasound gel but contained thin brown liquid (not gel) in the bottle. 2. On May 30, 2012 between 12:30 PM and 2:00 PM an interview was conducted with the Administrator in the Procedure Room. The Administrator confirmed that the plastic bottle labeled ultra sound gel contained brown Betadine liquid. The Administrator confirmed that an open bottle of Lidocaine failed to be dated once opened. An interview was conducted with the Administrator in the Recovery Room. The Administrator confirmed that the Tylenol/Codeine Phosphate 100 tablets in an unopened bottle had an	T 275	T 275 Tylenol with codeine has been discarded. Lidocaine that had not been marked with the opening date has been discarded. Plastic bottle with betadine has been discarded. 4 oz bottles of betadine have been purchased. Policies indicate that any opened items must have the date and initials of person who opened item. When setting up for procedures, items are to be checked and any item not properly labeled is to be discarded. Expiration log is to be completed monthly by the medical assistant. Her job description reflects this duty Completion date July 12, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-082	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	19768 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(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 275	Continued From Page 21 expiration dated 04/2012. 3. On May 30, 2012 between 3:00 PM to 5:00 PM the facility policies were reviewed in the Administrator's office. There were no policies to ensure that medications are not expired, out dated and/or contained within the original container.	T 275		
T 285	12 VAC 5-412-260 E Administration, storage and dispensing of dru E. Records of all drugs in Schedules I-V received, sold, administered, dispensed or otherwise disposed of shall be maintained in accordance with federal and state laws, to include the inventory and reporting requirements of a theft or loss of drugs found in 54.1-3404 of the Drug Control Act of the Code of Virginia. This RULE is not met as evidenced by: Based on the facility tour, review of the facility's policies and interview the facility failed to have a medication dispensing policy. The findings include: 1. On May 30, 2012 a facility tour was conducted between 12:30 PM and 1:30 PM in the facility. There was a locked medication box within a locked cabinet in the Recovery Room. There was medication present. The medication was not being documented when/who it was dispensed. 2. On May 30, 2012 the facility policies were reviewed between 1:30 PM and 5:00 PM in the Administrator's office. There was no medication dispensing policy. 2. On May 30, 2012 between 2:00 PM to 5:00 PM	T 285	T 285 Policies dealing with medication have been written. Policy on multi-use vials is complete. Logs of medication dispensed are being kept. Completion date July 12, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	16758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 18 supplies (refer to #1 (a-i)) 3. On May 31, 2012 between 9:30 am and 10:30 am a second interview was conducted with the Administrator and the facilities nurse consultant in the Administrator's office. Both acknowledged that there was no policy regarding services and/or care for a minor that was not emancipated.	T 175		
T 200	12 VAC 5-412-240 B Medical testing, patient counseling and labor 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. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure they developed, maintained and implemented policies and procedures pertaining to counseling and instructions in a language each patient could understand. The Findings include: On May 30 and 31, 2012 at approximately 11:30 A.M. the facility policies and procedures were reviewed and discussed with the facility Administrator. The facility did not have a policy on providing each patient in a language the patient could understand, information on the procedure or counseling both pre and post abortion. The Administrator stated, "We will get that."	T 200	T 200 Policy and procedure is in place for counseling and for provision of family planning and post-abortion counseling. Completion date July 12, 2012	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10738 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 175	Continued From Page 17 management of accidental exposures); d. Procedures for handling, storing and transporting clean linens, clean/sterile supplies and equipment; e. Procedures for handling/temporary storage/transport of soiled linens; f. Procedures for handling, storing, processing and transporting regulated medical waste in accordance with applicable regulations; g. 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; h. Procedures for appropriate disposal of non-reusable equipment; i. Policies and procedures for maintenance/repair of equipment in accordance with manufacturer recommendations; j. Procedures for cleaning of environmental surfaces with appropriate cleaning products; k. An effective pest control program, managed in accordance with local health and environmental regulations; and l. Other infection prevention procedures necessary to prevent/control transmission of an infectious agent in the facility as recommended or required by the department. 2. On May 30, 2012 an interview was conducted with both the facility Administrator and the nurse consultant in the Administrator's office. Both acknowledged that there were no policies for the management of the facility, equipment and	T 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-062	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	16758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 175	Continued From Page 16 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 the review of the facility's policies and interview there were no policies/procedures for the facility management of : hand hygiene; cleaning, disposal, storage and transport of equipment, linen and supplies; product specific instructions for use of cleaning agents; procedures for handling, storing and transporting of medical waste; policy/procedure for pest control; and other infection prevention procedures necessary to prevent/control transmission of an infectious agent in the facility The findings include: 1. On May 30, 2012 the facility policies were reviewed between 2:00 PM and 5:00 PM in the Administrator's office. There were no policies/procedures for the management of the facility, equipment and supplies for the following: a. Access to hand-washing equipment and adequate supplies (e.g., soap, alcohol-based hand rubs, disposable towels or hot air dryers); b. Availability of utility sinks, cleaning supplies and other materials for cleaning, disposal, storage and transport of equipment and supplies; c. 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,	T 175		

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PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 175	Continued From Page 15	T 175		
T 175	12 VAC 5-412-220 C Infection prevention C. Written policies and procedures for the management of the facility, equipment and supplies shall address the following: 1. Access to hand-washing equipment and adequate supplies (e.g., soap, alcohol-based hand rubs, disposable towels or hot air dryers); 2. Availability of utility sinks, cleaning supplies and other materials for cleaning, disposal, storage and transport of equipment and supplies; 3. Appropriate storage for cleaning agents (e.g., locked cabinets or rooms for chemicals used for cleaning) and product-specific instructions for use of cleaning agents (e.g., dilution, contact time, management of accidental exposures); 4. Procedures for handling, storing and transporting clean linens, clean/sterile supplies and equipment; 5. Procedures for handling/temporary storage/transport of soiled linens; 6. Procedures for handling, storing, processing and transporting regulated medical waste in accordance with applicable regulations; 7. Procedures for the processing of each type of reusable medical equipment between uses on different patients. The procedure shall address: (i) the level of cleaning/disinfection/sterilization to be used for each type of equipment, (ii) the process (e.g., cleaning, chemical disinfection, heat sterilization); and (iii) the method for verifying that the recommended level of disinfection/sterilization has been achieved. The procedure shall reference the manufacturer's recommendations and any applicable state or national infection control guidelines; 8. Procedures for appropriate disposal of non-reusable equipment; 9. Policies and procedures for maintenance/repair of equipment in accordance	T 175		

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	FTAF-082	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10788 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 170	Continued From Page 14 B. Training of all personnel in the proper infection prevention techniques. The findings include: 1. On May 30, 2012 the facility policies were reviewed between 2:00 PM and 5:00 PM in the Administrator's office. The facility's infection prevention policies failed to include: A. Procedures for the screening of incoming patients and visitors for acute infectious illnesses, applying appropriate measures to prevent transmission of community acquired infection within the facility; monitoring staff adherence to recommended infection prevention practices and documenting annual retraining of all staff in recommended infection prevention practices. B. Training of all personnel in the proper infection prevention techniques; correct hand-washing technique, including indications for use of soap and water and/or use of alcohol-based hand rubs; use of standard precautions; compliance with blood-bourne pathogen requirements of the U.S. Occupational Safety & Health Administration; use of personal protective equipment; safe injection practices and plans for annual retraining of all personnel in infection prevention methods. 2. On May 30, 2012 an interview was conducted with the Administrator between 3:00 PM and 5:00 PM in the agency. The Administrator acknowledged that the facility failed to provide the employee's with infection prevention training & policies.	T 170	T 170 Procedure for screening patients and visitors has been written. Policy for monitoring staff adherence to infection prevention practices has been written. Initial and annual training in infection control is included in infection control policy as well as personnel policy and orientation checklist. Infection Control Survey to be conducted quarterly. Results to be submitted to Quality Assurance Committee. Completion date July 12, 2012 Training of all personnel in infection prevention techniques to be conducted initially and annually. Documentation is to be in the Inservice Training Manual as well as each personnel file. Personnel files are to be reviewed annually for completeness. Completion date July 12, 2012	

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T 170	Continued From Page 13	T 170		
T 170	12 VAC 5-412-220 B Infection prevention B. Written infection prevention policies and procedures shall include, but not be limited to: 1. Procedures for screening incoming patients and visitors for acute infectious illnesses and applying appropriate measures to prevent transmission of community acquired infection within the facility; 2. Training of all personnel in proper infection prevention techniques; 3. Correct hand-washing technique, including indications for use of soap and water and use of alcohol-based hand rubs; 4. Use of standard precautions; 5. Compliance with blood-bourne pathogen requirements of the U.S. Occupational Safety & Health Administration. 6. Use of personal protective equipment; 7. Use of safe injection practices; 8. Plans for annual retraining of all personnel in infection prevention methods; 9. Procedures for monitoring staff adherence to recommended infection prevention practices; and 10. Procedures for documenting annual retraining of all staff in recommended infection prevention practices. This RULE is not met as evidenced by: Based on interview and the review of the agency's polices the facility failed to provide infection prevention training & policies for: A. Procedures for the screening of incoming patients and visitors for acute infectious illnesses, applying appropriate measures to prevent transmission of community acquired infection within the facility; monitoring staff adherence to recommended infection prevention practices and documenting annual retraining of all staff in recommended infection prevention practices.	T 170		

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PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 165	Continued From Page 12 implementation and maintenance of infection prevention policies and procedures and the regulations or guidance documents on which they are based shall be documented. 2. All infection prevention policies and procedures shall be reviewed at least annually by the administrator and appropriate members of the clinical staff. The annual review process and recommendations for changes/updates shall be documented in writing. 3. A designated person in the facility shall have received training in basic infection prevention, and shall also be involved in the annual review. This RULE: is not met as evidenced by: Based on interview and review of the infection control manual the facility failed to have an appointment of an individual trained in basic infection prevention and who is involved in the annual review of the infection control program. The findings include: 1. On May 30, 2012 the agency's laboratory policy/procedure manual was reviewed in the Administrator's office between 3:00 PM and 5:00 PM. The manual contained the agency's infection control policy content. The infection control content failed to identify a designated person in the facility who has received basic training in infection prevention and who shall also be involved in the annual review. 2. On May 31, 2012 an interview was conducted with the Administrator between 9:30 am and 12:00 PM in the facility. The Administrator acknowledged that no one has received basic training in infection prevention and who also is involved in the annual infection prevention review.	T 165	T 165 The physician is currently the designated person with basic training in infection control. The infection control plan is to be reviewed at least annually. Completion date July 12, 2012	

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	FTAF-062	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	19758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 130	Continued From Page 11 This RULE: is not met as evidenced by: Based on the review of the facility's policies and interview there was no policy regarding services and/or care for a minor that was not emancipated. The findings include: 1. On May 30, 2012 the facility policies were reviewed between 2:00 PM and 5:00 PM in the Administrator's office. There was no policy regarding services and/or care for a minor that was not emancipated. The Administrator acknowledged that there was no policy regarding services and/or care for a minor that was not emancipated. 2. On May 31, 2012 between 9:30 am and 10:30 am a second interview was conducted with the Administrator and the facilities nurse consultant in the Administrator's office. Both acknowledged that there was no policy regarding services and/or care for a minor that was not emancipated.	T 130	T 130 Policy on minors is in place. Policy and procedures manual is to be reviewed by administrator annually. Completion date June 22, 2012.	
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,	T 165		

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	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

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PENINSULA MEDICAL CENTER FOR WOMEN	16758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 110	Continued From Page 10 who are licensed to practice medicine in Virginia and who are qualified by training and experience to perform abortions. The facility shall develop, implement and maintain policies and procedures to ensure and document that abortions that occur in the facility are only performed by physicians who are qualified by training and experience. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure there were policies that ensure abortions are only performed by physicians who are qualified by training and experience. The Findings Include: On May 30 and 31, 2012 the policies and procedures were reviewed with the Administrator and a facility consultant. There was no evidence of policies and procedures indicating what experience and training was required of a physician to practice at the facility. The Administrator stated, "We will need to get that."	T 110	T 110 Physician competency policy is in place. Administrator is responsible for reviewing policy manual annually. Completion date June 15, 2012	
T 130	12 VAC 5-412-200 Minors No person may perform an abortion upon an unemancipated minor unless informed written consent is obtained from the minor and the minor's parent, guardian or other authorized person. If the emancipated minor elects not to seek the informed written consent of an authorized person, a copy of the court order authorizing the abortion entered pursuant to 16.1-241 of the Code of Virginia shall be obtained prior to the performance of the abortion.	T 130		

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T 095	Continued From Page 9 facility policies and procedures were reviewed with the Administrator and a facility consultant. Both facility employees stated their policies and procedures for personnel did not include written job descriptions, process for verifying current professional licensing or certification, process for annually evaluation employee performance and competency and a process for reporting licensed and certified health care practitioners for violations of their licensing and certification standards. The facility Administrator stated, "We will need to work on those."	T 095	T 095 Personnel policy includes job description, process for verifying licensure, process for annual performance evaluation, and process for reporting licensed health care practitioners for violations of their licensing and certification standards. Completion date June 20 2012	
T 105	12 VAC 5-412-180 A Clinical staff 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. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure the privileges of the physician were clearly defined for 1 of 1 physicians. The Findings include: On May 30, 2012 the credential file for 1 of 1 physicians was reviewed. The file did not contain in delineation of privileges or appointment by the governing body. The Administrator stated, "We will get that."	T 105	T 105 Granting of privileges document has been obtained. Privileges have been granted by the Governing Authority to the physician June 15, 2012.	
T 110	12 VAC 5-412-180 B Clinical staff B. Abortions shall be performed by physicians	T 110		

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T 090	Continued From Page 8 member was aware of their responsibilities. The Administrator stated, "We need to work on that."	T 090		
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 interviews the facility staff failed to ensure personnel policies and procedures included written job descriptions, process for verifying current professional licensing or certification, process for annually evaluation employee performance and competency and a process for reporting licensed and certified health care practitioners for violations of their licensing and certification standards. The Findings Include: On May 30 and 31, 2012 at various times the	T 095		

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PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 085	Continued From Page 7 On May 30, 2012 at 2:00 P.M. a review of the personnel files was performed with the facility Administrator on 5 of 5 personnel files. Two (2) of the files did not contain job descriptions and 5 of the 5 did not contain evidence that the staff member was aware of their responsibilities. The Administrator stated, "We need to work on that." T 090 12 VAC 5-412-170 G Personnel G. A personnel file shall be maintained for each staff member. The records shall be completely and accurately documented, readily available, and systematically organized to facilitate the compilation and retrieval of information. The file shall contain a current job description that reflects the individual's responsibilities and work assignments, and documentation of the person's in-service education, and professional licensure, if applicable. This RULE: Is not met as evidenced by: Based on document review and interviews the facility staff failed to have written job descriptions that adequately described the duties, specific responsibilities and minimum qualifications of each position and failed to show how each employee was provided a copy of the job description. The Findings include: On May 30, 2012 at 2:00 P.M. a review of the personnel files was performed with the facility Administrator on 5 of 5 personnel files. Two (2) of the files did not contain job descriptions and 5 of the 5 did not contain evidence that the staff	T 085 T 090	T 085 Job descriptions have been added to personnel files. Job descriptions have been revised to include a place for the staff member to sign and date to indicate that she is aware of the responsibilities of her position. Job descriptions will be reviewed at least annually. The personnel policy includes procedure for reviewing job descriptions at least annually. Personnel files will be reviewed annually by the administrator for completeness. Completion date June 20, 2012 T 090 Job descriptions have been provided to each staff member and signed and dated to indicate her awareness of responsibilities. Personnel policy and orientation checklist include job descriptions in them. Personnel files are to be reviewed annually for completeness. Job descriptions are to be reviewed annually. Administrator is responsible. Completion date June 20, 2012	

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	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 080	Continued From Page 6 reviewed for 4 of 4 staff personnel who provide care and services to the patients of the facility and for 1 of 1 security personnel. There was no documentation of training on infection control. In 3 of the 5 personnel files there was no training documented of any kind. On May 30, 2012 at 2:30 P.M. the Administrator was interviewed and stated, "I do not have any documentation for training other than what is in their (the facility staff) personnel folders. I do not have any policies on training or education other than what is in their (the facility staff) job descriptions." T 085 12 VAC 5-412-170 F Personnel F. Job descriptions. 1. Written job descriptions that adequately describe the duties of every position shall be maintained. 2. Each job description shall include: position title, authority, specific responsibilities and minimum qualifications. 3. Job descriptions shall be reviewed at least annually, kept current and given to each employee and volunteer when assigned to the position and when revised. This RULE is not met as evidenced by: Based on document review and interviews the facility staff failed to have written job descriptions that adequately described the duties, specific responsibilities and minimum qualifications of each position and failed to show how each employee was provided a copy of the job description. The Findings Include:	T 080 T 085	T 080 Training on infection control and fire safety is to be conducted initially and annually. This has been added to the orientation checklist and to the personnel policy. Documentation of in service training will be included in each staff member's personnel file as well as a manual dedicated to training documents. The Inservice Training manual will be reviewed annually. Personnel files will be reviewed annually of completeness. Administrator will be responsible for coordinating training and documentation. Training has been conducted for all of current staff. Videos and post tests were used as the means of training. Training done on July 5, 2012 Completion date July 12, 2012	

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	FTAF-062	A. BUILDING _____ B. WING _____	05/31/2012

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PENINSULA MEDICAL CENTER FOR WOMEN	16758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 070	Continued From Page 5 staff. The Findings Include: On May 30, 2012 at 2 P.M. the personnel files of the licensed personnel who have access to controlled substances were reviewed with the Administrator present. The Administrator and the primary physician's personnel files did not contain criminal history checks performed by the Virginia State Police pursuant to § 32.1-126.02 of the Code of Virginia. The Administrator stated, "I sent off for my criminal record check but signed my name in the wrong place so I had to resubmit it. (Name of Physician) is in our other office."	T 070	T 070 Criminal background checks have been obtained for administrator and physician. Personnel policy and orientation checklist indicate need for criminal background check for personnel who have access to controlled substances. Administrator is responsible for ensuring that the criminal background check is obtained. Completion date June 22, 2012	
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 interviews the facility staff failed to ensure it developed, implemented and maintained policies and procedures to document the facility staff participated in initial and ongoing training and education which included infection control training. The Findings Include: On May 30, 2012 the personnel files were	T 080		

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PENINSULA MEDICAL CENTER FOR WOMEN	10750 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 065	Continued From Page 4	T 065		
T 066	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 professional licensure, if applicable, and the health and personal background of each staff member. This RULE: is not met as evidenced by: Based on document review and interviews the facility failed to ensure licensure checks were performed on all licensed individuals for 1 of 2 licensed staff. The Findings Include: On 5/30/12 at 2 P.M. the credential file for the primary physician was reviewed. The file did not contain a verification of the Virginia medical license for this physician from the Department of Health Professions. The Administrator stated, "I can get that but I don't have it now."	T 066	T 065 The medical license for the physician has been downloaded from the Board of Medicine website. Personnel policy includes the need for license from online lookup. Orientation checklist has license item on it. Personnel files to be reviewed annually by administrator. Completion date June 14, 2012	
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 record review and interview the facility staff failed to ensure the criminal history check for compensated employees whose duties provide access to controlled substances within the abortion facility were performed for 2 of 2 facility	T 070		

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T 035	Continued From Page 3 The findings include: 1. On May 30, 2012 between 2:00 P.M. to 5:00 P.M. the agency's policies were reviewed in the Administrator's office. On May 31, 2012 between 9:30 P.M. to 12:00 P.M. the agency's policies were reviewed in the Administrator's office. The policies and procedures shall be based on recognized standards and guidelines. The facility failed to have policy and procedures to cover the following: Personnel, types of elective and emergency procedures that may be performed in the facility; admissions and discharges; when to use ultrasound to determine gestational age and when indicated to assess patient risk; infection prevention; risk and quality management; management and effective response to medical and/or surgical emergency;management and effective response to fire; ensuring compliance with all applicable federal, state and local laws; disaster preparedness and identification of the person to whom responsibility for operation and maintenance of the facility is delegated and methods established by the licensee for holding such individual responsible and accountable. 2. On May 30, 2012 between 2:00 P.M. to 5:00 P.M. the agency's Administrator was interviewed in the Administrator's office. The Administrator acknowledged and agreed that that the the facility failed to have the above named policy/procedures. 3. On May 31, 2012 between 9:30 A.M. and 10:30 A.M. a second interview was conducted with the Administrator in the Administrator's office. The Administrator re- confirmed that there were missing policies and procedures as listed in section #1.	T 035	T 035 Policies are in place: Personnel; admissions and discharges; ultrasound; infection prevention; Quality Assurance; management and effective response to fire; ensuring compliance with all federal, state and local laws; disaster preparedness; identification of person to whom responsibility is delegated and methods established for holding individual responsible and accountable; types of elective and emergency procedures that may be performed; management and effective response to medical and/or surgical emergency. Policy and procedures manual is to be reviewed annually by administrator. Completion date July 12, 2012	

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PENINSULA MEDICAL CENTER FOR WOMEN	19758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 035	Continued From Page 2	T 036		

This RULE: is not met as evidenced by:
Based on interview and review of the facility policies the facility failed to have policy/procedures for: Personnel, types of elective and emergency procedures that may be performed in the facility; admissions and discharges; when to use ultrasound to determine gestational age and when indicated to assess patient risk; infection prevention; risk and quality management; management and effective response to medical and/or surgical emergency;management and effective response to fire; ensuring compliance with all applicable federal, state and local laws; disaster preparedness and identification of the person to whom responsibility for operation and maintenance of the facility is delegated and methods established by the licensee for holding such individual responsible and accountable.

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T 035	Continued From Page 1	T 035		
T 035	12 VAC 5-412-150 Policy and procedure manual. Each abortion facility shall develop, implement and maintain an appropriate policy and procedures manual. The manual shall be reviewed annually and updated as necessary by the licensee. The manual shall include provisions covering at a minimum, the following topics: 1. Personnel; 2. Types of elective and emergency procedures that may be performed in the facility; 3. Types of anesthesia that may be used; 4. Admissions and discharges, including criteria for evaluating the patient before admission and before discharge; 5. Obtaining written informed consent of the patient prior to the initiation of any procedures; 6. When to use ultrasound to determine gestational age and when indicated to assess patient risk; 7. Infection prevention; 8. Risk and quality management; 9. Management and effective response to medical and/or surgical emergency; 10. Management and effective response to fire; 11. Ensuring compliance with all applicable federal, state and local laws; 12. Facility security; 13. Disaster preparedness; 14. Patient rights; 15. Functional safety and facility maintenance; and 16. Identification of the person to whom responsibility for operation and maintenance of the facility is delegated and methods established by the licensee for holding such individual responsible and accountable. These policies and procedures shall be based on recognized standards and guidelines.	T 035		

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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 May 30 and 31 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	RECEIVED AUG 13 2012 VDH/OLC	
T 015	12 VAC 5-412-140 B Organization and management B. There shall be disclosure of facility ownership. Ownership interest shall be reported to the OLC and in the case of corporations, all individuals or entities holding 5.0% or more of total ownership shall be identified by name and address. The OLC shall be notified of any changes in ownership. This RULE is not met as evidenced by: Based on interviews and document reviews the facility failed to provide disclosure of the ownership of the facility. The Findings Include: During the days of the survey (May 30 and 31, 2012) the facility Administrator was asked to provide names of the individuals who owned the facility. The Administrator stated on May 31, 2012 at approximately 10:30 A.M. "I don't have the information you are requesting."	T 015	T 015 Attached is the Corporate and Board Members including the sole stockholder for Governing Authority. Completion date June 15, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M Hunter, RN
TITLE: Administrator
(X6) DATE: 8-13-12

To: Kathaleen Creegan - Tedeschi
527-4503

From: Jill Abbey
Peninsula Medical Center for Women.
(804) 539-9599-cell

Date: Aug. 13, 2012.

I received a voice mail from Debbie on 8.10-12. She requested clarifications to Tag 35, 80, 105, 275, 285, & 290.

The entire report is enclosed with changes made to the above.

Thank you.

This is the revised version of both of these. They were re-faxed on 8.6.12.

Thank you.

Jill Abbey

State of Virginia

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T 015	12 VAC 5-412-140 B Organization and management B. There shall be disclosure of facility ownership. Ownership interest shall be reported to the OLC and in the case of corporations, all individuals or entities holding 5.0% or more of total ownership shall be identified by name and address. The OLC shall be notified of any changes in ownership. This RULE: is not met as evidenced by: Based on interviews and document reviews the facility failed to provide discloser of the ownership of the facility. The Findings Include: During the days of the survey (May 30 and 31, 2012) the facility Administrator was asked to provide names of the individuals who owned the facility. The Administrator stated on May 31, 2012 at approximately 10:30 A.M. "I don't have the information you are requesting."	T 015	T 015 Attached is the Corporate and Board Members including the sole stockholder for Governing Authority. Completion date June 15, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M Hunter, RN — TITLE: Administrator — (X6) DATE: 7-9-12

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T 035	Continued From Page 1	T 035		
T 035	12 VAC 5-412-150 Policy and procedure manual. Each abortion facility shall develop, implement and maintain an appropriate policy and procedures manual. The manual shall be reviewed annually and updated as necessary by the licensee. The manual shall include provisions covering at a minimum, the following topics: 1. Personnel; 2. Types of elective and emergency procedures that may be performed in the facility; 3. Types of anesthesia that may be used; 4. Admissions and discharges, including criteria for evaluating the patient before admission and before discharge; 5. Obtaining written informed consent of the patient prior to the initiation of any procedures; 6. When to use ultrasound to determine gestational age and when indicated to assess patient risk; 7. Infection prevention; 8. Risk and quality management; 9. Management and effective response to medical and/or surgical emergency; 10. Management and effective response to fire; 11. Ensuring compliance with all applicable federal, state and local laws; 12. Facility security; 13. Disaster preparedness; 14. Patient rights; 15. Functional safety and facility maintenance; and 16. Identification of the person to whom responsibility for operation and maintenance of the facility is delegated and methods established by the licensee for holding such individual responsible and accountable. These policies and procedures shall be based on recognized standards and guidelines.	T 035		

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T 035	Continued From Page 2 This RULE: is not met as evidenced by: Based on interview and review of the facility policies the facility failed to have policy/procedures for: Personnel, types of elective and emergency procedures that may be performed in the facility; admissions and discharges; when to use ultrasound to determine gestational age and when indicated to assess patient risk; infection prevention; risk and quality management; management and effective response to medical and/or surgical emergency;management and effective response to fire; ensuring compliance with all applicable federal, state and local laws; disaster preparedness and identification of the person to whom responsibility for operation and maintenance of the facility is delegated and methods established by the licensee for holding such individual responsible and accountable.	T 035		

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T 035	Continued From Page 3 The findings include: 1. On May 30, 2012 between 2:00 P.M. to 5:00 P.M. the agency's policies were reviewed in the Administrator's office. On May 31, 2012 between 9:30 P.M. to 12:00 P.M. the agency's policies were reviewed in the Administrator's office. The policies and procedures shall be based on recognized standards and guidelines. The facility failed to have policy and procedures to cover the following: Personnel, types of elective and emergency procedures that may be performed in the facility; admissions and discharges; when to use ultrasound to determine gestational age and when indicated to assess patient risk; infection prevention; risk and quality management; management and effective response to medical and/or surgical emergency;management and effective response to fire; ensuring compliance with all applicable federal, state and local laws; disaster preparedness and identification of the person to whom responsibility for operation and maintenance of the facility is delegated and methods established by the licensee for holding such individual responsible and accountable. 2. On May 30, 2012 between 2:00 P.M. to 5:00 P.M. the agency's Administrator was interviewed in the Administrator's office. The Administrator acknowledged and agreed that that the the facility failed to have the above named policy/procedures. 3. On May 31, 2012 between 9:30 A.M. and 10:30 A.M. a second interview was conducted with the Administrator in the Administrator's office. The Administrator re- confirmed that there were missing policies and procedures as listed in section #1.	T 035	T 035 Policies are in place: Personnel; admissions and discharges; ultrasound; infection prevention; Quality Assurance; management and effective response to fire; ensuring compliance with all federal, state and local laws; disaster preparedness; identification of person to whom responsibility is delegated and methods established for holding individual responsible and accountable; types of elective and emergency procedures that may be performed. To be written for: management and effective response to medical and/or surgical emergency. Policy and procedures manual is to be reviewed annually by administrator. Completion date July 12, 2012	

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T 065	Continued From Page 4	T 065		
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 professional licensure, if applicable, and the health and personal background of each staff member. This RULE: is not met as evidenced by: Based on document review and interviews the facility failed to ensure licensure checks were performed on all licensed individuals for 1 of 2 licensed staff. The Findings Include: On 5/30/12 at 2 P.M. the credential file for the primary physician was reviewed. The file did not contain a verification of the Virginia medical license for this physician from the Department of Health Professions. The Administrator stated, "I can get that but I don't have it now."	T 065	T 065 The medical license for the physician has been downloaded from the Board of Medicine website. Personnel policy includes the need for license from online lookup. Orientation checklist has license item on it. Personnel files to be reviewed annually by administrator. Completion date June 14, 2012	
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 record review and interview the facility staff failed to ensure the criminal history check for compensated employees whose duties provide access to controlled substances within the abortion facility were performed for 2 of 2 facility	T 070		

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T 070	Continued From Page 5 staff. The Findings Include: On May 30, 2012 at 2 P.M. the personnel files of the licensed personnel who have access to controlled substances were reviewed with the Administrator present. The Administrator and the primary physician's personnel files did not contain criminal history checks performed by the Virginia State Police pursuant to § 32.1-126.02 of the Code of Virginia. The Administrator stated, "I sent off for my criminal record check but signed my name in the wrong place so I had to resubmit it. (Name of Physician) is in our other office."	T 070	T 070 Criminal background checks have been obtained for administrator and physician. Personnel policy and orientation checklist indicate need for criminal background check for personnel who have access to controlled substances. Administrator is responsible for ensuring that the criminal background check is obtained. Completion date June 22, 2012	
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 interviews the facility staff failed to ensure it developed, implemented and maintained policies and procedures to document the facility staff participated in initial and ongoing training and education which included infection control training. The Findings Include: On May 30, 2012 the personnel files were	T 080		

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T 080	Continued From Page 6 reviewed for 4 of 4 staff personnel who provide care and services to the patients of the facility and for 1 of 1 security personnel. There was no documentation of training on infection control. In 3 of the 5 personnel files there was no training documented of any kind. On May 30, 2012 at 2:30 P.M. the Administrator was interviewed and stated, "I do not have any documentation for training other than what is in their (the facility staff) personnel folders. I do not have any policies on training or education other than what is in their (the facility staff) job descriptions."	T 080	T 080 Training on infection control and fire safety is to be conducted initially and annually. This has been added to the orientation checklist and to the personnel policy. Documentation of In service training will be included in each staff member's personnel file as well as a manual dedicated to training documents. The Inservice Training manual will be reviewed annually. Personnel files will be reviewed annually of completeness. Administrator will be responsible for coordinating training and documentation. Completion date July 12, 2012	
T 085	12 VAC 5-412-170 F Personnel F. Job descriptions. 1. Written job descriptions that adequately describe the duties of every position shall be maintained. 2. Each job description shall include: position title, authority, specific responsibilities and minimum qualifications. 3. Job descriptions shall be reviewed at least annually, kept current and given to each employee and volunteer when assigned to the position and when revised. This RULE: is not met as evidenced by: Based on document review and interviews the facility staff failed to have written job descriptions that adequately described the duties, specific responsibilities and minimum qualifications of each position and failed to show how each employee was provided a copy of the job description. The Findings Include:	T 085		

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T 085	Continued From Page 7 On May 30, 2012 at 2:00 P.M. a review of the personnel files was performed with the facility Administrator on 5 of 5 personnel files. Two (2) of the files did not contain job descriptions and 5 of the 5 did not contain evidence that the staff member was aware of their responsibilities. The Administrator stated, "We need to work on that."	T 085	T 085 Job descriptions have been added to personnel files. Job descriptions have been revised to include a place for the staff member to sign and date to indicate that she is aware of the responsibilities of her position. Job descriptions will be reviewed at least annually. The personnel policy includes procedure for reviewing job descriptions at least annually. Personnel files will be reviewed annually by the administrator for completeness. Completion date June 20, 2012	
T 090	12 VAC 5-412-170 G Personnel G. A personnel file shall be maintained for each staff member. The records shall be completely and accurately documented, readily available, and systematically organized to facilitate the compilation and retrieval of information. The file shall contain a current job description that reflects the individual's responsibilities and work assignments, and documentation of the person's in-service education, and professional licensure, if applicable. This RULE: Is not met as evidenced by: Based on document review and interviews the facility staff failed to have written job descriptions that adequately described the duties, specific responsibilities and minimum qualifications of each position and failed to show how each employee was provided a copy of the job description. The Findings Include: On May 30, 2012 at 2:00 P.M. a review of the personnel files was performed with the facility Administrator on 5 of 5 personnel files. Two (2) of the files did not contain job descriptions and 5 of the 5 did not contain evidence that the staff	T 090	T 090 Job descriptions have been provided to each staff member and signed and dated to indicate her awareness of responsibilities. Personnel policy and orientation checklist include job descriptions in them. Personnel files are to be reviewed annually for completeness. Job descriptions are to be reviewed annually. Administrator is responsible. Completion date June 20, 2012	

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T 090	Continued From Page 8 member was aware of their responsibilities. The Administrator stated, "We need to work on that."	T 090		
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 interviews the facility staff failed to ensure personnel policies and procedures included written job descriptions, process for verifying current professional licensing or certification, process for annually evaluation employee performance and competency and a process for reporting licensed and certified health care practitioners for violations of their licensing and certification standards. The Findings Include: On May 30 and 31, 2012 at various times the	T 095		

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T 095	Continued From Page 9 facility policies and procedures were reviewed with the Administrator and a facility consultant. Both facility employees stated their policies and procedures for personnel did not include written job descriptions, process for verifying current professional licensing or certification, process for annually evaluation employee performance and competency and a process for reporting licensed and certified health care practitioners for violations of their licensing and certification standards. The facility Administrator stated, "We will need to work on those."	T 095	T 095 Personnel policy includes job description, process for verifying licensure, process for annual performance evaluation, and process for reporting licensed health care practitioners for violations of their licensing and certification standards. Completion date June 20 2012	
T 105	12 VAC 5-412-180 A Clinical staff 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. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure the privileges of the physician were clearly defined for 1 of 1 physicians. The Findings include: On May 30, 2012 the credential file for 1 of 1 physicians was reviewed. The file did not contain in delineation of privileges or appointment by the governing body. The Administrator stated, "We will get that."	T 105	T 105 Granting of privileges document has been obtained. June 15, 2012	
T 110	12 VAC 5-412-180 B Clinical staff B. Abortions shall be performed by physicians	T 110		

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T 110	Continued From Page 10 who are licensed to practice medicine in Virginia and who are qualified by training and experience to perform abortions. The facility shall develop, implement and maintain policies and procedures to ensure and document that abortions that occur in the facility are only performed by physicians who are qualified by training and experience. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure there were policies that ensure abortions are only performed by physicians who are qualified by training and experience. The Findings Include: On May 30 and 31, 2012 the policies and procedures were reviewed with the Administrator and a facility consultant. There was no evidence of policies and procedures indicating what experience and training was required of a physician to practice at the facility. The Administrator stated, "We will need to get that."	T 110	T 110 Physician competency policy is in place. Administrator is responsible for reviewing policy manual annually. Completion date June 15, 2012	
T 130	12 VAC 5-412-200 Minors No person may perform an abortion upon an unemancipated minor unless informed written consent is obtained from the minor and the minor's parent, guardian or other authorized person. If the emancipated minor elects not to seek the informed written consent of an authorized person, a copy of the court order authorizing the abortion entered pursuant to 16.1-241 of the Code of Virginia shall be obtained prior to the performance of the abortion.	T 130		

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T 130	Continued From Page 11 This RULE: is not met as evidenced by: Based on the review of the facility's policies and interview there was no policy regarding services and/or care for a minor that was not emancipated. The findings include: 1. On May 30, 2012 the facility policies were reviewed between 2:00 PM and 5:00 PM in the Administrator's office. There was no policy regarding services and/or care for a minor that was not emancipated. The Administrator acknowledged that there was no policy regarding services and/or care for a minor that was not emancipated. 2. On May 31, 2012 between 9:30 am and 10:30 am a second interview was conducted with the Administrator and the facilities nurse consultant in the Administrator's office. Both acknowledged that there was no policy regarding services and/or care for a minor that was not emancipated.	T 130	T 130 Policy on minors is in place. Policy and procedures manual is to be reviewed by administrator annually. Completion date June 22, 2012.	
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,	T 165		

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T 165	Continued From Page 12 implementation and maintenance of infection prevention policies and procedures and the regulations or guidance documents on which they are based shall be documented. 2. All infection prevention policies and procedures shall be reviewed at least annually by the administrator and appropriate members of the clinical staff. The annual review process and recommendations for changes/updates shall be documented in writing. 3. A designated person in the facility shall have received training in basic infection prevention, and shall also be involved in the annual review. This RULE: is not met as evidenced by: Based on interview and review of the infection control manual the facility failed to have an appointment of an individual trained in basic infection prevention and who is involved in the annual review of the infection control program. The findings include: 1. On May 30, 2012 the agency's laboratory policy/procedure manual was reviewed in the Administrator's office between 3:00 PM and 5:00 PM. The manual contained the agency's infection control policy content. The infection control content failed to identify a designated person in the facility who has received basic training in infection prevention and who shall also be involved in the annual review. 2. On May 31, 2012 an interview was conducted with the Administrator between 9:30 am and 12:00 PM in the facility. The Administrator acknowledged that no one has received basic training in infection prevention and who also is involved in the annual infection prevention review.	T 165	T 165 The physician is currently the designated person with basic training in infection control. The infection control plan is to be reviewed at least annually. Completion date July 12, 2012	

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T 170	Continued From Page 13	T 170		
T 170	12 VAC 5-412-220 B Infection prevention B. Written infection prevention policies and procedures shall include, but not be limited to: 1. Procedures for screening incoming patients and visitors for acute infectious illnesses and applying appropriate measures to prevent transmission of community acquired infection within the facility; 2. Training of all personnel in proper infection prevention techniques; 3. Correct hand-washing technique, including indications for use of soap and water and use of alcohol-based hand rubs; 4. Use of standard precautions; 5. Compliance with blood-boume 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 interview and the review of the agency's polices the facility failed to provide infection prevention training & policies for: A. Procedures for the screening of incoming patients and visitors for acute infectious illnesses, applying appropriate measures to prevent transmission of community acquired infection within the facility; monitoring staff adherence to recommended infection prevention practices and documenting annual retraining of all staff in recommended infection prevention practices.	T 170		

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T 170	Continued From Page 14 B. Training of all personnel in the proper infection prevention techniques. The findings include: 1. On May 30, 2012 the facility policies were reviewed between 2:00 PM and 5:00 PM in the Administrator's office. The facility's infection prevention policies failed to include: A. Procedures for the screening of incoming patients and visitors for acute infectious illnesses, applying appropriate measures to prevent transmission of community acquired infection within the facility; monitoring staff adherence to recommended infection prevention practices and documenting annual retraining of all staff in recommended infection prevention practices. B. Training of all personnel in the proper infection prevention techniques; correct hand-washing technique, including indications for use of soap and water and/or use of alcohol-based hand rubs; use of standard precautions; compliance with blood-bourne pathogen requirements of the U.S. Occupational Safety & Health Administration; use of personal protective equipment; safe injection practices and plans for annual retraining of all personnel in infection prevention methods. 2. On May 30, 2012 an interview was conducted with the Administrator between 3:00 PM and 5:00 PM in the agency. The Administrator acknowledged that the facility failed to provide the employee's with infection prevention training & policies.	T 170	T 170 Procedure for screening patients and visitors has been written. Policy for monitoring staff adherence to infection prevention practices has been written. Initial and annual training in infection control is included in infection control policy as well as personnel policy and orientation checklist. Infection Control Survey to be conducted quarterly. Results to be submitted to Quality Assurance Committee. Completion date July 12, 2012 Training of all personnel in infection prevention techniques to be conducted initially and annually. Documentation is to be in the Inservice Training Manual as well as each personnel file. Personnel files are to be reviewed annually for completeness. Completion date July 12, 2012	

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T 175	Continued From Page 15	T 175		
T 175	12 VAC 5-412-220 C Infection prevention C. Written policies and procedures for the management of the facility, equipment and supplies shall address the following: 1. Access to hand-washing equipment and adequate supplies (e.g., soap, alcohol-based hand rubs, disposable towels or hot air dryers); 2. Availability of utility sinks, cleaning supplies and other materials for cleaning, disposal, storage and transport of equipment and supplies; 3. Appropriate storage for cleaning agents (e.g., locked cabinets or rooms for chemicals used for cleaning) and product-specific instructions for use of cleaning agents (e.g., dilution, contact time, management of accidental exposures); 4. Procedures for handling, storing and transporting clean linens, clean/sterile supplies and equipment; 5. Procedures for handling/temporary storage/transport of soiled linens; 6. Procedures for handling, storing, processing and transporting regulated medical waste in accordance with applicable regulations; 7. Procedures for the processing of each type of reusable medical equipment between uses on different patients. The procedure shall address: (i) the level of cleaning/disinfection/sterilization to be used for each type of equipment, (ii) the process (e.g., cleaning, chemical disinfection, heat sterilization); and (iii) the method for verifying that the recommended level of disinfection/sterilization has been achieved. The procedure shall reference the manufacturer's recommendations and any applicable state or national infection control guidelines; 8. Procedures for appropriate disposal of non-reusable equipment; 9. Policies and procedures for maintenance/repair of equipment in accordance	T 175		

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T 175	Continued From Page 16 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 the review of the facility's policies and interview there were no policies/procedures for the facility management of : hand hygiene; cleaning, disposal, storage and transport of equipment, linen and supplies; product specific instructions for use of cleaning agents; procedures for handling, storing and transporting of medical waste; policy/procedure for pest control; and other infection prevention procedures necessary to prevent/control transmission of an infectious agent in the facility The findings include: 1. On May 30, 2012 the facility policies were reviewed between 2:00 PM and 5:00 PM in the Administrator's office. There were no policies/procedures for the management of the facility, equipment and supplies for the following: a. Access to hand-washing equipment and adequate supplies (e.g., soap, alcohol-based hand rubs, disposable towels or hot air dryers); b. Availability of utility sinks, cleaning supplies and other materials for cleaning, disposal, storage and transport of equipment and supplies; c. 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,	T 175		

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T 175	Continued From Page 17 management of accidental exposures); d. Procedures for handling, storing and transporting clean linens, clean/sterile supplies and equipment; e. Procedures for handling/temporary storage/transport of soiled linens; f. Procedures for handling, storing, processing and transporting regulated medical waste in accordance with applicable regulations; g. 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; h. Procedures for appropriate disposal of non-reusable equipment; i. Policies and procedures for maintenance/repair of equipment in accordance with manufacturer recommendations; j. Procedures for cleaning of environmental surfaces with appropriate cleaning products; k. An effective pest control program, managed in accordance with local health and environmental regulations; and l. Other infection prevention procedures necessary to prevent/control transmission of an infectious agent in the facility as recommended or required by the department. 2. On May 30, 2012 an interview was conducted with both the facility Administrator and the nurse consultant in the Administrator's office. Both acknowledged that there were no policies for the management of the facility, equipment and	T 175		

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T 175	Continued From Page 18 supplies (refer to #1 (a-l)) 3. On May 31, 2012 between 9:30 am and 10:30 am a second interview was conducted with the Administrator and the facilities nurse consultant in the Administrator's office. Both acknowledged that there was no policy regarding services and/or care for a minor that was not emancipated.	T 175		
T 200	12 VAC 5-412-240 B Medical testing, patient counseling and labor 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. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure they developed, maintained and implemented policies and procedures pertaining to counseling and instructions in a language each patient could understand. The Findings include: On May 30 and 31, 2012 at approximately 11:30 A.M. the facility policies and procedures were reviewed and discussed with the facility Administrator. The facility did not have a policy on providing each patient in a language the patient could understand, information on the procedure or counseling both pre and post abortion. The Administrator stated, "We will get that."	T 200	T 200 Policy and procedure is in place for counseling and for provision of family planning and post-abortion counseling. Completion date July 12, 2012	

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	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(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 210	Continued From Page 19	T 210		
T 210	12 VAC 5-412-240 D Medical testing, patient counseling and labor D. All tissues removed resulting from the abortion procedure shall be examined 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 for further pathologic examination and the patient alerted to the possibility of an ectopic pregnancy, and referred appropriately. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure they had a process and equipment available to have tissue specimens sent to a lab when the physician could not be certain the villi or fetal parts were present. The Findings Include: On May 30, 2012 a comprehensive tour of the facility was performed. There was no evidence of containers being available to transport tissue specimens to a lab for further testing. On May 31, 2012 at approximately 11:30 A.M. the facility physician and Administrator was interviewed. The physician stated, "I check each specimen to make sure villi and or fetal parts are present. When I can't be sure the specimen is sent to the lab. The specimens are transported the day of the procedure to the lab. They are transported in a specimen cup with saline." The Administrator stated, "We don't have any specimen cups. I will order them."	T 210	T 210 Specimen cups had in the past been brought by procedure assistant. That is why administrator did not have specimen cups on hand. Specimen cups are now stocked in the lab at the facility. Completion date July 5, 2012	

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T 275	Continued From Page 20	T 275		
T 275	12 VAC 5-412-280 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, policies and interview the agency staff failed to ensure that medications were not expired, were dated and/or contained within its original container when opened and/or used. The findings include: 1. On May 30, 2012 a facility tour was conducted between 12:30 PM and 2:00 PM in the facility. During the tour the following was identified: a) Tylenol/Codeine Phosphate with 100 tablets in an unopened bottle with expiration dated 04/2012. b) Lidocaine bottle 10 units/ml in a 10 ml bottle opened with no date when the bottle was opened. c) A plastic bottle labeled ultrasound gel but contained thin brown liquid (not gel) in the bottle. 2. On May 30, 2012 between 12:30 PM and 2:00 PM an interview was conducted with the Administrator in the Procedure Room. The Administrator confirmed that the plastic bottle labeled ultra sound gel contained brown Betadine liquid. The Administrator confirmed that an open bottle of Lidocaine failed to be dated once opened. An interview was conducted with the Administrator in the Recovery Room. The Administrator confirmed that the Tylenol/Codeine Phosphate 100 tablets in an unopened bottle had an	T 275	T 275 Tylenol with codeine has been discarded. Lidocaine that had not been marked with the opening date has been discarded. Plastic bottle with betadine has been discarded. 4 oz bottles of betadine have been purchased. Policies indicate that any opened items must have the date and initials of person who opened item. When setting up for procedures, items are to be checked and any item not properly labeled is to be discarded. Expiration log is to be completed monthly. Completion date July 12, 2012	

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T 275	Continued From Page 21 expiration dated 04/2012. 3. On May 30, 2012 between 3:00 PM to 5:00 PM the facility policies were reviewed in the Administrator's office. There were no policies to ensure that medications are not expired, out dated and/or contained within the original container.	T 275		
T 285	12 VAC 5-412-260 E Administration, storage and dispensing of dru E. Records of all drugs in Schedules I-V received, sold, administered, dispensed or otherwise disposed of shall be maintained in accordance with federal and state laws, to include the inventory and reporting requirements of a theft or loss of drugs found in 54.1-3404 of the Drug Control Act of the Code of Virginia. This RULE: is not met as evidenced by: Based on the facility tour, review of the facility's policies and interview the facility failed to have a medication dispensing policy. The findings include: 1. On May 30, 2012 a facility tour was conducted between 12:30 PM and 1:30 PM in the facility. There was a locked medication box within a locked cabinet in the Recovery Room. There was medication present. The medication was not being documented when/who it was dispensed. 2. On May 30, 2012 the facility policies were reviewed between 1:30 PM and 5:00 PM in the Administrator's office. There was no medication dispensing policy. 2. On May 30, 2012 between 2:00 PM to 5:00 PM	T 285	T 285 Policies dealing with medication are being written. Policy on multi-use vials is complete. Logs of medication dispensed are being kept. Completion date July 12, 2012	

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T 285	Continued From Page 22 the agency's Administrator was interviewed in the Administrator's office. The Administrator acknowledged that there was no mediation dispensing policy. 3. On May 31, 2012 between 9:30 am and 10:30 am a second interview was conducted with the Administrator and the facilities nurse consultant in the Administrator's office. Both acknowledged that there was no medication dispensing policy.	T 285		
T 290	12 VAC 5-412-270 Equipment and supplies An abortion facility shall maintain medical equipment and supplies appropriate and adequate to care for patients based on the level, scope and intensity of services provided, to include: 1. A bed or recliner suitable for recovery; 2. Oxygen with flow meters and masks or equivalent; 3. Mechanical suction; 4. Resuscitation equipment to include; as a minimum, resuscitation bags and oral airways; 5. Emergency medications, intravenous fluids, and related supplies and equipment; 6. Sterile suturing equipment and supplies; 7. Adjustable examination light; 8. Containers for soiled linen and waste materials with covers; and 9. Refrigerator. This RULE: Is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure the necessary medical equipment and supplies were available to care for patients. The Findings Include:	T 290		

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T 290	Continued From Page 23 On May 30, 2012 at approximately 3:30 P.M. during the comprehensive tour of the facility with the Administrator and facility consultant there was no evidence of oxygen being available should a patient require oxygen. Also during the tour the emergency cart was checked with the facility consultant. The cart did not contain any IV (intravenous) tubing to connect IV fluids to the needles for administration in the event of an emergency. The Administrator stated, "We will have the tubing tomorrow. I did not think we needed oxygen."	T 290	T 290 IV tubing has been stocked. Oxygen has been stocked. Log for checking supplies has been written. Completion date July 12, 2012	
T 300	12 VAC 5-412-290 A Emergency services A. An abortion facility shall provide ongoing urgent or emergent care and maintain on the premises adequate monitoring equipment, suction apparatus, oxygen and related items for resuscitation and control of hemorrhage and other complications. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure the necessary medical equipment and supplies were available to care for patients in the event of an emergency. The Findings Include: On May 30, 2012 during the comprehensive tour of the facility with the Administrator and facility consultant there was no evidence of oxygen being available should a patient require oxygen and no evidence of suction other than the suction used in a procedure. On May 30, 2012 the emergency cart was checked with the facility consultant. The cart did not contain any IV (intravenous) tubing to connect IV fluids to the needles for administration	T 300	T 300 Oxygen has been stocked. Gomco suction for airway has been obtained. IV tubing has been stocked. Completion date July 12, 2012	

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T 300	Continued From Page 24 in the event of an emergency. The Administrator stated, "We will have the tubing tomorrow. I did not think we needed oxygen."	T 300		
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 document review and interview the facility staff failed to have a quality assurance program that will evaluate the following aspects: Staffing patterns and performance; supervision appropriate to the level of service; patient records; patient satisfaction; complaint resolution; infections, complications and other adverse events; and staff concerns regarding patient care. The findings include: 1. On May 30, 2012 between 1:00 PM to 5:00 PM the agency's policies were reviewed in the Administrator's office. The facility failed to have a quality assurance policy that will evaluate the following aspects: Staffing patterns and performance; supervision appropriate to the level of service; patient records; patient satisfaction;	T 320	T 320 Quality Assurance policy is in place. Policy manual to be reviewed annually by administrator Completion date June 29, 2012	

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T 320	Continued From Page 25 complaint resolution; infections, complications and other adverse events; and staff concerns regarding patient care. 2. On May 33, 2012 between 3:00 PM and 5:00 PM an interview was conducted with the Administrator and the facilities nurse consultant in the Administrator's office. Both acknowledged that there was there was no QA policy or program that will evaluate the above concerns.	T 320		
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 observation, interview and policies/procedures of the facility the 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 and to use cleaning products that kill organisms between patient use of exam table. The findings include: 1. On May 30, 2012 between 12:30 PM and 1:30	T 360		

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T 360	Continued From Page 26 PM a facility tour was conducted. During the tour a sharps container was noted in the Procedure Room on the floor and in the Recovery Room on top of the nurses desk. Both containers were not secure to any surface and had an open area 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: "Disposal opening-the disposal opening should prevent spills of the contents. Security may be a concern in some areas of facilities, the facility should consider selecting containers with guards to prevent hands or fingers from entering the containers. Stability-containers should be stable when place in a horizontal surface." During the facility tour there were Clorox wipes noted in the Ultrasound and Procedure Rooms. The Administrator stated that the Clorox wipes were used to clean the exam table surface between patients. A request was made for the Material Safety Data Sheet (MSDS) sheet to review for what organisms the the wipes kill. 2. On May 30, 2012 between 12:30 PM and 1:30 PM an interview was conducted with the Administrator during the facility tour. The Administrator acknowledged that the sharps container in the Procedure and Recovery Rooms were easily accessible through the unsecured opening on top of the containers. 3. On May 31, 2012 between 10:00 AM and 11:00 AM the cleaning of the exam table between patient's use were observed being wipe down with the use of Clorox wipes between patient use. 4. On May 31, 2012 between 9:30 AM and 11:00 AM an interview was conducted with the Administrator in the facility. The Administrator	T 360	T 360 Sharps containers which are wall mounted and have the mail slot type opening have been installed. A rack for the procedure room sharps container has been set up to make the container stable. Clorox wipes have been replaced with wipes indicated for medical setting. MSDS sheet in the MSDS manual. Completion date July 5, 2012	

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T 360	Continued From Page 27 stated that the facility failed to have the MSDS form for the Clorox wipes.	T 360		
T 380	12 VAC 5-412-360 B Maintenance B. When patient monitoring equipment is utilized, a written preventative maintenance program shall be developed and implemented. This equipment shall be checked and/or tested in accordance with manufacturer's specifications at periodic intervals, no less than annually, to ensure proper operation and a state of good repair. After repairs and/or alterations are made to any equipment, the equipment shall be thoroughly tested for proper operation before it is returned to service. Records shall be maintained on each piece of equipment to indicate its history of testing and maintenance. This RULE: is not met as evidenced by: Based on observations, review of facility policies and interview the facility staff failed to maintain a preventative maintenance program at least annually on all equipment. Specifically no preventative and or safety checks were documented for two (2) exam lights, one (1) lab. refrigerator, one (1) centrifuge and one (1) suction machine. The findings include: 1. On May 30, 2012 a facility tour was conducted between 12:30 PM and 2:00 PM. The preventive maintenance failed to be documented at least annually for safety on the following: two (2) exam lights, one (1) lab refrigerator, one (1) centrifuge and one (1) suction machine. 2. On May 30, 2012 the facility policies were reviewed between 2:00 PM and 5:00 PM in the	T 380	T 380 Preventive maintenance has been done exam light, refrigerator, centrifuge and suction machine. Preventive maintenance manual to be kept up to date by the administrator. Preventive maintenance visits to be scheduled annually. Completion date July 12, 2012	

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PENINSULA MEDICAL CENTER FOR WOMEN	10768 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 380	Continued From Page 28 Administrator's office. There was no preventive maintenance policy. 3. On May 30, 2012 during the facility tour the Administrator was interviewed between 12:30 PM and 2:00 PM. The Administrator acknowledged there was no evidence of preventive maintenance safety checks on the following: two (2) exam lights, one (1) lab refrigerator, one (1) centrifuge and one (1) suction machine.	T 380		
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 observations, document review and	T 400		

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T 400	Continued From Page 29 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. The Findings Include: An initial tour of the facility was conducted with the Administrator and facility consultant on May 30, 2012 beginning at about 1:00 P.M. During the tour it was noted that the facility had no provision for a separate collection, storage or disposal of soiled materials, 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, had no evidence of maintenance or performance testing on the facility's suction equipment stored in the attic, doorways where not grade level and were not 5 foot wide, hallway was less than 5 feet in areas where patients would have access, failed to have sinks that could be used without hands, 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 Administrator stated during the tour that the facility had contacted a firm who would assist the facility in complying with the regulations.	T 400		

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527-4503

To: Kathaleen Creegan-Fedeschi

From: Jill Ahlberg (804) 539-9599-cell
Peninsula Medical Center for Women

Re: Plan of Correction

Date: July 9, 2012

I spoke with Debbie this morning who requested I tweak the plan of correction -

Please find it attached

Thank you

re-sent
8.6.12

COMMONWEALTH of VIRGINIA

Karen Remley, MD, MBA, FAAP
State Health Commissioner

Department of Health
P O BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

June 11, 2012

Certified Mail Delivery

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Monica Hunter, R.N., Administrator
Peninsula Medical Center for Women
10758 A Jefferson Avenue
Newport News, Virginia 23601

Dear Ms. Hunter:

RE: Peninsula Medical Center for Women – Newport News, Virginia
Abortion Facility Initial Licensure Survey

An announced Initial Abortion Facility Licensure survey of the above agency was completed on May 31, 2012 by a Medical Facilities Inspector team from the Virginia Department of Health's Office of Licensure and Certification (OLC).

Enclosed is the Licensure Inspection Report. This document contains a listing of deficiencies found at the time of this inspection.

You are required to file a plan for correcting these deficiencies. Your statements shall reflect the specific detailed actions you will take to correct deficiencies, prevent a recurrence of the deficiencies, and measures implemented to maintain compliance. You must also give the expected completion date of each deficiency.

Completion of corrective actions shall not exceed 30 working days from the last day of the inspection (due June 30, 2012) except for those corrective actions for deficiencies cited under 12VAC5-412-380 of the Regulations for the Licensure of Abortion Facilities, for which corrective action must be completed within two years of the issuance of the license.

After signing and dating your Plan of Correction, retain one copy of the report for your files and return the original to OLC within **15 working days** of receipt of this inspection report. Please provide written documentation of the corrective actions taken by your agency for each of the deficiencies cited on the enclosed Licensure Inspection Report.

A copy of the completed form "Licensure Inspection Report" will be kept on file in this office and will be available for public review. OLC is required to make copies of this report available to other Federal and State regulatory or reimbursement agencies upon request.

Should you have any questions, please feel free to call Kathaleen Creegan-Tedeschi, Supervisor, Acute Care Licensing, Office of Licensure and Certification, at (804) 367-2156.

Sincerely,

Karen Remley, M.D., M.B.A., F.A.A.P.
State Health Commissioner

c: Erik Bodin, Director
Office of Licensure and Certification

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	15758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	12 VAC 5-412 Initial comments An announced Initial Licensure Abortion Facility Inspection was conducted at the above referenced facility on May 30 and 31 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 015	12 VAC 5-412-140 B Organization and management B. There shall be disclosure of facility ownership. Ownership interest shall be reported to the OLC and in the case of corporations, all individuals or entities holding 5.0% or more of total ownership shall be identified by name and address. The OLC shall be notified of any changes in ownership. This RULE: is not met as evidenced by: Based on interviews and document reviews the facility failed to provide discloser of the ownership of the facility. The Findings Include: During the days of the survey (May 30 and 31, 2012) the facility Administrator was asked to provide names of the individuals who owned the facility. The Administrator stated on May 31, 2012 at approximately 10:30 A.M. "I don't have the information you are requesting."	T 015	RECEIVED JUN 06 2012 VDH/OLC T 015 Attached is the Corporate and Board Members including the sole stockholder for Governing Authority. Completion Date June 15, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M Hunter, RN — TITLE: Administrator — (X5) DATE: 7-2-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

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PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 035	Continued From Page 1	T 035		
T 035	12 VAC 5-412-160 Policy and procedure manual. Each abortion facility shall develop, implement and maintain an appropriate policy and procedures manual. The manual shall be reviewed annually and updated as necessary by the licensee. The manual shall include provisions covering at a minimum, the following topics: 1. Personnel; 2. Types of elective and emergency procedures that may be performed in the facility; 3. Types of anesthesia that may be used; 4. Admissions and discharges, including criteria for evaluating the patient before admission and before discharge; 5. Obtaining written informed consent of the patient prior to the initiation of any procedures; 6. When to use ultrasound to determine gestational age and when indicated to assess patient risk; 7. Infection prevention; 8. Risk and quality management; 9. Management and effective response to medical and/or surgical emergency; 10. Management and effective response to fire; 11. Ensuring compliance with all applicable federal, state and local laws; 12. Facility security; 13. Disaster preparedness; 14. Patient rights; 15. Functional safety and facility maintenance; and 16. Identification of the person to whom responsibility for operation and maintenance of the facility is delegated and methods established by the licensee for holding such individual responsible and accountable. These policies and procedures shall be based on recognized standards and guidelines.	T 035		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	19758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(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 035	Continued From Page 2	T 035		

This RULE: is not met as evidenced by:
Based on interview and review of the facility policies the facility failed to have policy/procedures for: Personnel, types of elective and emergency procedures that may be performed in the facility; admissions and discharges; when to use ultrasound to determine gestational age and when indicated to assess patient risk; infection prevention; risk and quality management; management and effective response to medical and/or surgical emergency;management and effective response to fire; ensuring compliance with all applicable federal, state and local laws; disaster preparedness and identification of the person to whom responsibility for operation and maintenance of the facility is delegated and methods established by the licensee for holding such individual responsible and accountable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10736 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(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 035	Continued From Page 3 The findings include: 1. On May 30, 2012 between 2:00 P.M. to 5:00 P.M. the agency's policies were reviewed in the Administrator's office. On May 31, 2012 between 9:30 P.M. to 12:00 P.M. the agency's policies were reviewed in the Administrator's office. The policies and procedures shall be based on recognized standards and guidelines. The facility failed to have policy and procedures to cover the following: Personnel, types of elective and emergency procedures that may be performed in the facility; admissions and discharges; when to use ultrasound to determine gestational age and when indicated to assess patient risk; infection prevention; risk and quality management; management and effective response to medical and/or surgical emergency;management and effective response to fire; ensuring compliance with all applicable federal, state and local laws; disaster preparedness and identification of the person to whom responsibility for operation and maintenance of the facility is delegated and methods established by the licensee for holding such individual responsible and accountable. 2. On May 30, 2012 between 2:00 P.M. to 5:00 P.M. the agency's Administrator was interviewed in the Administrator's office. The Administrator acknowledged and agreed that that the the facility failed to have the above named policy/procedures. 3. On May 31, 2012 between 9:30 A.M. and 10:30 A.M. a second interview was conducted with the Administrator in the Administrator's office. The Administrator re- confirmed that there were missing policies and procedures as listed in section #1.	T 035	T 035 Policies are in place: Personnel; admissions and discharges; ultrasound; infection prevention; Quality Assurance; management and effective response to fire; ensuring compliance with all federal, state and local laws; disaster preparedness; identification of person to whom responsibility is delegated and methods established for holding individual responsible and accountable; types of elective and emergency procedures that may be performed. To be written for: management and effective response to medical and/or surgical emergency. Policy and procedures manual is to be reviewed annually by administrator. Completion date July 12, 2012	

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	FTAF-062	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	19798 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 065	Continued From Page 4	T 065		
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 professional licensure, if applicable, and the health and personal background of each staff member. This RULE: is not met as evidenced by: Based on document review and interviews the facility failed to ensure licensure checks were performed on all licensed individuals for 1 of 2 licensed staff. The Findings Include: On 5/30/12 at 2 P.M. the credential file for the primary physician was reviewed. The file did not contain a verification of the Virginia medical license for this physician from the Department of Health Professions. The Administrator stated, "I can get that but I don't have it now."	T 065	T 065 The medical license for the physician has been downloaded from the Board of Medicine website. Personnel policy includes the need for license from online lookup. Orientation checklist has license item on it. Personnel files to be reviewed annually by administrator. Completion date June 14, 2012	
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 record review and interview the facility staff failed to ensure the criminal history check for compensated employees whose duties provide access to controlled substances within the abortion facility were performed for 2 of 2 facility	T 070		

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	FTAF-062	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	1575B A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 070	Continued From Page 5 staff. The Findings Include: On May 30, 2012 at 2 P.M. the personnel files of the licensed personnel who have access to controlled substances were reviewed with the Administrator present. The Administrator and the primary physician's personnel files did not contain criminal history checks performed by the Virginia State Police pursuant to § 32.1-126.02 of the Code of Virginia. The Administrator stated, "I sent off for my criminal record check but signed my name in the wrong place so I had to resubmit it. (Name of Physician) is in our other office."	T 070	T 070 Criminal background checks have been obtained for administrator and physician. Personnel policy and orientation checklist indicate need for criminal background check for personnel who have access to controlled substances. Administrator is responsible for ensuring that the criminal background check is obtained. Completion date June 22, 2012	
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 interviews the facility staff failed to ensure it developed, implemented and maintained policies and procedures to document the facility staff participated in initial and ongoing training and education which included infection control training. The Findings Include: On May 30, 2012 the personnel files were	T 080		

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T 080	Continued From Page 6 reviewed for 4 of 4 staff personnel who provide care and services to the patients of the facility and for 1 of 1 security personnel. There was no documentation of training on infection control. In 3 of the 5 personnel files there was no training documented of any kind. On May 30, 2012 at 2:30 P.M. the Administrator was interviewed and stated, "I do not have any documentation for training other than what is in their (the facility staff) personnel folders. I do not have any policies on training or education other than what is in their (the facility staff) job descriptions."	T 080	T 080 Training on infection control and fire safety is to be conducted initially and annually. This has been added to the orientation checklist and to the personnel policy. Documentation of In service training will be included in each staff member's personnel file as well as a manual dedicated to training documents. The Inservice Training manual will be reviewed annually. Personnel files will be reviewed annually of completeness. Administrator will be responsible for coordinating training and documentation. Completion date July 12, 2012	
T 085	12 VAC 5-412-170 F Personnel F. Job descriptions. 1. Written job descriptions that adequately describe the duties of every position shall be maintained. 2. Each job description shall include: position title, authority, specific responsibilities and minimum qualifications. 3. Job descriptions shall be reviewed at least annually, kept current and given to each employee and volunteer when assigned to the position and when revised. This RULE: is not met as evidenced by: Based on document review and interviews the facility staff failed to have written job descriptions that adequately described the duties, specific responsibilities and minimum qualifications of each position and failed to show how each employee was provided a copy of the job description. The Findings Include:	T 085		

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PENINSULA MEDICAL CENTER FOR WOMEN	19768 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 085	Continued From Page 7 On May 30, 2012 at 2:00 P.M. a review of the personnel files was performed with the facility Administrator on 5 of 5 personnel files. Two (2) of the files did not contain job descriptions and 5 of the 5 did not contain evidence that the staff member was aware of their responsibilities. The Administrator stated, "We need to work on that."	T 085	T 085 Job descriptions have been added to personnel files. Job descriptions have been revised to include a place for the staff member to sign and date to indicate that she is aware of the responsibilities of her position. Job descriptions will be reviewed at least annually. The personnel policy includes procedure for reviewing job descriptions at least annually. Personnel files will be reviewed annually by the administrator for completeness. Completion date June 20, 2012	
T 090	12 VAC 5-412-170 G Personnel G. A personnel file shall be maintained for each staff member. The records shall be completely and accurately documented, readily available, and systematically organized to facilitate the compilation and retrieval of information. The file shall contain a current job description that reflects the individual's responsibilities and work assignments, and documentation of the person's in-service education, and professional licensure, if applicable. This RULE: Is not met as evidenced by: Based on document review and interviews the facility staff failed to have written job descriptions that adequately described the duties, specific responsibilities and minimum qualifications of each position and failed to show how each employee was provided a copy of the job description. The Findings include: On May 30, 2012 at 2:00 P.M. a review of the personnel files was performed with the facility Administrator on 5 of 5 personnel files. Two (2) of the files did not contain job descriptions and 5 of the 5 did not contain evidence that the staff	T 090	T 090 Job descriptions have been provided to each staff member and signed and dated to indicate her awareness of responsibilities. Personnel policy and orientation checklist include job descriptions in them. Personnel files are to be reviewed annually for completeness. Job descriptions are to be reviewed annually. Administrator is responsible. Completion date June 20, 2012	

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T 090	Continued From Page 8 member was aware of their responsibilities. The Administrator stated, "We need to work on that."	T 090		
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 interviews the facility staff failed to ensure personnel policies and procedures included written job descriptions, process for verifying current professional licensing or certification, process for annually evaluation employee performance and competency and a process for reporting licensed and certified health care practitioners for violations of their licensing and certification standards. The Findings Include: On May 30 and 31, 2012 at various times the	T 095		

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	FTAF-802	A. BUILDING _____ B. WING _____	05/31/2012

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T 095	Continued From Page 9 facility policies and procedures were reviewed with the Administrator and a facility consultant. Both facility employees stated their policies and procedures for personnel did not include written job descriptions, process for verifying current professional licensing or certification, process for annually evaluation employee performance and competency and a process for reporting licensed and certified health care practitioners for violations of their licensing and certification standards. The facility Administrator stated, "We will need to work on those."	T 095	T 095 Personnel policy includes job description, process for verifying licensure, process for annual performance evaluation, and process for reporting licensed health care practitioners for violations of their licensing and certification standards. Completion date June 20 2012 Administrator is responsible for carrying out policy	
T 105	12 VAC 5-412-180 A Clinical staff 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. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure the privileges of the physician were clearly defined for 1 of 1 physicians. The Findings include: On May 30, 2012 the credential file for 1 of 1 physicians was reviewed. The file did not contain in delineation of privileges or appointment by the governing body. The Administrator stated, "We will get that."	T 105	T 105 Granting of privileges document has been obtained. June 15, 2012	
T 110	12 VAC 5-412-180 B Clinical staff B. Abortions shall be performed by physicians	T 110		

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T 110	Continued From Page 10 who are licensed to practice medicine in Virginia and who are qualified by training and experience to perform abortions. The facility shall develop, implement and maintain policies and procedures to ensure and document that abortions that occur in the facility are only performed by physicians who are qualified by training and experience. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure there were policies that ensure abortions are only performed by physicians who are qualified by training and experience. The Findings Include: On May 30 and 31, 2012 the policies and procedures were reviewed with the Administrator and a facility consultant. There was no evidence of policies and procedures indicating what experience and training was required of a physician to practice at the facility. The Administrator stated, "We will need to get that."	T 110	T 110 Physician competency policy is in place. Administrator is responsible for reviewing policy manual annually. Completion date June 15, 2012	
T 130	12 VAC 5-412-200 Minors No person may perform an abortion upon an unemancipated minor unless informed written consent is obtained from the minor and the minor's parent, guardian or other authorized person. If the emancipated minor elects not to seek the informed written consent of an authorized person, a copy of the court order authorizing the abortion entered pursuant to 16.1-241 of the Code of Virginia shall be obtained prior to the performance of the abortion.	T 130		

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	FTAF-082	A. BUILDING _____ B. WING _____	05/31/2012

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PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 130	Continued From Page 11 This RULE: is not met as evidenced by: Based on the review of the facility's policies and interview there was no policy regarding services and/or care for a minor that was not emancipated. The findings include: 1. On May 30, 2012 the facility policies were reviewed between 2:00 PM and 5:00 PM in the Administrator's office. There was no policy regarding services and/or care for a minor that was not emancipated. The Administrator acknowledged that there was no policy regarding services and/or care for a minor that was not emancipated. 2. On May 31, 2012 between 9:30 am and 10:30 am a second interview was conducted with the Administrator and the facilities nurse consultant in the Administrator's office. Both acknowledged that there was no policy regarding services and/or care for a minor that was not emancipated.	T 130	T 130 Policy on minors is in place. Policy and procedures manual is to be reviewed by administrator annually. Completion date June 22, 2012.	
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,	T 165		

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	FTAF-802	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	16798 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 165	Continued From Page 12 implementation and maintenance of infection prevention policies and procedures and the regulations or guidance documents on which they are based shall be documented. 2. All infection prevention policies and procedures shall be reviewed at least annually by the administrator and appropriate members of the clinical staff. The annual review process and recommendations for changes/updates shall be documented in writing. 3. A designated person in the facility shall have received training in basic infection prevention, and shall also be involved in the annual review. This RULE is not met as evidenced by: Based on interview and review of the infection control manual the facility failed to have an appointment of an individual trained in basic infection prevention and who is involved in the annual review of the infection control program. The findings include: 1. On May 30, 2012 the agency's laboratory policy/procedure manual was reviewed in the Administrator's office between 3:00 PM and 5:00 PM. The manual contained the agency's infection control policy content. The infection control content failed to identify a designated person in the facility who has received basic training in infection prevention and who shall also be involved in the annual review. 2. On May 31, 2012 an interview was conducted with the Administrator between 9:30 am and 12:00 PM in the facility. The Administrator acknowledged that no one has received basic training in infection prevention and who also is involved in the annual infection prevention review.	T 165	T 165 The physician is currently the designated person with basic training in infection control. The infection control plan is to be reviewed at least annually. Completion date July 12, 2012	

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T 170	Continued From Page 13	T 170		
T 170	12 VAC 5-412-220 B Infection prevention B. Written infection prevention policies and procedures shall include, but not be limited to: 1. Procedures for screening incoming patients and visitors for acute infectious illnesses and applying appropriate measures to prevent transmission of community acquired infection within the facility; 2. Training of all personnel in proper infection prevention techniques; 3. Correct hand-washing technique, including indications for use of soap and water and use of alcohol-based hand rubs; 4. Use of standard precautions; 5. Compliance with blood-bourne pathogen requirements of the U.S. Occupational Safety & Health Administration. 6. Use of personal protective equipment; 7. Use of safe injection practices; 8. Plans for annual retraining of all personnel in infection prevention methods; 9. Procedures for monitoring staff adherence to recommended infection prevention practices; and 10. Procedures for documenting annual retraining of all staff in recommended infection prevention practices. This RULE is not met as evidenced by: Based on interview and the review of the agency's polices the facility failed to provide infection prevention training & policies for: A. Procedures for the screening of incoming patients and visitors for acute infectious illnesses, applying appropriate measures to prevent transmission of community acquired infection within the facility; monitoring staff adherence to recommended infection prevention practices and documenting annual retraining of all staff in recommended infection prevention practices.	T 170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(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 170	Continued From Page 14 B. Training of all personnel in the proper infection prevention techniques. The findings include: 1. On May 30, 2012 the facility policies were reviewed between 2:00 PM and 5:00 PM in the Administrator's office. The facility's infection prevention policies failed to include: A. Procedures for the screening of incoming patients and visitors for acute infectious illnesses, applying appropriate measures to prevent transmission of community acquired infection within the facility; monitoring staff adherence to recommended infection prevention practices and documenting annual retraining of all staff in recommended infection prevention practices. B. Training of all personnel in the proper infection prevention techniques; correct hand-washing technique, including indications for use of soap and water and/or use of alcohol-based hand rubs; use of standard precautions; compliance with blood-bourne pathogen requirements of the U.S. Occupational Safety & Health Administration; use of personal protective equipment; safe injection practices and plans for annual retraining of all personnel in infection prevention methods. 2. On May 30, 2012 an interview was conducted with the Administrator between 3:00 PM and 5:00 PM in the agency. The Administrator acknowledged that the facility failed to provide the employee's with infection prevention training & policies.	T 170	T 170 Procedure for screening patients and visitors has been written. Policy for monitoring staff adherence to infection prevention practices has been written. Initial and annual training in infection control is included in infection control policy as well as personnel policy and orientation checklist. Infection Control Survey to be conducted quarterly. Results to be submitted to Quality Assurance Committee. Completion date July 12, 2012 Training of all personnel in infection prevention techniques to be conducted initially and annually. Documentation is to be in the Inservice Training Manual as well as each personnel file. Personnel files are to be reviewed annually for completeness. Completion date July 12, 2012	

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	FTAF-002	A. BUILDING _____ B. WING _____	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 175	Continued From Page 15	T 175		
T 175	12 VAC 5-412-220 C Infection prevention C. Written policies and procedures for the management of the facility, equipment and supplies shall address the following: 1. Access to hand-washing equipment and adequate supplies (e.g., soap, alcohol-based hand rubs, disposable towels or hot air dryers); 2. Availability of utility sinks, cleaning supplies and other materials for cleaning, disposal, storage and transport of equipment and supplies; 3. Appropriate storage for cleaning agents (e.g., locked cabinets or rooms for chemicals used for cleaning) and product-specific instructions for use of cleaning agents (e.g., dilution, contact time, management of accidental exposures); 4. Procedures for handling, storing and transporting clean linens, clean/sterile supplies and equipment; 5. Procedures for handling/temporary storage/transport of soiled linens; 6. Procedures for handling, storing, processing and transporting regulated medical waste in accordance with applicable regulations; 7. Procedures for the processing of each type of reusable medical equipment between uses on different patients. The procedure shall address: (i) the level of cleaning/disinfection/sterilization to be used for each type of equipment, (ii) the process (e.g., cleaning, chemical disinfection, heat sterilization); and (iii) the method for verifying that the recommended level of disinfection/sterilization has been achieved. The procedure shall reference the manufacturer's recommendations and any applicable state or national infection control guidelines; 8. Procedures for appropriate disposal of non-reusable equipment; 9. Policies and procedures for maintenance/repair of equipment in accordance	T 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-062	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10798 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 175	Continued From Page 16 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 the review of the facility's policies and interview there were no policies/procedures for the facility management of : hand hygiene; cleaning, disposal, storage and transport of equipment, linen and supplies; product specific instructions for use of cleaning agents; procedures for handling, storing and transporting of medical waste; policy/procedure for pest control; and other infection prevention procedures necessary to prevent/control transmission of an infectious agent in the facility The findings include: 1. On May 30, 2012 the facility policies were reviewed between 2:00 PM and 5:00 PM in the Administrator's office. There were no policies/procedures for the management of the facility, equipment and supplies for the following: a. Access to hand-washing equipment and adequate supplies (e.g., soap, alcohol-based hand rubs, disposable towels or hot air dryers); b. Availability of utility sinks, cleaning supplies and other materials for cleaning, disposal, storage and transport of equipment and supplies; c. 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,	T 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	15758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 176	Continued From Page 17 management of accidental exposures); d. Procedures for handling, storing and transporting clean linens, clean/sterile supplies and equipment; e. Procedures for handling/temporary storage/transport of soiled linens; f. Procedures for handling, storing, processing and transporting regulated medical waste in accordance with applicable regulations; g. 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; h. Procedures for appropriate disposal of non-reusable equipment; i. Policies and procedures for maintenance/repair of equipment in accordance with manufacturer recommendations; j. Procedures for cleaning of environmental surfaces with appropriate cleaning products; k. An effective pest control program, managed in accordance with local health and environmental regulations; and l. Other infection prevention procedures necessary to prevent/control transmission of an infectious agent in the facility as recommended or required by the department. 2. On May 30, 2012 an interview was conducted with both the facility Administrator and the nurse consultant in the Administrator's office. Both acknowledged that there were no policies for the management of the facility, equipment and	T 176		

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T 175	Continued From Page 18 supplies (refer to #1 (a-l)) 3. On May 31, 2012 between 9:30 am and 10:30 am a second interview was conducted with the Administrator and the facilities nurse consultant in the Administrator's office. Both acknowledged that there was no policy regarding services and/or care for a minor that was not emancipated.	T 175		
T 200	12 VAC 5-412-240 B Medical testing, patient counseling and labor 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. This RULE is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure they developed, maintained and implemented policies and procedures pertaining to counseling and instructions in a language each patient could understand. The Findings include: On May 30 and 31, 2012 at approximately 11:30 A.M. the facility policies and procedures were reviewed and discussed with the facility Administrator. The facility did not have a policy on providing each patient in a language the patient could understand, information on the procedure or counseling both pre and post abortion. The Administrator stated, "We will get that."	T 200	T 200 Policy and procedure is in place for counseling and for provision of family planning and post-abortion counseling. Completion date July 12, 2012 Administrator is responsible for supervising counseling	

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PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 210	Continued From Page 19	T 210		
T 210	12 VAC 5-412-240 D Medical testing, patient counseling and labor D. All tissues removed resulting from the abortion procedure shall be examined 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 for further pathologic examination and the patient alerted to the possibility of an ectopic pregnancy, and referred appropriately. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure they had a process and equipment available to have tissue specimens sent to a lab when the physician could not be certain the villi or fetal parts were present. The Findings Include: On May 30, 2012 a comprehensive tour of the facility was performed. There was no evidence of containers being available to transport tissue specimens to a lab for further testing. On May 31, 2012 at approximately 11:30 A.M. the facility physician and Administrator was interviewed. The physician stated, "I check each specimen to make sure villi and or fetal parts are present. When I can't be sure the specimen is sent to the lab. The specimens are transported the day of the procedure to the lab. They are transported in a specimen cup with saline." The Administrator stated, "We don't have any specimen cups. I will order them."	T 210	T 210 Specimen cups had in the past been brought by procedure assistant. That is why administrator did not have specimen cups on hand. Specimen cups are now stocked in the lab at the facility. Completion date July 5, 2012	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	19768 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 275	Continued From Page 20	T 275		
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, policies and interview the agency staff failed to ensure that medications were not expired, were dated and/or contained within its original container when opened and/or used. The findings include: 1. On May 30, 2012 a facility tour was conducted between 12:30 PM and 2:00 PM in the facility. During the tour the following was identified: a) Tylenol/Codeine Phosphate with 100 tablets in an unopened bottle with expiration dated 04/2012. b) Lidocaine bottle 10 units/ml in a 10 ml bottle opened with no date when the bottle was opened. c) A plastic bottle labeled ultrasound gel but contained thin brown liquid (not gel) in the bottle. 2. On May 30, 2012 between 12:30 PM and 2:00 PM an interview was conducted with the Administrator in the Procedure Room. The Administrator confirmed that the plastic bottle labeled ultra sound gel contained brown Betadine liquid. The Administrator confirmed that an open bottle of Lidocaine failed to be dated once opened. An interview was conducted with the Administrator in the Recovery Room. The Administrator confirmed that the Tylenol/Codeine Phosphate 100 tablets in an unopened bottle had an	T 275	T 275 Tylenol with codeine has been discarded. Lidocaine that had not been marked with the opening date has been discarded. Plastic bottle with betadine has been discarded. 4 oz bottles of betadine have been purchased. Policies indicate that any opened items must have the date and initials of person who opened item. When setting up for procedures, items are to be checked and any item not properly labeled is to be discarded. Expiration log is to be completed monthly. Completion date July 12, 2012	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	19758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 275	Continued From Page 21 expiration dated 04/2012. 3. On May 30, 2012 between 3:00 PM to 5:00 PM the facility policies were reviewed in the Administrator's office. There were no policies to ensure that medications are not expired, out dated and/or contained within the original container.	T 275		
T 285	12 VAC 5-412-280 E Administration, storage and dispensing of dru E. Records of all drugs in Schedules I-V received, sold, administered, dispensed or otherwise disposed of shall be maintained in accordance with federal and state laws, to include the inventory and reporting requirements of a theft or loss of drugs found in 54.1-3404 of the Drug Control Act of the Code of Virginia. This RULE: is not met as evidenced by: Based on the facility tour, review of the facility's policies and interview the facility failed to have a medication dispensing policy. The findings include: 1. On May 30, 2012 a facility tour was conducted between 12:30 PM and 1:30 PM in the facility. There was a locked medication box within a locked cabinet in the Recovery Room. There was medication present. The medication was not being documented when/who it was dispensed. 2. On May 30, 2012 the facility policies were reviewed between 1:30 PM and 5:00 PM in the Administrator's office. There was no medication dispensing policy. 2. On May 30, 2012 between 2:00 PM to 5:00 PM	T 285	T 285 Policies dealing with medication are being written. Policy on multi-use vials is complete. Logs of medication dispensed are being kept. Completion date July 12, 2012 Administrator is responsible for supervising	

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PENINSULA MEDICAL CENTER FOR WOMEN	10768 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 285	Continued From Page 22 the agency's Administrator was interviewed in the Administrator's office. The Administrator acknowledged that there was no mediation dispensing policy. 3. On May 31, 2012 between 9:30 am and 10:30 am a second interview was conducted with the Administrator and the facilities nurse consultant in the Administrator's office. Both acknowledged that there was no medication dispensing policy.	T 285		
T 290	12 VAC 5-412-270 Equipment and supplies An abortion facility shall maintain medical equipment and supplies appropriate and adequate to care for patients based on the level, scope and intensity of services provided, to include: 1. A bed or recliner suitable for recovery; 2. Oxygen with flow meters and masks or equivalent; 3. Mechanical suction; 4. Resuscitation equipment to include; as a minimum, resuscitation bags and oral airways; 5. Emergency medications, intravenous fluids, and related supplies and equipment; 6. Sterile suturing equipment and supplies; 7. Adjustable examination light; 8. Containers for soiled linen and waste materials with covers; and 9. Refrigerator. This RULE is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure the necessary medical equipment and supplies were available to care for patients. The Findings Include:	T 290		

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T 290	Continued From Page 23 On May 30, 2012 at approximately 3:30 P.M. during the comprehensive tour of the facility with the Administrator and facility consultant there was no evidence of oxygen being available should a patient require oxygen. Also during the tour the emergency cart was checked with the facility consultant. The cart did not contain any IV (intravenous) tubing to connect IV fluids to the needles for administration in the event of an emergency. The Administrator stated, "We will have the tubing tomorrow. I did not think we needed oxygen."	T 290	T 290 IV tubing has been stocked. Oxygen has been stocked. Log for checking supplies has been written. Completion date July 12, 2012	
T 300	12 VAC 5-412-290 A Emergency services A. An abortion facility shall provide ongoing urgent or emergent care and maintain on the premises adequate monitoring equipment, suction apparatus, oxygen and related items for resuscitation and control of hemorrhage and other complications. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure the necessary medical equipment and supplies were available to care for patients in the event of an emergency. The Findings Include: On May 30, 2012 during the comprehensive tour of the facility with the Administrator and facility consultant there was no evidence of oxygen being available should a patient require oxygen and no evidence of suction other than the suction used in a procedure. On May 30, 2012 the emergency cart was checked with the facility consultant. The cart did not contain any IV (intravenous) tubing to connect IV fluids to the needles for administration	T 300	T 300 Oxygen has been stocked. Gomco suction for airway has been obtained. IV tubing has been stocked. Completion date July 12, 2012	

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PENINSULA MEDICAL CENTER FOR WOMEN	15758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 300	Continued From Page 24 In the event of an emergency. The Administrator stated, "We will have the tubing tomorrow. I did not think we needed oxygen."	T 300		
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 document review and interview the facility staff failed to have a quality assurance program that will evaluate the following aspects: Staffing patterns and performance; supervision appropriate to the level of service; patient records; patient satisfaction; complaint resolution; infections, complications and other adverse events; and staff concerns regarding patient care. The findings include: 1. On May 30, 2012 between 1:00 PM to 5:00 PM the agency's policies were reviewed in the Administrator's office. The facility failed to have a quality assurance policy that will evaluate the following aspects: Staffing patterns and performance; supervision appropriate to the level of service; patient records; patient satisfaction;	T 320	T 320 Quality Assurance policy is in place. Policy manual to be reviewed annually. Completion date June 29, 2012 by administrator	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10736 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 320	Continued From Page 25 complaint resolution; infections, complications and other adverse events; and staff concerns regarding patient care. 2. On May 33, 2012 between 3:00 PM and 5:00 PM an interview was conducted with the Administrator and the facilities nurse consultant in the Administrator's office. Both acknowledged that there was there was no QA policy or program that will evaluate the above concerns.	T 320		
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 observation, interview and policies/procedures of the facility the 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 and to use cleaning products that kill organisms between patient use of exam table. The findings include: 1. On May 30, 2012 between 12:30 PM and 1:30	T 360		

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	FTAF-062	A. BUILDING _____ B. WING _____	05/31/2012

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PENINSULA MEDICAL CENTER FOR WOMEN	10756 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 360	Continued From Page 26 PM a facility tour was conducted. During the tour a sharps container was noted in the Procedure Room on the floor and in the Recovery Room on top of the nurses desk. Both containers were not secure to any surface and had an open area 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: "Disposal opening-the disposal opening should prevent spills of the contents. Security may be a concern in some areas of facilities, the facility should consider selecting containers with guards to prevent hands or fingers from entering the containers. Stability-containers should be stable when place in a horizontal surface." During the facility tour there were Clorox wipes noted in the Ultrasound and Procedure Rooms. The Administrator stated that the Clorox wipes were used to clean the exam table surface between patients. A request was made for the Material Safety Data Sheet (MSDS) sheet to review for what organisms the the wipes kill. 2. On May 30, 2012 between 12:30 PM and 1:30 PM an interview was conducted with the Administrator during the facility tour. The Administrator acknowledged that the sharps container in the Procedure and Recovery Rooms were easily accessible through the unsecured opening on top of the containers. 3. On May 31, 2012 between 10:00 AM and 11:00 AM the cleaning of the exam table between patient's use were observed being wipe down with the use of Clorox wipes between patient use. 4. On May 31, 2012 between 9:30 AM and 11:00 AM an interview was conducted with the Administrator in the facility. The Administrator	T 360	T 360 Sharps containers which are wall mounted and have the mail slot type opening have been installed. A rack for the procedure room sharps container has been set up to make the container stable. Clorox wipes have been replaced with wipes indicated for medical setting. MSDS sheet in the MSDS manual. Completion date July 5, 2012	

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	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 380	Continued From Page 27 stated that the facility failed to have the MSDS form for the Clorox wipes. T 380 12 VAC 5-412-360 B Maintenance B. When patient monitoring equipment is utilized, a written preventative maintenance program shall be developed and implemented. This equipment shall be checked and/or tested in accordance with manufacturer's specifications at periodic intervals, no less than annually, to ensure proper operation and a state of good repair. After repairs and/or alterations are made to any equipment, the equipment shall be thoroughly tested for proper operation before it is returned to service. Records shall be maintained on each piece of equipment to indicate its history of testing and maintenance. This RULE is not met as evidenced by: Based on observations, review of facility policies and interview the facility staff failed to maintain a preventative maintenance program at least annually on all equipment. Specifically no preventative and or safety checks were documented for two (2) exam lights, one (1) lab refrigerator, one (1) centrifuge and one (1) suction machine. The findings include: 1. On May 30, 2012 a facility tour was conducted between 12:30 PM and 2:00 PM. The preventive maintenance failed to be documented at least annually for safety on the following: two (2) exam lights, one (1) lab refrigerator, one (1) centrifuge and one (1) suction machine. 2. On May 30, 2012 the facility policies were reviewed between 2:00 PM and 5:00 PM in the	T 380 T 380	T 380 Preventive maintenance has been done exam light, refrigerator, centrifuge and suction machine. Preventive maintenance manual to be kept up to date by the administrator. Preventive maintenance visits to be scheduled annually. Completion date July 12, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	16796 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 380	Continued From Page 28 Administrator's office. There was no preventive maintenance policy. 3. On May 30, 2012 during the facility tour the Administrator was interviewed between 12:30 PM and 2:00 PM. The Administrator acknowledged there was no evidence of preventive maintenance safety checks on the following: two (2) exam lights, one (1) lab refrigerator, one (1) centrifuge and one (1) suction machine.	T 380		
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 observations, document review and	T 400		

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T 400	Continued From Page 29 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 9.1 and 9.7 of FGI (Facilities Guidelines Institute 2010 Guidelines for Design and Construction of Health Care Facilities) as required. The Findings Include: An initial tour of the facility was conducted with the Administrator and facility consultant on May 30, 2012 beginning at about 1:00 P.M. During the tour it was noted that the facility had no provision for a separate collection, storage or disposal of soiled materials, 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, had no evidence of maintenance or performance testing on the facility's suction equipment stored in the attic, doorways where not grade level and were not 5 foot wide, hallway was less than 5 feet in areas where patients would have access, failed to have sinks that could be used without hands, could not provide evidence of airflow filters being of at least 30 % efficiency rating, no ventilation in non-sensitive and patient areas, 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 Administrator stated during the tour that the facility had contacted a firm who would assist the facility in complying with the regulations.	T 400	T 400 See attached	

Richmond Medical Center for Women
359- 5066- phone
353- 2718- fax

From: Jill Abbey

TO: Kathaleen Creegan- Tedeschi

fax: 804- 527- 4503-

I spoke with Brenda this morning who requested some changes to my Plan of Correction.

Thank you.

sent
7-9-12

re-sent
8-6-12

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

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T 000	12 VAC 5- 412 Initial comments An announced Initial Licensure First Trimester Abortion Facility inspection was conducted at the above referenced facility on May 15, 2012 through May 16, 2012 by three (3) Medical Facilities Inspectors from the Virginia Department of Health's, Office of Licensure and Certification. The facility was out of compliance with the State Board of Health 12 VAC 5-412, Regulations for First Trimester Abortion Facility's effective December 29, 2011. Deficiencies were identified, cited, and will follow in this report.	T 000		
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 employee record review, center document review, and staff interview, the center staff failed to ensure a criminal record check was obtained for 8 of 10 employees who provided access to controlled substances. Employee #'s 3, 7, 8, 11, 15, 16, 20, and 21. On 5/15/12 at 1:00 p.m., employee records were reviewed. Ten records were included for employees who provided access to controlled substances within the center. For 8 (eight) of the 10 (ten) records, no criminal background check was found. The center policy and procedure "Personnel Policies" was reviewed and evidenced the following, in part: "Criminal history checks will be conducted for staff with access to controlled	T 070	T070 Criminal background checks will be obtained for all employees whose job duties provide access to controlled substances. An item will be added to the orientation checklist for every employee whose job duties provide access to controlled substances that a criminal background has to be obtained. Personnel policy revised to include need for criminal background checks. Job descriptions for those staff will also include need for a criminal background check. Personnel files will be reviewed for completeness on an annual basis. The administrator is responsible for ensuring that the criminal background check is obtained as well as being responsible for reviewing job descriptions and files. Completion date June 28, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	7-9-12

State of Virginia

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T 070	Continued From Page 1 substances." On 5/16/12 at 9:30 a.m., Staff #2 was interviewed regarding the criminal record checks being completed for the 8 employees. Staff #2 stated the criminal background checks had not been done. No further information was provided by the end of the survey.	T 070		
T 075	12 VAC 5-412-170 D Personnel D. When abortions are being performed, a staff member currently certified to perform cardio-pulmonary resuscitation shall be available on site for emergency care. This RULE: Is not met as evidenced by: Based on employee record review and staff interview, the center staff failed to ensure cardiopulmonary resuscitation certification (CPR) training was received and documented for 7 of 10 licensed/certified employees. Employee #'s 3, 5, 7, 8, 15, 16, and #20. No evidence of CPR training/recertification was present in the employee records. The findings included: On 5/15/12 at 1:00 p.m., employee records were reviewed. Of the 10 (ten) licensed/certified employee records, 7 (seven) did not have evidence of CPR training/recertification. Employees # 5, 7, 8 and 16 were Certified Registered Nurse Anesthetists, #3 was a Nurse Practitioner, and # 15 and 20 were Registered Nurses. In an interview with Staff #2 on 5/16/12 at 12:00 p.m., he/she stated he/she knew each of the employees held current CPR certifications, however acknowledged the evidence of certification was not present in the employee records.	T 075	T 075 CPR documentation obtained for Certified Registered Nurse Anesthetist and Registered Nurses. CPR training will be added to the orientation list. CPR training will be added to the Personnel Policy. Personnel files will be reviewed for completeness annually. Job descriptions will also include need for CPR training. Administrator is responsible for ensuring certification is up to date. Completion date: June 21, 2012	

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	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	116 N. BOULEVARD RICHMOND, VA 23220

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T 080	Continued From Page 2	T 080	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 employee record review, center document review, and staff interview, the center failed to ensure 16 of 24 employees participated in annual infection control training. Employee #'s 2, 3, 4, 5, 7, 8, 9, 11, 12, 14, 15, 16, 19, 20, 21, and 23. The findings included: Employee records were reviewed on 5/15/12 at 1:00 p.m. There was no evidence of annual infection control training for 16 employees. On 5/16/12 at 9:30 a.m., Staff #2 stated the employees had not received annual infection control training. "Most all of our employees have been here a long time and I guess we just became complacent ..." No further information was provided by the end of the survey.	T 080	Fire Safety and Infection Prevention In-Service Training will be conducted initially and annually for staff. This has been added to the orientation checklist. This has been added to Personnel Policy. Documentation of in-service training will be included in each staff member's personnel file as well as a manual dedicated to training documents. The Inservice Training manual will be reviewed annually. Personnel files will be reviewed annually for completeness. Administrator will ultimately be responsible but will assign Infection Control Officer (the Nurse Practitioner) the duty of coordinating training and documentation. Completion date June 28, 2012	
T 085	12 VAC 5-412-170 F Personnel F. Job descriptions. 1. Written job descriptions that adequately describe the duties of every position shall be maintained. 2. Each job description shall include: position title, authority, specific responsibilities and minimum qualifications.	T 085	T 085 Job descriptions will be included in every employee's personnel file. She will sign the job description to indicate that she is aware of the responsibilities of her position. Job descriptions will be reviewed at least annually with new copies given to the employee in the event of revisions. The personnel policy will include procedure for	

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T 085	Continued From Page 3 3. Job descriptions shall be reviewed at least annually, kept current and given to each employee and volunteer when assigned to the position and when revised. This RULE: is not met as evidenced by: Based on employee record review and staff interview, the center staff failed to ensure job descriptions for employees were reviewed at least annually for 19 of 24 employee records reviewed. Employee #'s 1 through 9, 11, 12, 15, 16, 18 through 21, #23 and #24. The findings included: On 5/15/12 at 1:00 p.m., employee records were reviewed. Of the 24 records reviewed, 19 employees did not have evidence the job description was reviewed at least annually in their personnel record. The employees were as follows: Employee #1 - date of hire (DOH) 10/91, #2 - DOH 1/2008, #3 - DOH 9/2010, #4 - DOH 12/2009, #5 - DOH 8/2010, #6 - DOH 8/2006, #7 - DOH 1992 (no month listed), #8 - DOH 9/2008, #9 - DOH 1978 (no month listed), #11 - DOH 12/2010, #12 - DOH 4/2008, #15 - DOH 4/2011, #16 - DOH 5/2006, #18 - DOH 1992 (no month listed), #19 - DOH 12/2000, #20 - DOH 7/2008, #21 - DOH 1993 (no month listed), #23 - DOH 1/2006, and #24 - DOH 1999 (no month listed). On 5/16/12 at 12:00 p.m., Staff #2 was informed of the findings. No further evidence was provided by the end of the survey.	T 085	T085 cont'd reviewing job descriptions at least annually. Personnel files will be reviewed for completeness annually. Job descriptions will be revised to include the date that the employee received the job description. Administrator is responsible for ensuring job descriptions are provided and employee is aware of her responsibilities. Administrator is responsible for ensuring that job description is reviewed annually. Completion date June 28, 2012	
T 090	12 VAC 5-412-170 G Personnel G. A personnel file shall be maintained for each staff member. The records shall be completely and accurately documented, readily available, and systematically organized to facilitate the	T 090		

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T 090	Continued From Page 4 compilation and retrieval of information. The file shall contain a current job description that reflects the individual's responsibilities and work assignments, and documentation of the person's in-service education, and professional licensure, if applicable. This RULE: is not met as evidenced by: Based on employee record review and staff interview, the center staff failed to ensure all employee records contained a current job description for 6 of 24 employee records reviewed. Employee #'s 2, 3, 4, 11, 15, and #20. No job description was present in the employee records when reviewed. The findings included: On 5/15/12 at 1:00 p.m., employee records were reviewed. Of the 24 records reviewed, 6 employees did not have a job description contained in their personnel record: Employee #2 (Housekeeping), #3 (Nurse Practitioner), #4 (Housekeeping), #11 (Registered Nurse), # 15 (registered Nurse), and #20 (Registered Nurse). On 5/16/12 at 12:00 p.m., Staff #2 was informed of the findings. No further evidence was provided by the end of the survey.	T 090	Job descriptions have been added to the personnel files for those staff who did not have them. Orientation checklist includes job descriptions. Personnel policy includes job descriptions must be in the personnel file for each employee. Personnel files will be reviewed annually to ensure completeness. Administrator is responsible for ensuring job descriptions are in each file and that employees are aware of their responsibilities. Administrator is responsible for annual review of files and job descriptions. Completion date June 18, 2012	T090
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	T 170		

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T 170	Continued From Page 5	T 170		

alcohol-based hand rubs;
4. Use of standard precautions;
5. Compliance with blood-bourne pathogen requirements of the U.S. Occupational Safety & Health Administration.
6. Use of personal protective equipment;
7. Use of safe injection practices;
8. Plans for annual retraining of all personnel in infection prevention methods;
9. Procedures for monitoring staff adherence to recommended infection prevention practices; and
10. Procedures for documenting annual retraining of all staff in recommended infection prevention practices.

This RULE: is not met as evidenced by:
Based on observations, interviews and record review the facility failed to ensure:

1. That staff wore the correct personal protective equipment (PPE) related to risk of exposure to blood and body fluids for one (1) of one staff observed in the "soiled" utility room.

2. The development of a procedure/process to monitor staff's adherence to the facility's infection prevention practices. The development of a process for retraining staff annually to infection prevention practices.

3. That staff had documented infection prevention training for sixteen (16) of twenty-four (24) employee records reviewed. (Employee # ' s 2, 3, 4, 5, 7, 8, 9, 11, 12, 14, 15, 16, 19, 20, 21, and 23)

The findings included:

1. Observations and interview were conducted on May 15, 2012 from 12:10 p.m. through 1:30 p.m. with Staff #5 in the "Soiled" utility room after two

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(2) procedures. Staff #5 wore a blue cloth jacket over his/her scrub attire. When questioned related to the type of PPE needed to work or be in the "Soiled" utility room; Staff #5 stated, "I just wear this jacket over my clothes and gloves." Staff #5 denied the need for a mask, face shield or eye protection. Staff #5 did not wear a face shield or eye protection when cleaning soiled items in the utility room.

The observation revealed Staff #5 retrieved a re-usable glass suction jar from the pass through opening in the wall between the procedure room and the "Soiled" utility room. Staff #5 emptied the liquid contents, blood and other body fluids, from the glass jars into the utility sink. Staff #5 rinsed the jars with tap water and used a bottlebrush to "remove any clotted blood".

Staff #5 poured approximately one-forth (1/4) to one-third (1/3) cup of bleach into the glass bottle and swirled the bleach around the inner bottom of the jar. Staff #5 did not have a face shield or eye protection in place to guard against blood, body fluid or bleach splatter.

Staff # 5 used a bristled brush to remove blood and body tissues from the instruments utilized during the procedure. At the completion of the first of two-soiled equipment cleaning, Staff #5 had wet splatter areas on the front of his/her blue jacket.

A second post procedure cleaning process was observed with Staff #5 in the "Soiled" utility room. Staff #5 followed the same processes. Staff #5 previously confirmed the outside of the glass jar had been rinsed in water only and had not been disinfected prior to placing the jar on the "Clean" utility counter. Staff #5 did not put on gloves prior to placing the stopper into the glass jar and transporting the contaminated glass jar from the "Clean" utility room to the procedure room.

An interview was conducted on May 15, 2012 at 3:15 p.m. with Staff #2. The surveyor informed

Staff member retrained in the proper use of PPE. Documentation of training included in the personnel file. Policy for monitoring infection control compliance written. Infection Control Survey written; to be performed quarterly. Results to be submitted to Quality Assurance Committee.
Completion June 23, 2012

State of Virginia

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RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

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T 170	Continued From Page 7 Staff #2 of the findings from the observation of Staff #5's use of PPE and the handling of soiled equipment. Review of the facility's policy titled "Personal Protective Equipment" effective date January 1, 2012 read "... All staff will receive training on the proper selection of and use of PPE ... Wear mouth, nose, and eye protection during procedures that are likely to generate splashes or sprays of blood or other body fluids ..." 2. The center had no procedure for monitoring staff compliance of infection control procedures and had no documentation of annual retraining for infection control. The Center's "Policies and Procedures" were reviewed on 5/15/12 at 10:00 a.m. There was no policy or procedure regarding how staff would be monitored to ensure they were adhering to infection control practices. 3. Employee records were reviewed on 5/15/12 at 1:00 p.m. There was no evidence of annual infection control training for 16 employees. On 5/16/12 at 9:30 a.m., Staff #2 stated the employees had not received annual infection control training. When interviewed regarding how staff was being monitored to ensure they were following proper infection control practices, Staff #2 stated, "Most all of our employees have been here a long time and I guess we just became complacent ..." Staff #2 stated there was no policy/procedure which addressed the process for monitoring staff. No further information was provided by the end of the survey.	T 170	T 170 Policy for monitoring infection control compliance written. Infection Control Survey tool to be used quarterly to monitor adherence to plan. Results to be reported to Quality Assurance Committee. Infection control training to be done initially and at least annually. This has been added to orientation checklist and personnel policy. Personnel files to be reviewed annually for completeness. Completion date June 28, 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:	T 175		

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1. Access to hand-washing equipment and adequate supplies (e.g., soap, alcohol-based hand rubs, disposable towels or hot air dryers);
2. Availability of utility sinks, cleaning supplies and other materials for cleaning, disposal, storage and transport of equipment and supplies;
3. Appropriate storage for cleaning agents (e.g., locked cabinets or rooms for chemicals used for cleaning) and product-specific instructions for use of cleaning agents (e.g., dilution, contact time, management of accidental exposures);
4. Procedures for handling, storing and transporting clean linens, clean/sterile supplies and equipment;
5. Procedures for handling/temporary storage/transport of soiled linens;
6. Procedures for handling, storing, processing and transporting regulated medical waste in accordance with applicable regulations;
7. Procedures for the processing of each type of reusable medical equipment between uses on different patients. The procedure shall address:
(i) the level of cleaning/disinfection/sterilization to be used for each type of equipment,
(ii) the process (e.g., cleaning, chemical disinfection, heat sterilization); and
(iii) the method for verifying that the recommended level of disinfection/sterilization has been achieved. The procedure shall reference the manufacturer's recommendations and any applicable state or national infection 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

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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, interview and record review the facility failed to ensure the implementation of infection prevention practices as evidenced by:

1. Dried blood was observed on the sling between the seat and footrest on two (2) of three (3) Recovery recliners.

2. Three (3) of three (3) Recovery recliners had torn surfaces and could not be disinfected between patients. Two (2) of two (2) Recovery stretcher pads had multiple torn surfaces and could not be disinfected between patients. The metal finish and armrest pad were not intact and could not be disinfected between patients for one (1) of one (1) Procedure table.

3. The facility staff was not able to determine that linens laundered on-site were processed at the correct water temperature of 160 degrees Fahrenheit.

4. Staff failing to perform hand hygiene between glove changes and the lack of hand hygiene supplies.

5. Chemicals were stored on the shelves with "Clean" supplies; expired supplies were readily availability for access and supplies stored in opened packages.

6. The failure to perform preventative maintenance on equipment utilized in direct

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patient care.
7. Snacks provided for patients were multiple unwrapped items in opened packages, which increased cross-contamination of the food products.
8. The staff's handling of clean and dirty equipment between patients and staff's knowledge of manufacturer's recommendations for cleaning re-usable equipment between patients. Staff re-used sponges for cleaning blood and body fluid spills post procedures.
9. A failure to develop procedures for the processing of each type of reusable medical equipment between uses on different patients, procedures for appropriate disposal of non-reusable equipment, and procedures for cleaning of environmental surfaces with appropriate cleaning products.
The findings included:
1. An observation and interview was conducted with Staff #2 on May 15, 2012 at 10:50 a.m. in the Recovery room. Staff #2 reported the Recovery recliners were cleaned between each patient use. Staff #2 reported the Recovery recliners had not been utilized since the last procedure day (May 5, 2012) and were ready for patients. Staff #2 and the surveyor placed the Recovery recliners in a raised foot position. The observation revealed two (2) of the three (3) Recovery recliners had an area of five (5) inches or greater of dark reddish brown substance on the sling between the seat and the footrest. Staff #2 identified the dark reddish brown substance as dried blood. Staff #2 reported understanding the infection risk related to blood left on the Recovery recliners between patients.
2. An observation and interview was conducted on May 15, 2012 from 10:20 a.m. to 11:18 a.m. with Staff #2. Staff # 2 reported the procedure table was wiped down with a 1:10 bleach/water solution between patients. The observation in the procedure room revealed the procedure table's

T 175

Staff retrained regarding need to disinfect surfaces between each patient use. Job descriptions revised to include disinfecting as a job responsibility.
Infection Control Survey to be conducted quarterly to monitor adherence to infection control practices. Results to be reported to Quality Assurance Committee.
Staff instructed to monitor condition of equipment and advise administrator in the event of a tear or other condition which would hinder disinfection. Job descriptions reflect that responsibility. Administrator to be advised of any condition that requires repair/ replacement of equipment.
Completion date June 28, 2012

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metal finish was not intact. The full length of the bilateral leg supports for the stirrups (used to position the patient during the procedure) had rust. The ledge of the table that surrounded the table's padded surface had multiple areas of rust. The pedestal of the procedure table had multiple areas of rust. The procedure table's armrest had multiple worn and non-intact areas. The non-intact surfaces prevented the disinfection of the procedure table and its armrest between patients. Staff #2 observed the findings and stated, "You're right the surfaces are not intact." Staff #2 verbally acknowledged the non-intact surfaces prevented disinfection of the procedure table between patients.
The observation conducted with Staff #2 in the Recovery room revealed three (3) of three (3) Recovery room recliners did not have intact surfaces. Staff #2 reported the Recovery "recliners are cleaned between each patient use." Two (2) recliners had torn armrest, one (1) recliner had a torn area on the sling between the seat and the footrest, and all three (3) recliners had torn areas on the back of the headrest. Staff #2 verbally acknowledged the non-intact surfaces prevented the disinfection of the Recovery room recliners between patients.
The observation conducted in the Recovery room with Staff #2 revealed that two (2) of two (2) Recovery Room stretcher pads had extensive torn areas with exposure of the inner padding. The observation revealed a zippered area that separated the upper and lower portion of the pads was torn the width of each pad. The torn area left the inner foam padding exposed on both pads. Both stretcher pads had multiple worn areas and non-intact surfaces, which would allow blood or body fluids to be absorbed into the underlying exposed foam. Staff #2 confirmed the pads on the Recovery room stretchers had non-intact surfaces with exposed foam, which prevented

T 175

Procedure table replaced. Staff retrained to monitor equipment routinely and advise administrator of problem areas. Infection control survey to be conducted quarterly. Results to Quality Assurance Committee. Completion date June 26, 2012

T 175

One recliner replaced. Two recliners repaired. Staff trained to monitor equipment routinely and advise administrator of problem areas. Job descriptions reflect responsibility of staff. Infection control survey to be conducted quarterly. Results to be reported to Quality Assurance Committee.
completion date June 18, 2012

T 175

Stretcher pads replaced. Staff trained to monitor equipment routinely and advise administrator of problem areas. Job descriptions reflect staff responsibility of advising administrator of need for repair/ replacement of equipment. Infection control survey to be conducted quarterly and results reported to Quality Assurance Committee.
completion date June 26, 2012

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T 175	Continued From Page 12	T 175	T 175 Washing machine being replaced. Replacement ordered with expected delivery date June 26, 2012. Preventive maintenance to be conducted annually and results to be forwarded to Quality Assurance Committee.	

disinfection of the stretchers pads between patients.
3 An observation was conducted on May 16, 2012 during the initial tour. The observation revealed a standard washer and dryer used by the facility to launder linens.
An interview was conducted on May 16, 2012 at 9:08 a.m. with Staff #2. Staff #2 reported the facility's linens were washed in hot water. Staff #2 was not able to confirm the linens were laundered at the correct water temperature of 160 degrees Fahrenheit. Staff #2 reported the facility had a single hot water heater, which supplied hot water to all areas (utility and hand washing sinks) Staff #2 reported the washer did not have a water temperature booster or separate water heating unit.
4. Observations and interview was conducted on May 15, 2012 from 12:10 p.m. through 1:30 p.m. with Staff #5. Observations were conducted with Staff #5 in the "Soiled" utility room for two (2) procedures. With two (2) surveyors present, Staff #5 washed his/her hands at the utility sink in the "Soiled" utility room and used his/her hand to turn off the water. Staff #5 did not have paper towel available to turn off the water at the sink or to dry his/her hands. Staff #5 with contaminated wet hands entered the "Clean" utility room and tore off paper towel from that roll. Staff #5 with contaminated hands pulled gloves from a box of gloves in the "Clean" utility room. Staff #5 did not wash his/her hands between three glove changes or when changing task between the "Soiled" and "Clean" utility rooms. Staff #5 stated, "This is the way I usually do things I hope I'm doing it right." The surveyor informed Staff #5 that his/her current practices introduced contaminates from the "Soiled" utility room into the "Clean" utility room.
5. An observation and interview conducted during the initial tour of the "Clean" utility and Procedure rooms on May 15, 2012 from 10:09 a.m. to 10:50

T 175
Paper towel dispenser installed in "soiled" utility room. Retraining on proper hand hygiene and glove changing conducted. Infection Control Survey to be conducted quarterly. Report of results to Quality Assurance Commitee.
Completion date June 26, 2012

damaged the boxes.
The observation revealed the following expired supplies were available for use in the procedure room:
Two (2) curettage instruments wrapped in sterilization packs, which did not have dates related to sterilization. [A curettage is a surgical instrument used to scrape or remove the lining of the uterus.];
One (1) 3/15 dilator wrapped in a sterilization pack, which did not have a date of sterilization. [A dilator is a surgical instrument used to dilate (widen) the opening of the cervix.];
Two (2) tracheal tubes (7.0 and 3.0) had expired (exp.) 12/31/1995;
One tracheal tube (5.0) had exp. 06/30/1996;
Four (4) ECG (electro cardiogram) monitoring pads had exp. March 2000;
Five (5) packages of snap electrodes had exp. 06/2007;
One container of Formalin had exp. 11/ 2004 (Formalin is an aqueous solution of the chemical compound formaldehyde used to preserve tissue samples for analysis.);
Six (6) packs of Ethicon 0.5 silk sutures had exp. 01/2009;
One of one containers of glucometer test strips had exp. 05/2007; and
One of one sets of glucometer test/calibration

T 175
Instruments must have the date of sterilization and initials of staff person written on them. When setting up the procedure room each day, staff is to monitor appropriate dating and initialling of packs. Pack is to be rejected if not marked appropriately and re-sterilized. Utility and procedure staff responsible for monitoring daily stocking. Infection Control Survey to be completed quarterly with results to QA comm.
Completion date May 16, 2012

T 175
Expired tracheal tubes discarded. Expired ECG electrodes discarded. Expired Formalin container discarded. Expired ethicon discarded. Expired glucometer test strips discarded.
Expiration dates to be checked monthly and logged. Administrator is responsible for ensuring expiration log completed monthly.
Completion date May 16, 2012

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solutions had exp. 07/2007.
Staff #2 reported facility staff had inspected the Procedure room and had missed the expired supplies. Staff #2 acknowledged the expired supplies were available for use, but should have been discarded by the expiration date.
The following items were stored in a cabinet next to the anesthesia cart. The tracheal tube packages were open, with an inserted guide stylus and left uncovered exposed to contaminates:
Two (2) tracheal tubes (7.0).
Two (2) tracheal tubes (7.5), and
One (8.5) tracheal tube.
Staff #2 reported the nurse anesthetists were aware that the tracheal tubes could not be stored in open packages with the guide stylus in place.
6. Observation on May 15, 2012 during the initial tour revealed the following equipment utilized during direct patient care did not have proof of preventative maintenance per the manufacturer's recommendations:
One of one anesthesia Co 2 (carbon dioxide) absorber;
One of one suction pump used during procedures;
One of one ultrasound devices;
One of two autoclaves; and
One of one glucometer.
Staff #2 acknowledged the findings and was not able to provide proof of preventative maintenance on the above direct care equipment. Staff #2 was not able to provide proof the glucometer was for single or multiple patient use. The facility failed to have an infection prevention process in place related to preventing the spread of hepatitis by glucometers, which have not been thoroughly disinfected.
7. An observation and interview was conducted on May 15, 2012 between 10:50 a.m. and 11:18 a.m. with Staff #2. The observation revealed a plastic container with opened packages of various cookies. The cookies were not individually

T 175
Anesthetists to change to a tracheal tube with an inserted guide stylus packaged with it. This will allow the anesthetists to be prepared but with an unopened package. Administrator is responsible for ensuring proper packaging.
Completion date June 23, 2012

T 175
PM has been performed on suction pump, ultrasound machine, autoclave. CO 2 absorber is filtering system, not electrical. Glucometer removed from service until it can be thoroughly researched whether it may be properly used in this setting.
Completion date June 28, 2012

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wrapped and some cookies were scattered unprotected on the bottom of the container. Staff #2 reported the cookies were used as snacks for patients during their Recovery room wait. Staff #2 acknowledged the cookies were loose inside the plastic container and not protected from contaminates when staff or patients reached into the plastic container.

8. Observations and interview was conducted on May 16, 2012 from 12:10 p.m. through 1:30 p.m. with Staff #5 in the "Soiled" utility room after two (2) procedures. Staff #5 wore a blue cloth jacket over his/her scrub attire. Staff #5 placed three (3) sponges on the ledge of the opening between the procedure room and the "Soiled " utility room. Staff #5 reported the sponges were used to "wipe up after the procedures." Staff #5 reported the same sponges were reused. Staff #5 reported the sponges were rinse in tap water, then dipped in the 1:10 bleach/water solution and placed back on the ledge.

Staff #5 collected the re-usable glass suction jars from the pass through opening in the wall between the procedure room and the "Soiled" utility room. Staff #5 emptied the liquid contents of the glass jars into the utility sink, rinsed the jars with water, used a bottlebrush to "remove any clotted blood", pour approximately one-forth (1/4) to one-third (1/3) cup of bleach into the glass bottle and swirled the bleach around the inner bottom of the jar. Staff #5 used tap water to rinsed the black stopper, utilized with the suction bottle during procedures then placed the stopper in a container with 1:10 bleach/water solution. The stopper was not submersed in the bleach/water solution. Staff #5 did not have a clock in the "Soiled" utility room. When asked regarding the length of time the bleach needed to be in the glass jar or the stopper needed to be in contact with the 1:10 bleach/water solution; Staff #5 stated, "Not long, a couple of minutes." Staff #5 acknowledged the "Soiled"

T 175

Staff is to wear gloves and package several cookies and crackers in individual sized baggies each day prior to seeing patients. Recovery room staff is responsible. Administrator is to monitor that staff is handling snacks appropriately.
Completion date June 14, 2012

T 175

Sponges are not to be used in the facility in patient areas. One time use saniwipes designated for medical facilities will be used. Staff trained on CDC Principles of Cleaning and Disinfecting Environment Surfaces. Documentation of training in personnel file. Infection control survey to be conducted quarterly. Results to be reported to Qual Assurance Committee.
Completion date June 23, 2012

T 175

Stopper and glass bottle to be sprayed with Cavicide and allowed to remain wet for 3 minutes. A clock or timer to be used in soiled utility. Staff trained to procedure. Documentation of training in personnel file. Infection control survey to be conducted quarterly and reported to Qual Assurance Committee. Infection control training to be conducted initially and at least annually. Administrator and Infection Control Officer are responsible for training.
Completion date June 23, 2012

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utility room did not have a clock. Staff #5 did not utilize a wristwatch to time the contact time of the stopper in the 1:10 bleach/water solution. Staff #5 did not turn the stopper to ensure all surfaces of the stopper had contact with the 1:10 bleach/water solution. Staff #5 removed the stopper from the bleach/water solution placed the stopper in a metal bowl for transport to the "Clean" utility room. Staff #5 emptied the bleach from the glass jar, removed one "Soiled" glove to open the door between the "Soiled" and "Clean" utility rooms. Staff #5 holding the jar with the other "Soiled" gloved hand placed the jar on the counter in the "Clean" utility room. Staff #5 did not remove the blue cloth jacket worn in the "Soiled" utility room during the cleaning process before he/she entered the "Clean" utility room. Staff #5 acknowledged the bleach poured into the glass jar did not contact the total inner surface of the jar. Staff #5 confirmed the outside of the glass jar had been rinsed in water only and had not been disinfected prior to placing the jar on the "Clean" utility counter.

The observation revealed after the first procedure was completed Staff #2 from the procedure side of the opening retrieved the sponges from the ledge. Staff #2 used the sponges in the procedure room and returned them to the ledge. The sponges were contaminated with bloody fluids. Staff #5 removed the sponges from the ledge, rinsed them in tap water, and dipped them in the 1:10 bleach/water solution. Staff #5 squeezed the sponges over the utility sink and placed the same sponges back on the ledge. The observation revealed the sponges were dipped into the 1:10 bleach/water solution for less that one (1) minute. Staff #5 was asked about the multiple re-using of the sponges and the amount of time the sponges needed to be in the bleach/water solution. Staff #5 stated, "I try to keep them (the sponges) as long as I can, but the

T 175
Stopper and jar to be placed in a closed container designated for the transport of equipment from soiled utility to clean utility. In the clean utility room the stopper and jar to be placed on the counter until ready to be used in the procedure room. It is then placed in a lidded container designated for transport from clean utility to procedure.
Staff to be trained in process. Documentation to be placed in personnel file. Infection Control Survey to be conducted quarterly. Results to Quality Assurance Committee.
Completion date June 23, 2012

T 175
Sponges not to be used in patient areas. Bloody fluids to be cleaned according to CDC Principles of Cleaning and Disinfecting Environment Surfaces using disposable wipes.
Training to be documented in personnel file.
Infection Control Survey to be conducted quarterly. Results to Quality Assurance Committee.
Completion date June 23, 2012

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bleach makes them (the sponges) disintegrate." Staff #5 was not able to provide the amount of contact time needed to ensure the sponges were disinfected between uses.
A second post procedure process was observed with Staff #5 in the "Soiled" utility room. Staff #5 followed the same processes. The bottlebrush was not disinfected between usages. Staff #5 did not put on gloves prior to placing the stopper into the glass jar and transporting the contaminated glass jar to the procedure room. Staff #5 did not remove the blue jacket he/she wore in the "Soiled" utility room prior to entering the "Clean" utility room or the procedure room.
The observation after the second procedure revealed from the procedure side Staff #2 retrieved the sponges from the ledge. Staff #2 was observed from the opening by the surveyor to wipe down equipment then return the sponges to the ledge contaminated with bloody fluids. Staff #5 removed the sponges from the ledge, rinsed them in tap water, dipped them in the 1:10 bleach/water solution, squeezed the sponges over the utility sink and placed the same sponges back on the ledge. Staff #2 passed soiled suction pump lines through the opening and in the process dripped bloody fluids on the ledge. Staff #5 used one of the sponges to clean the ledge then cleaned the sponge in the above cited manner and replaced the sponge on the ledge for re-used.
An interview was conducted on May 16, 2012 at 3:15 p.m. with Staff #2. Staff #2 reported the purpose of separating the "Clean" and "Soiled" utility rooms was to reduce cross-contamination. The surveyor informed Staff #2 of the findings from the observation of staff handling "Clean" and "Soiled" equipment. The requested documentation was not received prior to exit related to the procedure, the effectiveness or contact time of the 1:10 bleach/water solution as a

T 175
Bottle brush to be sprayed with Cavicide and allowed to remain wet for 3 minutes. Staff will wear gloves prior to placing the disinfected stopper and glass jar in the designated container.
Staff trained to remove PPE prior to leaving soiled utility room. Infection Control Survey to be conducted quarterly and results reported to QA Committee
Completion date June 23, 2012
T 175
Sponges are not to be used. Disposable wipes to be used to disinfect surfaces contaminated with blood and other body fluids. Infection Control Survey to be conducted quarterly with results reported to QA Committee.
Completion date June 23, 2012
T 175
Training on infection control to be conducted initially and at least annually. Infection control policies to be reviewed at least annually. A designated steff member to receive certification in infection control and be available to review procedures and facilitate further staff training. Infection Control Survey to be conducted quarterly with results reported to Quality Assurance Committee.
Completion date June 23, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 18	T 175		

disinfectant for the stopper and glass jar.
Review of the facility's policy titled "Personal Protective Equipment" effective date January 1, 2012 read "...Perform hand hygiene immediately after removing gloves ..."
Review of the facility's policy titled Hand Hygiene" effective date January 1, 2012 read "... Key situations where hand hygiene should be performed include but are not limited to...after glove removal ... Soap and working sinks with hot and cold running water and disposable paper towels will be available near any area involving body fluids ..."
According to the USDA Agriculture Research Service (ARS) newsletter dated February 2008 "...Sponges were soaked in 10% bleach solution for 3 minutes, lemon juice for 1 minute, or pure water for 1 minute, placed in a microwave oven for 1 minute at full power, or placed in a dishwasher for a full wash-dry cycle, or left untreated (control). Microwaving and dishwashing treatments significantly lowered bacterial counts compared to any of the immersion chemical treatments or the control. Counts of yeasts and molds recovered from sponges receiving microwave or dishwashing treatments were significantly lower than those recovered from sponges immersed in chemical treatments."
According to ARS website Best Ways to Clean Kitchen Sponges - April 23, 2007 - News from the USDA Agricultural Research Service.mht read: "...treated each sponge in one of five ways: soaked for three minutes in a 10 percent chlorine bleach solution, soaked in lemon juice or deionized water for one minute, heated in a microwave for one minute, placed in a dishwasher operating with a drying cycle-or left untreated...They found that between 37 and 87 percent of bacteria were killed on sponges soaked in the 10 percent bleach solution, lemon juice or deionized water-and those left untreated. That still

T 175
Sponges not to be used in patient areas.
Infection Control Survey to be conducted quarterly with results reported to Quality Assurance Committee.
Completion date June 21, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATP-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

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T 175	Continued From Page 19 left enough bacteria to potentially cause disease. Microwaving sponges killed 99.99999 percent of bacteria present on them, while dishwashing killed 99.9998 percent of bacteria..." 9. The center staff failed to ensure development of procedures for the processing of each type of reusable medical equipment between uses on different patients, procedures for appropriate disposal of non-reusable equipment, and procedures for cleaning of environmental surfaces with appropriate cleaning products. On 5/15/12 at 10:00 a.m., the center "policy and procedures" were reviewed. The surveyor was unable to locate any procedural processes regarding reusable medical equipment, non-reusable medical equipment, and cleaning procedures. The "Infection Control Plan" identified the following: E. Laundry Procedures - Facility policies and procedures will outline the handling, processing and storage of clean and dirty linen, as well as the use of disposable supplies ..." No corresponding "procedure/outline " was found. On 5/16/12 at 10:15 a.m., Staff #2 was interviewed. He/she stated there were no procedures for the reusable equipment, non-reusable equipment and for the cleaning of environmental surfaces. No further information was provided by the end of the survey.	T 175	T 175 Policy and procedure for processing reusable equipment has been written. Policy manual to be reviewed annually by administrator. Completion date June 22, 2012 T 175 Policy and procedure for handling soiled linen has been written. Policy manual to be reviewed annually by administrator. Completion date June 22, 2012	
T 180	12 VAC 5-412-220 D Infection prevention D. The facility shall have an employee health program that includes: 1. Access to recommended vaccines; 2. Procedures for assuring that employees with communicable diseases are identified and prevented from work activities that could result in transmission to other personnel or patients;	T 180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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T 180	Continued From Page 20	T 180		

3. An exposure control plan for blood-bourne pathogens;
4. Documentation of screening and immunizations offered/received by employees in accordance with statute, regulation or recommendations of public health authorities, including documentation of screening for tuberculosis and access to hepatitis B vaccine;
5. Compliance with requirements of the U.S. Occupational Safety & Health Administration for reporting of workplace-associated injuries or exposure to infection.

This RULE: is not met as evidenced by:
Based on employee record review and staff interview, the center staff failed to ensure documentation of screening for tuberculosis (TB/PPD) for 19 of 24 employee records reviewed. Employee # 1, 2, 3, 4, 7, 8, 9, 11, 12, and 14 through 23.
The findings included:
Employee records were reviewed on 5/16/12 at 1:00 p.m. For 19 of the 24 employee records reviewed, there was no evidence that employees had received TB/PPD screening.
On 5/16/12 at 12:00 p.m., Staff #2 was apprised of the findings and no further information was provided by the end of the survey.

T 180

TB/PPD Screening to be completed for all employees who have not been screened elsewhere in the past year. Personnel files are to be reviewed by administrator for completeness.
Completion date June 28, 2012

T 275 12 VAC 5-412-260 C Administration, storage and dispensing of dru — T 275

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

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	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

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T 275	Continued From Page 21 This RULE: Is not met as evidenced by: Based on observations and staff interviews the facility failed to discard expired medications and medications that had not been dated when opened. The findings included: An observation and interview was conducted on May 15, 2012 from 10:20 a.m. to 11:18 a.m. with Staff #2 during the initial tour of the procedure room. The observation revealed the following medications were expired and available for administration: Diazepam 10 mg (milligram)/ 2 ml (milliliter) syringe had expired (exp.) "2/2012"; Labetalol 20 mg/ 4 ml vial had exp. "4/2012"; Succinylcholine 100 mg/ 5 ml vial had exp. "1 May 12"; One tank of nitrous oxide had exp. "29 Mar (March) 2000." The following medications were not dated when opened: Pitocin 10 u (units)/ ml vial; and One tube of KY jelly. An interview was conducted with Staff #2 on May 15, 2012 from 10:20 a.m. to 11:18 a.m. during the observations. Staff #2 confirmed each finding and reported the expired medication should have been discarded. Staff #2 stated, "It is our practice to date each medication when it's opened. These have to be discarded."	T 275	T 275 Expired medications have been discarded. Expiration log to be completed monthly. Nitrous oxide tank has been removed from facility. All opened medications are to be labeled with the date and the initials of staff who opened them. Any opened medications found not to be properly labeled must be discarded. When setting up each procedure day, all items will be checked for proper labeling. Staff trained to procedure. Documentation of training in personnel files. Administrator is responsible for monitoring expiration dates. Completion date June 28, 2012	
T 360	12 VAC 5-412-340 Policies and procedures The abortion facility shall develop, implement and maintain policies and procedures to ensure	T 360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

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T 360	Continued From Page 22	T 360		

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:
12 VAC 5- 412-340 (2)
Based on observation and interview the facility failed to secure six (6) portable oxygen tanks.

The findings included:

An observation conducted in the building that housed the procedure room on May 15, 2102 at 11:22 a.m. with Staff #2 revealed six (6) unsecured portable oxygen tanks. The oxygen tanks were located between a file cabinet and the wall in an office. Staff #2 reported Staff #1 did not want the the additional oxygen tanks stored in the procedure room. Staff #2 was aware the oxygen tanks needed to be secured.

Review of "Title 29 CFR 1926.350(a)(9) requires employers to store all compressed gas cylinders (including empty ones) upright at all times. This paragraph provides: Compressed gas cylinders shall be secured in an upright position at all times except, if necessary, for short periods of time while cylinders are actually being hoisted or carried. 1926.350(a)(11) Inside of buildings, cylinders shall be stored in a well-protected, well-ventilated, dry location, at least 20 feet (6.1 m) from highly combustible materials such as oil or excelsior. Cylinders should be stored in

Oxygen tanks to be secured in current setting. Administrator is responsible for ensuring that all gas cylinders are kept securely.
Completion date June 28, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

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T 360	Continued From Page 23 definitely assigned places away from elevators, stairs, or gangways. Assigned storage places shall be located where cylinders will not be knocked over or damaged by passing or falling objects, or subject to tampering by unauthorized persons. Cylinders shall not be kept in unventilated enclosures such as lockers and cupboards..."	T 360		
T 375	12 VAC 5-412-360 A Maintenance 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. This RULE: is not met as evidenced by: Based on observation and interview the facility failed to maintain the procedure table, recovery stretcher pads, and recovery recliners in good repair. The findings included: An observation and interview was conducted on May 15, 2012 from 10:20 a.m. to 11:18 a.m. with Staff #2. The observation in the procedure room revealed the procedure table's metal finish was not intact. The full length of the bilateral leg supports for the stirrups (used to position the patient during the procedure) had rust. The ledge of the table that surrounded the table's padded surface had multiple areas of rust. The pedestal of the procedure table had multiple areas of rust. The procedure table's armrest had multiple worn and non-intact areas. Staff #2 verbally	T 375	T 375 Procedure table replaced. Staff trained to routinely monitor equipment for tears and rust and to advise administrator if problems identified. Job descriptions reflect staff responsibility. Administrator ultimately responsible. Completion date June 26, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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T 375	Continued From Page 24 acknowledged the procedure table was in need of re-finishing. The observation conducted with Staff #2 in the Recovery room revealed three (3) of three (3) Recovery room recliners had tears in their surface material. Two (2) recliners had torn armrest, one (1) recliner had a torn area on the sling between the seat and the footrest, and all three (3) recliners had torn areas on the back of the headrest. Staff #2 verbally acknowledged the Recovery room recliners were not in good repair. The observation conducted in the Recovery room with Staff #2 revealed that two (2) of two (2) Recovery Room stretcher pads had extensive torn areas with exposure of the inner padding. The observation revealed a zippered area that separated the upper and lower portion of the pads was torn the width of each pad. The torn area left the inner foam padding exposed on both pads. Both stretcher pads had multiple worn areas and non-intact surfaces, which would allow blood or body fluids to be absorbed into the underlying exposed foam. Staff #2 reported the pads on the Recovery room stretchers needed to be replaced.	T 375	T 375 One recliner has been replaced and 2 have been repaired. Completion date June 18, 2012 Stretcher pads replaced Completion date June 26, 2012 Staff trained to routinely monitor equipment and advise administrator if problems identified. Job descriptions reflect that responsibility. Administrator is ultimately responsible. Completion date June 28, 2012	
T 380	12 VAC 5-412-360 B Maintenance B. When patient monitoring equipment is utilized, a written preventative maintenance program shall be developed and implemented. This equipment shall be checked and/or tested in accordance with manufacturer's specifications at periodic intervals, no less than annually, to ensure proper operation and a state of good repair. After repairs and/or alterations are made to any equipment, the equipment shall be thoroughly tested for proper operation before it is returned to service. Records shall be maintained on each piece of equipment to indicate its history of testing and maintenance.	T 380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-008	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

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T 380	Continued From Page 25	T 380		

This RULE: is not met as evidenced by:
Based on observation, interview and record review the facility failed to develop a process to ensure equipment used in direct patient care underwent preventative maintenance (PM) and failed to document proof of preventative maintenance on required direct patient care equipment.

The findings included:

1. An observation on May 15, 2012 during the initial tour revealed the following equipment utilized during direct patient care did not have proof of preventative maintenance per the manufacturer's recommendations:
One of one anesthesia Co 2 (carbon dioxide) absorber;
One of one suction pump used during procedures;
One of one ultrasound devices;
One of two autoclaves; and
One of one glucometer.
Staff #2 acknowledged the findings and was not able to provide proof of preventative maintenance on the above direct care equipment. Staff #2 was not able to provide proof the glucometer was for single or multiple patient use.
A review of the facility's PM log revealed it did not include documentation for all direct care equipment that needed preventative maintenance. The PM log was reviewed with Staff #2, who reported the log was not up-to-date.

Suction pump, ultrasound machine, autoclave have had PMs performed. CO 2 absorber is a filter, not electrical equipment.. Glucometer has been removed from service until it can be researched for appropriate use in this facility. Administrator is responsible for preventive maintenance program.
Completion date June 28, 2012

T 400 12 VAC 5-412-380 Local and state codes and standards — T 400

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

State of Virginia

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	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

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T 400	Continued From Page 26	T 400		

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 interview and facility tour it was determined the facility failed to have an architect attestation and failed to meet FGI (AIA) Guidelines for Chapters 3.1 and 3.7.

The findings include:

1. On May 15, 2012 a facility tour was conducted with the Administrator and the Medical Director, between 9:00 a.m. and 11:30 a.m. During the facility tour there was no evidence that the facility met the state and local codes and building ordinances.

The facility failed to have an attestation from a licensed Architecture that the facility met the required FGI (AIA) guidelines. There was no over head shelter for Buildings #1 and #2 to protect patients from inclement weather. The Medication Distribution Station was located in the Procedure

Have been consulting architects and mechanical engineers to survey areas that need to be retrofitted to come into compliance. See attached
Completion date December 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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T 400	Continued From Page 27	T 400		

Room, without a sink present for hand hygiene Nourishments were located within the Recovery Room; the staff failed to have documentation of a temperature log for the refrigerator. No temperature control or separate ventilation was seen in the Clean Storage Room. Chemicals were not secured and separated from clean supplies stored in the Clean Storage Room. Soiled Holding failed to have a flushing-rim clinical sink. The facility did not have a wheelchair present or a designated area for wheelchair storage. The facility was not able to provide proof of on-site laundry water temperature (which needs to be at 160 degrees Fahrenheit), prior to exit on 5/16/12 at 12:15 p.m. The facility's Public Corridors failed to meet the minimum 5 feet width. The facility's sinks failed to have valves that could be opened with hands (single handle or wrist blades at least 4 inches in length).

The Administrator was unable to provide documentation that insulation provided: conserve energy, protect personnel, prevent vapor condensation and reduce noise. Insulation have a flame-spread rating of 25 or less and a smoke-developed rating of 50 or less in accordance with NFPA 255. The facility was unable to provide any information for HVAC ductwork.
The facility's electrical receptacle (convenience outlets) were not grounded without use of adapters for three pronged equipment. No manual fire system was available as required.

2. On May 16, 2012 at 12:18 p.m., an interview was conducted with the Administrator in the agency's office. The Administrator acknowledged that the facility was unable to provide evidence that the facility met the state and local codes and building ordinances.

Purell dispenser in the procedure room for hand hygiene for medication preparation area. Completion date May 1, 2012
Temperature log started for refrigerator. June 28. 2012
Mechanical engineer to address ventilation in clean storage room.
Completion date July 30, 2012
Chemicals secured and separated from clean supplies.
Completion date May 17, 2012
Wheelchair purchased and stored in designated area.
Completion date June 28, 2012
New washing machine purchased.
Sink to be replaced with sink with knee operation.
Mechanical engineer and electricians being brought in to address ventilation and electrical concerns
Completion date October 2012
See attached for remainder of timeline.

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JUL 02 2012
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State of Virginia

PRINTED: 06/07/2012
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	18758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	12 VAC 5- 412 Initial comments An announced Initial Licensure Abortion Facility inspection was conducted at the above referenced facility on May 30 and 31 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 015	12 VAC 5-412-140 B Organization and management B. There shall be disclosure of facility ownership. Ownership interest shall be reported to the OLC and in the case of corporations, all individuals or entities holding 5.0% or more of total ownership shall be identified by name and address. The OLC shall be notified of any changes in ownership. This RULE: is not met as evidenced by: Based on interviews and document reviews the facility failed to provide discloser of the ownership of the facility. The Findings Include: During the days of the survey (May 30 and 31, 2012) the facility Administrator was asked to provide names of the individuals who owned the facility. The Administrator stated on May 31, 2012 at approximately 10:30 A.M. "I don't have the information you are requesting."	T 015	T 015 Attached is the Corporate and Board Members including the sole stockholder for Governing Authority. Completion Date June 15, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M Hunter, RN
TITLE: Administrator
(X6) DATE: 7-2-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	19758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 035	Continued From Page 1	T 035		
T 035	12 VAC 5-412-150 Policy and procedure manual. Each abortion facility shall develop, implement and maintain an appropriate policy and procedures manual. The manual shall be reviewed annually and updated as necessary by the licensee. The manual shall include provisions covering at a minimum, the following topics: 1. Personnel; 2. Types of elective and emergency procedures that may be performed in the facility; 3. Types of anesthesia that may be used; 4. Admissions and discharges, including criteria for evaluating the patient before admission and before discharge; 5. Obtaining written informed consent of the patient prior to the initiation of any procedures; 6. When to use ultrasound to determine gestational age and when indicated to assess patient risk; 7. Infection prevention; 8. Risk and quality management; 9. Management and effective response to medical and/or surgical emergency; 10. Management and effective response to fire; 11. Ensuring compliance with all applicable federal, state and local laws; 12. Facility security; 13. Disaster preparedness; 14. Patient rights; 15. Functional safety and facility maintenance; and 16. Identification of the person to whom responsibility for operation and maintenance of the facility is delegated and methods established by the licensee for holding such individual responsible and accountable. These policies and procedures shall be based on recognized standards and guidelines.	T 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	16758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(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 035	Continued From Page 2	T 035		

This RULE: is not met as evidenced by:
Based on interview and review of the facility policies the facility failed to have policy/procedures for: Personnel, types of elective and emergency procedures that may be performed in the facility; admissions and discharges; when to use ultrasound to determine gestational age and when indicated to assess patient risk; infection prevention; risk and quality management; management and effective response to medical and/or surgical emergency;management and effective response to fire; ensuring compliance with all applicable federal, state and local laws; disaster preparedness and identification of the person to whom responsibility for operation and maintenance of the facility is delegated and methods established by the licensee for holding such individual responsible and accountable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10798 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 035	Continued From Page 3 The findings include: 1. On May 30, 2012 between 2:00 P.M. to 5:00 P.M. the agency's policies were reviewed in the Administrator's office. On May 31, 2012 between 9:30 P.M. to 12:00 P.M. the agency's policies were reviewed in the Administrator's office. The policies and procedures shall be based on recognized standards and guidelines. The facility failed to have policy and procedures to cover the following: Personnel, types of elective and emergency procedures that may be performed in the facility; admissions and discharges; when to use ultrasound to determine gestational age and when indicated to assess patient risk; infection prevention; risk and quality management; management and effective response to medical and/or surgical emergency;management and effective response to fire; ensuring compliance with all applicable federal, state and local laws; disaster preparedness and identification of the person to whom responsibility for operation and maintenance of the facility is delegated and methods established by the licensee for holding such individual responsible and accountable. 2. On May 30, 2012 between 2:00 P.M. to 5:00 P.M. the agency's Administrator was interviewed in the Administrator's office. The Administrator acknowledged and agreed that that the the facility failed to have the above named policy/procedures. 3. On May 31, 2012 between 9:30 A.M. and 10:30 A.M. a second interview was conducted with the Administrator in the Administrator's office. The Administrator re- confirmed that there were missing policies and procedures as listed in section #1.	T 035	T 035 Policies are in place: Personnel; admissions and discharges; ultrasound; infection prevention; Quality Assurance; management and effective response to fire ensuring compliance with all federal, state, and local laws; disaster preparedness; identification of person to whom responsibility is delegated and methods established for holding individual responsible and accountable. To be written for: types of elective and emergency procedures that may be performed; management and effective response to medical and/or surgical emergency. Policy and procedures manual is to be reviewed annually. Completion date July 12, 2012	

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T 065	Continued From Page 4	T 065		
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 professional licensure, if applicable, and the health and personal background of each staff member. This RULE: is not met as evidenced by: Based on document review and interviews the facility failed to ensure licensure checks were performed on all licensed individuals for 1 of 2 licensed staff. The Findings Include: On 5/30/12 at 2 P.M. the credential file for the primary physician was reviewed. The file did not contain a verification of the Virginia medical license for this physician from the Department of Health Professions. The Administrator stated, "I can get that but I don't have it now."	T 065	T 065 The medical license for the physician has been downloaded from the Board of Medicine website. Personnel policy includes the need for license from online lookup. Orientation checklist has license item on it. Personnel files to be reviewed annually. Completion date June 14, 2012.	
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 record review and interview the facility staff failed to ensure the criminal history check for compensated employees whose duties provide access to controlled substances within the abortion facility were performed for 2 of 2 facility	T 070		

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T 070	Continued From Page 5 staff. The Findings Include: On May 30, 2012 at 2 P.M. the personnel files of the licensed personnel who have access to controlled substances were reviewed with the Administrator present. The Administrator and the primary physician's personnel files did not contain criminal history checks performed by the Virginia State Police pursuant to § 32.1-126.02 of the Code of Virginia. The Administrator stated, "I sent off for my criminal record check but signed my name in the wrong place so I had to resubmit it. (Name of Physician) is in our other office."	T 070	T 070 Criminal background checks have been obtained for administrator and physician. Personnel policy and orientation checklist indicated need for criminal background check for personnel who have access to controlled substances. Completion date June 22, 2012	
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 interviews the facility staff failed to ensure it developed, implemented and maintained policies and procedures to document the facility staff participated in initial and ongoing training and education which included infection control training. The Findings Include: On May 30, 2012 the personnel files were	T 080		

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T 080	Continued From Page 6 reviewed for 4 of 4 staff personnel who provide care and services to the patients of the facility and for 1 of 1 security personnel. There was no documentation of training on infection control. In 3 of the 5 personnel files there was no training documented of any kind. On May 30, 2012 at 2:30 P.M. the Administrator was interviewed and stated, "I do not have any documentation for training other than what is in their (the facility staff) personnel folders. I do not have any policies on training or education other than what is in their (the facility staff) job descriptions."	T 080	T 080 Training on infection control and fire safety is to be conducted initially and annually. This has been added to the orientation checklist and to the personnel policy. Documentation of In service training will be included in each staff member's personnel file as well as a manual dedicated to training documents. The Inservice Training manual will be reviewed annually. Personnel files will be reviewed annually for completeness. Administrator will be responsible for coordinating training and documentation. Completion date July 12, 2012	
T 085	12 VAC 5-412-170 F Personnel F. Job descriptions. 1. Written job descriptions that adequately describe the duties of every position shall be maintained. 2. Each job description shall include: position title, authority, specific responsibilities and minimum qualifications. 3. Job descriptions shall be reviewed at least annually, kept current and given to each employee and volunteer when assigned to the position and when revised. This RULE: Is not met as evidenced by: Based on document review and interviews the facility staff failed to have written job descriptions that adequately described the duties, specific responsibilities and minimum qualifications of each position and failed to show how each employee was provided a copy of the job description. The Findings Include:	T 085		

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T 085	Continued From Page 7 On May 30, 2012 at 2:00 P.M. a review of the personnel files was performed with the facility Administrator on 5 of 5 personnel files. Two (2) of the files did not contain job descriptions and 5 of the 5 did not contain evidence that the staff member was aware of their responsibilities. The Administrator stated, "We need to work on that."	T 085	T 085 Job descriptions have been added to personnel files. Job descriptions have been revised to include a place for the staff member to sign and date to indicate that she is aware of the responsibilities of her position. Job descriptions will be reviewed at least annually. The personnel policy will include procedure for reviewing job descriptions at least annually. Personnel files will be reviewed annually for completeness. Completion date June 20, 2012	
T 090	12 VAC 5-412-170 G Personnel G. A personnel file shall be maintained for each staff member. The records shall be completely and accurately documented, readily available, and systematically organized to facilitate the compilation and retrieval of information. The file shall contain a current job description that reflects the individual's responsibilities and work assignments, and documentation of the person's in-service education, and professional licensure, if applicable. This RULE: Is not met as evidenced by: Based on document review and interviews the facility staff failed to have written job descriptions that adequately described the duties, specific responsibilities and minimum qualifications of each position and failed to show how each employee was provided a copy of the job description. The Findings include: On May 30, 2012 at 2:00 P.M. a review of the personnel files was performed with the facility Administrator on 5 of 5 personnel files. Two (2) of the files did not contain job descriptions and 5 of the 5 did not contain evidence that the staff	T 090	T 090 Job descriptions have been provided to each staff member and signed and dated to indicate her awareness of responsibilities. Personnel policy and orientation checklist include job descriptions in them. Personnel files are to be reviewed annually for completeness. Job descriptions are to be reviewed annually. Completion date June 20, 2012	

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T 090	Continued From Page 8 member was aware of their responsibilities. The Administrator stated, "We need to work on that."	T 090		
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 interviews the facility staff failed to ensure personnel policies and procedures included written job descriptions, process for verifying current professional licensing or certification, process for annually evaluation employee performance and competency and a process for reporting licensed and certified health care practitioners for violations of their licensing and certification standards. The Findings Include: On May 30 and 31, 2012 at various times the	T 095		

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T 095	Continued From Page 9 facility policies and procedures were reviewed with the Administrator and a facility consultant. Both facility employees stated their policies and procedures for personnel did not include written job descriptions, process for verifying current professional licensing or certification, process for annually evaluation employee performance and competency and a process for reporting licensed and certified health care practitioners for violations of their licensing and certification standards. The facility Administrator stated, "We will need to work on those."	T 095	T 095 Personnel policy includes job description, process for verifying licensure, process for annual performance evaluation, and process for reporting licensed health care practitioners for violations of their licensing and certification standards. Completion date June 20, 2012	
T 105	12 VAC 5-412-180 A Clinical staff 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. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure the privileges of the physician were clearly defined for 1 of 1 physicians. The Findings Include: On May 30, 2012 the credential file for 1 of 1 physicians was reviewed. The file did not contain in delineation of privileges or appointment by the governing body. The Administrator stated, "We will get that."	T 105	T 105 Granting of privileges document has been obtained. June 15, 2012	
T 110	12 VAC 5-412-180 B Clinical staff B. Abortions shall be performed by physicians	T 110		

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T 110	Continued From Page 10 who are licensed to practice medicine in Virginia and who are qualified by training and experience to perform abortions. The facility shall develop, implement and maintain policies and procedures to ensure and document that abortions that occur in the facility are only performed by physicians who are qualified by training and experience. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure there were policies that ensure abortions are only performed by physicians who are qualified by training and experience. The Findings Include: On May 30 and 31, 2012 the policies and procedures were reviewed with the Administrator and a facility consultant. There was no evidence of policies and procedures indicating what experience and training was required of a physician to practice at the facility. The Administrator stated, "We will need to get that."	T 110	T 110 Physician competency policy is in place. Completion date June 15, 2012	
T 130	12 VAC 5-412-200 Minors No person may perform an abortion upon an unemancipated minor unless informed written consent is obtained from the minor and the minor's parent, guardian or other authorized person. If the emancipated minor elects not to seek the informed written consent of an authorized person, a copy of the court order authorizing the abortion entered pursuant to 16.1-241 of the Code of Virginia shall be obtained prior to the performance of the abortion.	T 130		

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T 130	Continued From Page 11 This RULE: is not met as evidenced by: Based on the review of the facility's policies and interview there was no policy regarding services and/or care for a minor that was not emancipated. The findings include: 1. On May 30, 2012 the facility policies were reviewed between 2:00 PM and 5:00 PM in the Administrator's office. There was no policy regarding services and/or care for a minor that was not emancipated. The Administrator acknowledged that there was no policy regarding services and/or care for a minor that was not emancipated. 2. On May 31, 2012 between 9:30 am and 10:30 am a second interview was conducted with the Administrator and the facilities nurse consultant in the Administrator's office. Both acknowledged that there was no policy regarding services and/or care for a minor that was not emancipated.	T 130	T 130 Policy on minors is in place. Policy and procedures manual to be reviewed annually. Completion date June 22, 2012	
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,	T 165		

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T 165	Continued From Page 12 implementation and maintenance of infection prevention policies and procedures and the regulations or guidance documents on which they are based shall be documented. 2. All infection prevention policies and procedures shall be reviewed at least annually by the administrator and appropriate members of the clinical staff. The annual review process and recommendations for changes/updates shall be documented in writing. 3. A designated person in the facility shall have received training in basic infection prevention, and shall also be involved in the annual review. This RULE: is not met as evidenced by: Based on interview and review of the infection control manual the facility failed to have an appointment of an individual trained in basic infection prevention and who is involved in the annual review of the infection control program. The findings include: 1. On May 30, 2012 the agency's laboratory policy/procedure manual was reviewed in the Administrator's office between 3:00 PM and 5:00 PM. The manual contained the agency's infection control policy content. The infection control content failed to identify a designated person in the facility who has received basic training in infection prevention and who shall also be involved in the annual review. 2. On May 31, 2012 an interview was conducted with the Administrator between 9:30 am and 12:00 PM in the facility. The Administrator acknowledged that no one has received basic training in infection prevention and who also is involved in the annual infection prevention review.	T 165	T 165 The physician is currently the designated person with basic training in infection control. The infection control plan is to be reviewed at least annually. Completion date July 12, 2012	

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T 170	Continued From Page 13	T 170		
T 170	12 VAC 5-412-220 B Infection prevention B. Written infection prevention policies and procedures shall include, but not be limited to: 1. Procedures for screening incoming patients and visitors for acute infectious illnesses and applying appropriate measures to prevent transmission of community acquired infection within the facility; 2. Training of all personnel in proper infection prevention techniques; 3. Correct hand-washing technique, including indications for use of soap and water and use of alcohol-based hand rubs; 4. Use of standard precautions; 5. Compliance with blood-boume 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 interview and the review of the agency's polices the facility failed to provide infection prevention training & policies for: A. Procedures for the screening of incoming patients and visitors for acute infectious illnesses, applying appropriate measures to prevent transmission of community acquired infection within the facility; monitoring staff adherence to recommended infection prevention practices and documenting annual retraining of all staff in recommended infection prevention practices.	T 170		

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T 170	Continued From Page 14 B. Training of all personnel in the proper infection prevention techniques. The findings include: 1. On May 30, 2012 the facility policies were reviewed between 2:00 PM and 5:00 PM in the Administrator's office. The facility's infection prevention policies failed to include: A. Procedures for the screening of incoming patients and visitors for acute infectious illnesses, applying appropriate measures to prevent transmission of community acquired infection within the facility; monitoring staff adherence to recommended infection prevention practices and documenting annual retraining of all staff in recommended infection prevention practices. B. Training of all personnel in the proper infection prevention techniques; correct hand-washing technique, including indications for use of soap and water and/or use of alcohol-based hand rubs; use of standard precautions; compliance with blood-bourne pathogen requirements of the U.S. Occupational Safety & Health Administration; use of personal protective equipment; safe injection practices and plans for annual retraining of all personnel in infection prevention methods. 2. On May 30, 2012 an interview was conducted with the Administrator between 3:00 PM and 5:00 PM in the agency. The Administrator acknowledged that the facility failed to provide the employee's with infection prevention training & policies.	T 170	T 170 Procedure for screening patients and visitors has been written. Policy for monitoring staff adherence to infection prevention practices has been written. Initial and annual training in infection control is included in infection control policy as well as personnel policy and orientation checklist. Infection Control Survey to be conducted quarterly. Results to be submitted to Quality Assurance Committee. Completion date July 12, 2012 Training of all personnel in infection prevention techniques to be conducted initially and annually. Documentation is to be in the Inservice Training Manual as well as each personnel file. Personnel files are to be reviewed annually for completeness. Completion date July 12, 2012	

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PENINSULA MEDICAL CENTER FOR WOMEN	19738 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 175	Continued From Page 16 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 the review of the facility's policies and interview there were no policies/procedures for the facility management of : hand hygiene; cleaning, disposal, storage and transport of equipment, linen and supplies; product specific instructions for use of cleaning agents; procedures for handling, storing and transporting of medical waste; policy/procedure for pest control; and other infection prevention procedures necessary to prevent/control transmission of an infectious agent in the facility The findings include: 1. On May 30, 2012 the facility policies were reviewed between 2:00 PM and 5:00 PM in the Administrator's office. There were no policies/procedures for the management of the facility, equipment and supplies for the following: a. Access to hand-washing equipment and adequate supplies (e.g., soap, alcohol-based hand rubs, disposable towels or hot air dryers); b. Availability of utility sinks, cleaning supplies and other materials for cleaning, disposal, storage and transport of equipment and supplies; c. 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,	T 175		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

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T 175	Continued From Page 17 management of accidental exposures); d. Procedures for handling, storing and transporting clean linens, clean/sterile supplies and equipment; e. Procedures for handling/temporary storage/transport of soiled linens; f. Procedures for handling, storing, processing and transporting regulated medical waste in accordance with applicable regulations; g. 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; h. Procedures for appropriate disposal of non-reusable equipment; i. Policies and procedures for maintenance/repair of equipment in accordance with manufacturer recommendations; j. Procedures for cleaning of environmental surfaces with appropriate cleaning products; k. An effective pest control program, managed in accordance with local health and environmental regulations; and l. Other infection prevention procedures necessary to prevent/control transmission of an infectious agent in the facility as recommended or required by the department. 2. On May 30, 2012 an interview was conducted with both the facility Administrator and the nurse consultant in the Administrator's office. Both acknowledged that there were no policies for the management of the facility, equipment and	T 175		

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T 175	Continued From Page 18 supplies (refer to #1 (a-l)) 3. On May 31, 2012 between 9:30 am and 10:30 am a second interview was conducted with the Administrator and the facilities nurse consultant in the Administrator's office. Both acknowledged that there was no policy regarding services and/or care for a minor that was not emancipated.	T 175		
T 200	12 VAC 5-412-240 B Medical testing, patient counseling and labor 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. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure they developed, maintained and implemented policies and procedures pertaining to counseling and instructions in a language each patient could understand. The Findings Include: On May 30 and 31, 2012 at approximately 11:30 A.M. the facility policies and procedures were reviewed and discussed with the facility Administrator. The facility did not have a policy on providing each patient in a language the patient could understand, information on the procedure or counseling both pre and post abortion. The Administrator stated, "We will get that."	T 200	T 200 Policy and procedure is in place for counseling and for provision of family planning and post-abortion counseling. Completion date July 12, 2012	

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T 210	Continued From Page 19	T 210		
T 210	12 VAC 5-412-240 D Medical testing, patient counseling and labor D. All tissues removed resulting from the abortion procedure shall be examined 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 for further pathologic examination and the patient alerted to the possibility of an ectopic pregnancy, and referred appropriately. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure they had a process and equipment available to have tissue specimens sent to a lab when the physician could not be certain the villi or fetal parts were present. The Findings Include: On May 30, 2012 a comprehensive tour of the facility was performed. There was no evidence of containers being available to transport tissue specimens to a lab for further testing. On May 31, 2012 at approximately 11:30 A.M. the facility physician and Administrator was interviewed. The physician stated, "I check each specimen to make sure villi and or fetal parts are present. When I can't be sure the specimen is sent to the lab. The specimens are transported the day of the procedure to the lab. They are transported in a specimen cup with saline." The Administrator stated, "We don't have any specimen cups. I will order them."	T 210	T 210 Specimen cups have been ordered. Arrangements have been made for pathology testing. Completion date July 6, 2012	

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T 275	Continued From Page 20	T 275		
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, policies and interview the agency staff failed to ensure that medications were not expired, were dated and/or contained within its original container when opened and/or used. The findings include: 1. On May 30, 2012 a facility tour was conducted between 12:30 PM and 2:00 PM in the facility. During the tour the following was identified: a) Tylenol/Codeine Phosphate with 100 tablets in an unopened bottle with expiration dated 04/2012. b) Lidocaine bottle 10 units/ml in a 10 ml bottle opened with no date when the bottle was opened. c) A plastic bottle labeled ultrasound gel but contained thin brown liquid (not gel) in the bottle. 2. On May 30, 2012 between 12:30 PM and 2:00 PM an interview was conducted with the Administrator in the Procedure Room. The Administrator confirmed that the plastic bottle labeled ultra sound gel contained brown Betadine liquid. The Administrator confirmed that an open bottle of Lidocaine failed to be dated once opened. An interview was conducted with the Administrator in the Recovery Room. The Administrator confirmed that the Tylenol/Codeine Phosphate 100 tablets in an unopened bottle had an	T 275	T 275 Tylenol with codeine has been discarded. Lidocaine that had not been marked with the opening date has been discarded. Plastic bottle with betadine has been discarded. 4 oz bottles of betadine have been purchased. Policies indicate that any opened items must have the date and initials of person who opened item. When setting up for procedures, items are to be checked and any item not properly labeled is to be discarded. Expiration log is to be completed monthly. Completion date June 29, 2012	

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T 275	Continued From Page 21 expiration dated 04/2012. 3. On May 30, 2012 between 3:00 PM to 5:00 PM the facility policies were reviewed in the Administrator's office. There were no policies to ensure that medications are not expired, out dated and/or contained within the original container.	T 275		
T 285	12 VAC 5-412-280 E Administration, storage and dispensing of dru E. Records of all drugs in Schedules I-V received, sold, administered, dispensed or otherwise disposed of shall be maintained in accordance with federal and state laws, to include the inventory and reporting requirements of a theft or loss of drugs found in 54.1-3404 of the Drug Control Act of the Code of Virginia. This RULE: is not met as evidenced by: Based on the facility tour, review of the facility's policies and interview the facility failed to have a medication dispensing policy. The findings include: 1. On May 30, 2012 a facility tour was conducted between 12:30 PM and 1:30 PM in the facility. There was a locked medication box within a locked cabinet in the Recovery Room. There was medication present. The medication was not being documented when/who it was dispensed. 2. On May 30, 2012 the facility policies were reviewed between 1:30 PM and 5:00 PM in the Administrator's office. There was no medication dispensing policy. 2. On May 30, 2012 between 2:00 PM to 5:00 PM	T 285	T 285 Policies dealing with medication are being written. Logs of medication dispensed are being kept. Completion date July 6, 2012	

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T 285	Continued From Page 22 the agency's Administrator was interviewed in the Administrator's office. The Administrator acknowledged that there was no mediation dispensing policy. 3. On May 31, 2012 between 9:30 am and 10:30 am a second interview was conducted with the Administrator and the facilities nurse consultant in the Administrator's office. Both acknowledged that there was no medication dispensing policy.	T 285		
T 290	12 VAC 5-412-270 Equipment and supplies An abortion facility shall maintain medical equipment and supplies appropriate and adequate to care for patients based on the level, scope and intensity of services provided, to include: 1. A bed or recliner suitable for recovery; 2. Oxygen with flow meters and masks or equivalent; 3. Mechanical suction; 4. Resuscitation equipment to include; as a minimum, resuscitation bags and oral airways; 5. Emergency medications, intravenous fluids, and related supplies and equipment; 6. Sterile suturing equipment and supplies; 7. Adjustable examination light; 8. Containers for soiled linen and waste materials with covers; and 9. Refrigerator. This RULE: Is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure the necessary medical equipment and supplies were available to care for patients. The Findings Include:	T 290		

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T 290	Continued From Page 23 On May 30, 2012 at approximately 3:30 P.M. during the comprehensive tour of the facility with the Administrator and facility consultant there was no evidence of oxygen being available should a patient require oxygen. Also during the tour the emergency cart was checked with the facility consultant. The cart did not contain any IV (intravenous) tubing to connect IV fluids to the needles for administration in the event of an emergency. The Administrator stated, "We will have the tubing tomorrow. I did not think we needed oxygen."	T 290	T 290 IV tubing has been stocked. Oxygen has been stocked. Completion date June 7, 2012	
T 300	12 VAC 5-412-290 A Emergency services A. An abortion facility shall provide ongoing urgent or emergent care and maintain on the premises adequate monitoring equipment, suction apparatus, oxygen and related items for resuscitation and control of hemorrhage and other complications. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure the necessary medical equipment and supplies were available to care for patients in the event of an emergency. The Findings Include: On May 30, 2012 during the comprehensive tour of the facility with the Administrator and facility consultant there was no evidence of oxygen being available should a patient require oxygen and no evidence of suction other than the suction used in a procedure. On May 30, 2012 the emergency cart was checked with the facility consultant. The cart did not contain any IV (intravenous) tubing to connect IV fluids to the needles for administration	T 300	Oxygen has been stocked. Gomco suction for airway has been obtained. IV tubing has been stocked. Completion date June 7, 2012	

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T 300	Continued From Page 24 in the event of an emergency. The Administrator stated, "We will have the tubing tomorrow. I did not think we needed oxygen."	T 300		
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 document review and interview the facility staff failed to have a quality assurance program that will evaluate the following aspects: Staffing patterns and performance; supervision appropriate to the level of service; patient records; patient satisfaction; complaint resolution; infections, complications and other adverse events; and staff concerns regarding patient care. The findings include: 1. On May 30, 2012 between 1:00 PM to 5:00 PM the agency's policies were reviewed in the Administrator's office. The facility failed to have a quality assurance policy that will evaluate the following aspects: Staffing patterns and performance; supervision appropriate to the level of service; patient records; patient satisfaction;	T 320	T 320 Quality Assurance policy is in place. Policy manual to be reviewed annually. Completion date June 29, 2012	

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T 320	Continued From Page 25 complaint resolution; infections, complications and other adverse events; and staff concerns regarding patient care. 2. On May 33, 2012 between 3:00 PM and 5:00 PM an interview was conducted with the Administrator and the facilities nurse consultant in the Administrator's office. Both acknowledged that there was there was no QA policy or program that will evaluate the above concerns.	T 320		
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 observation, interview and policies/procedures of the facility the 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 and to use cleaning products that kill organisms between patient use of exam table. The findings include: 1. On May 30, 2012 between 12:30 PM and 1:30	T 360		

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T 360	Continued From Page 28 PM a facility tour was conducted. During the tour a sharps container was noted in the Procedure Room on the floor and in the Recovery Room on top of the nurses desk. Both containers were not secure to any surface and had an open area 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: "Disposal opening-the disposal opening should prevent spills of the contents. Security may be a concern in some areas of facilities, the facility should consider selecting containers with guards to prevent hands or fingers from entering the containers. Stability-containers should be stable when place in a horizontal surface." During the facility tour there were Clorox wipes noted in the Ultrasound and Procedure Rooms. The Administrator stated that the Clorox wipes were used to clean the exam table surface between patients. A request was made for the Material Safety Data Sheet (MSDS) sheet to review for what organisms the the wipes kill. 2. On May 30, 2012 between 12:30 PM and 1:30 PM an interview was conducted with the Administrator during the facility tour. The Administrator acknowledged that the sharps container in the Procedure and Recovery Rooms were easily accessible through the unsecured opening on top of the containers. 3. On May 31, 2012 between 10:00 AM and 11:00 AM the cleaning of the exam table between patient's use were observed being wipe down with the use of Clorox wipes between patient use. 4. On May 31, 2012 between 9:30 AM and 11:00 AM an interview was conducted with the Administrator in the facility. The Administrator	T 360	T 360 Sharps containers which are wall mounted and have the mail slot type opening have been ordered and are to be wall mounted. A rack for the other sharps container has been set up to make the container stable. Clorox wipes have been replaced with wipes indicated for medical setting. MSDS sheet in MSDS manual. Completion date July 5, 2012	

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T 360	Continued From Page 27 stated that the facility failed to have the MSDS form for the Clorox wipes.	T 360		
T 380	12 VAC 5-412-360 B Maintenance B. When patient monitoring equipment is utilized, a written preventative maintenance program shall be developed and implemented. This equipment shall be checked and/or tested in accordance with manufacturer's specifications at periodic intervals, no less than annually, to ensure proper operation and a state of good repair. After repairs and/or alterations are made to any equipment, the equipment shall be thoroughly tested for proper operation before it is returned to service. Records shall be maintained on each piece of equipment to indicate its history of testing and maintenance. This RULE: is not met as evidenced by: Based on observations, review of facility policies and interview the facility staff failed to maintain a preventative maintenance program at least annually on all equipment. Specifically no preventative and or safety checks were documented for two (2) exam lights, one (1) lab refrigerator, one (1) centrifuge and one (1) suction machine. The findings include: 1. On May 30, 2012 a facility tour was conducted between 12:30 PM and 2:00 PM. The preventive maintenance failed to be documented at least annually for safety on the following: two (2) exam lights, one (1) lab refrigerator, one (1) centrifuge and one (1) suction machine. 2. On May 30, 2012 the facility policies were reviewed between 2:00 PM and 5:00 PM in the	T 380	T 380 Preventive maintenance visit has been rescheduled. Preventive maintenance manual to be kept up to date by the administrator. Preventive maintenance visits to be scheduled annually. Completion date July 12, 2012	

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T 380	Continued From Page 28 Administrator's office. There was no preventive maintenance policy. 3. On May 30, 2012 during the facility tour the Administrator was interviewed between 12:30 PM and 2:00 PM. The Administrator acknowledged there was no evidence of preventive maintenance safety checks on the following: two (2) exam lights, one (1) lab refrigerator, one (1) centrifuge and one (1) suction machine.	T 380		
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 5-560-120 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	T 400		

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PENINSULA MEDICAL CENTER FOR WOMEN	16756 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(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 29 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. The Findings Include: An initial tour of the facility was conducted with the Administrator and facility consultant on May 30, 2012 beginning at about 1:00 P.M. During the tour it was noted that the facility had no provision for a separate collection, storage or disposal of soiled materials, 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, had no evidence of maintenance or performance testing on the facility's suction equipment stored in the attic, doorways where not grade level and were not 5 foot wide, hallway was less than 5 feet in areas where patients would have access, failed to have sinks that could be used without hands, 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 Administrator stated during the tour that the facility had contacted a firm who would assist the facility in complying with the regulations.	T 400	T 400 See attached	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	16758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(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

W.K.G. and J., Incorporated

Corporation and Governing Board Members

T015

President and Treasurer

Jill Abbey
118 North Boulevard
Richmond, Virginia 23220

Secretary

Marianne Fitzhugh
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Peninsula 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. 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:	6/12									
Reviewed: Date & Initial										

The finding of deficiency for noncompliance with 12VAC5-412-380 is inappropriate because Peninsula Medical Center for Women (PMCW) 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 PMCW a variance. The plan that PMCW 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 14, 2012 – Brought in an architect to do an assessment of PMCW's facility for compliance with 12VAC5-412-380.

April 15, 2012 Fire Marshal conducted an inspection and found facility in compliance with fire code.

July-Oct. 2012

- Identify mechanical engineer and schedule inspections or evaluation visits as appropriate to obtain a report on HVAC/ventilation requirements and design a plan for coming into compliance.
- Schedule inspections or evaluation visits as appropriate regarding compliance with electrical code.
- Building owner states they will 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.

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 PMCW 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 PMCW 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.

Peninsula Medical Center for Women

Clinical Policies and Procedures Manual

Department: Patient Care; Infection Prevention	**Policy Description:** Pre-screening
Page: 1 of 1	**Replaces Policy Dated:**
Effective Date: 1/1/12	**Reference Number: 12VAC5-412-150, -220**
Approved:	

Scope:	All patients and visitors
Purpose:	To provide for continued quality of care in the facility; to reduce infection spread among patients and visitors
Policy:	Patients and visitors will be screened for acute illness prior to receiving care
Procedure:	All staff are responsible for visually screening patients and visitors who exhibit symptoms of acute illness, especially: Cough Sore throat Severe widespread muscle aches Extreme fatigue Diarrhea Undiagnosed rash or skin lesions Febrile state If possible, patient or visitor will be isolated in a private room. The physician will be consulted about the symptoms and if advised, the patient or visitor will be sent to their own physician or hospital
Reference:	**12VAC5-412-150, -220**

Revised: Date & Initial:										
Reviewed: Date & Initial										

Peninsula Medical Center for Women

Clinical Policies and Procedures Manual

Department: Surgical Services	**Policy Description:** Discharge Criteria
Page: 1 of 2	**Replaces Policy Dated:**
Effective Date: 7/12	**Reference Number: 12VAC5-412-150**
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) Prescription given 10) Authorization signed 11) Patient given follow-up instruction sheet 12) Pain scale on discharge recorded 13) 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) **PMCW** 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.
Reference:	**12VAC5-412-150**

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Reviewed: Date & Initial										

Peninsula Medical Center for Women
Policy and Procedure Manual

Department: Quality of Care	**Policy Description:** Ultrasound Use
Page: 1 of 1	**Replaces Policy Dated**:
Effective Date:	**Reference Number: 12VAC5-412-150**
Approved:	

Scope:	Clinical Staff
Purpose:	To provide for continued quality of patient care at this facility.
Policy:	Proper use of ultrasound can inform clinical decision-making and enhance the safety and efficacy of abortion care.
Procedure:	• Staff members who perform ultrasound exams and clinicians who interpret those exams must either show documentation that they have completed a program of training or must complete such a program developed by the facility. Training must include a period of direct supervision. Documentation of this training must be maintained. Following initial training, evidence of ongoing proficiency and training will be documented. • Patients must be informed of the purpose and limitations of the ultrasound exam in the abortion care setting, and offered a chance to view the images. • The findings of all ultrasound exams and the interpretation of those findings must be documented in the medical record. Photos or another method of storing the ultrasound images will be included as part of the documentation, and will include the name(s) of the staff members who performed and interpreted the exam. • In the first trimester, the ultrasound exam will include the following: a. a full scan of the uterus in both the transverse and longitudinal planes; b. measurements to document gestational age; c. views to document the location of the pregnancy; d. evaluation of fetal number; and e. evaluation of the presence or absence of fetal cardiac activity. • Technology permitting both abdominal and transvaginal scanning will be available. • A procedure must be in place for further evaluation or referral of a patient in whom an intrauterine pregnancy has not been definitively identified or for whom an initial finding on the ultrasound may affect abortion management or future patient care. • Real-time ultrasound scanners must be used. Ultrasound equipment must be properly calibrated and maintained. • Ultrasound transducers must be disinfected between patients according to applicable infection control standards. Adequate precautions must be taken to protect both staff members and patients from the potential toxicity of chemical agents.
Reference:	**12VAC5-412-150**

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Reviewed: Date & Initial										

Peninsula Medical Center for Women

Clinical Policies and Procedures Manual

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

Scope:	All stakeholders
Purpose:	The center will maintain an ongoing Infection Control program designed to prevent, control and investigate infections and communicable diseases among patients, healthcare workers, and visitors.
Policy:	
Procedure:	COMPONENTS: Components of the Infection Control program are: A. Defined Responsibility The Governing Body is the ultimate authority for the Infection Control program. The ongoing responsibility for the program is assigned by the Administrator to an individual who receives special training regarding Infection Control and the responsibilities of the position. The designated individual will be a member of the center's Quality Improvement Committee and provide quarterly reports regarding the program activities, findings, and improvement strategies. Professional guidelines to be utilized in the implementation of the Infection Control Program: Evidence-based policies and procedures have been developed from CDC, APIC, and OSHA resources. B. Surveillance Surveillance is an active process to identify and analyze outcomes related to infection control, and includes: 1. Environmental surveillance to identify and correct practices found in the workplace 2. Preventive surveillance such as immunization of staff 3. Observation and documentation of sterilization and disinfection practices 4. Verification of education and training for staff 5. Conformity with safe sharps handling 6. Public Health reporting and monitoring of community trends 7. Postsurgical surveillance conducted through maintaining a log of complications C. Patient Assessment and Triage a. All patients will receive a pre-operative or pre-procedure assessment of current and past health history, including a symptom-based evaluation for current communicable disease. The ambulatory care setting does not provide for isolation rooms and therefore contact with patients who are potentially contagious must be limited. D. Hand Hygiene Protocols for proper hand hygiene and surgical hand antisepsis are an essential element of the program. E. Laundry Services Facility policies and procedures will outline the handling, processing, and storage of clean and dirty linen, as well as the use of disposable supplies.

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	F. Environment of Care Environmental factors reviewed as part of the Infection Control plan include work flow to prevent cross contamination, sterilization and reprocessing procedures and documentation, ventilation, temperature and humidity of rooms, appropriate ventilation and maintenance of systems (including measurement of air exchanges), housekeeping responsibilities, disinfection of surfaces between patients, cleaning schedules, and pest management. G. Education Orientation and training regarding infection prevention and control will be conducted by the designated Infection Control person and will include the topics of hand hygiene, high level disinfection/sterilization, waste management procedures, and infection prevention practices. Information related to employee health will also be included. H. Improvement Strategies Monitoring of infection control measures will be conducted and variances will be reported for specific occurrences. Corrective and preventive measures for improvement will be undertaken immediately as needed. I. Policies and Procedures/ Facility References The following Infection Control policies and procedures will be maintained and made part of the facility's infection control plan: 1. Exposure Control Plan 2. Procedure for postoperative surveillance 3. Procedure for follow up on reported infections 4. Infection Control Best Practices pack 5. Procedures for cleaning, disinfection and sterilization of rooms, equipment, and medical devices 6. Hand hygiene 7. Biohazardous waste management 8. Handling of linen 9. Mandatory reporting of communicable disease conditions 10. Asepsis technique 11. Traffic patterns 12. Gowning and gloving 13. Employee health program 14. Monitoring the environment of care 15. Disaster preparedness 16. Orientation and training program/documentation of competencies 17. Policies addressing state-specific requirements
Reference:	**12VAC5-412-220-B** Association for Professionals in Infection Control and Epidemiology, Inc.(APIC) 1275 K Street, NW Suite 100 Washington, D.C. 20005-1890 Phone 202-789-1890 Fax 202-789-1899 E-mail apicinfo@apic.org Internet www.apic.org 2005 APIC Text of Infection Control and Epidemiology/Ambulatory Care Centers for Disease Control and Prevention (CDC) www.cdc.gov Occupational Safety and Health Administration http://www.osha.gov Parham Surgery Center Policy manual Sections 8 Facilities and Environment and 10 Surgical Services Infection Control Nurse-Parham Doctor's Hospital

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Peninsula Medical Center for Women
Policy and Procedure Manual

Department: Clinical	**Policy Description:** Employee Communicable Diseases
Page: 1 of	**Replaces Policy Dated**:
Effective Date:	**Reference Number:**
Approved:	

Scope:	All facility personnel.
Purpose:	To protect the patient population and co-workers from a known communicable disease of an employee.
Policy:	To provide protection to our patient population and staff by implementing work restrictions for those colleagues who may possibly transmit an infectious disease within the center.
Procedure:	• Any employee who becomes aware that they may have been exposed to a community based infectious disease will immediately notify their clinical supervisor/manager. • The employee will be referred to the Medical Director or designee who will assess the situation and assist the employee with follow up with their personal physician and/or contracted employee health service as appropriate. • The Medical Director or designee /personal physician will counsel employee and the susceptible employee will be placed on work restrictions as deemed necessary. • Employees on work restrictions may ask to take a Leave of Absence (L.O.A.) without pay. For paid time off, the colleague may utilize their accrued sick time. • When the exposure and acquisition of the disease occurred within the work place, Workers' Compensation benefits will be utilized for the colleague's paid time off and their medical expenses associated with the specific disease. • Employee/ Medical Director or designee and/or Workers' Comp physician will determine the need for post-exposure laboratory testing, care and follow-up.
Reference:	**12VAC5-412-220-D** "Guide to Infection Prevention in Outpatient Settings: Minimum Expectations for Safe Care", published by the U.S. Centers for Disease Control and Prevention. See Attached List of Disease/Problem Listing

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Peninsula Medical Center for Women
Policy and Procedure Manual

Department: Clinical	**Policy Description:** Employee Communicable Diseases
Page: 2 of 3	**Replaces Policy Dated**:
Effective Date:	**Reference Number:**
Approved:	

DISEASE/PROBLEM	PT CARE	WORK RESTRICTION	DURATION
Conjunctivitis, infections	no		until discharge ceases
Cytomegalovirus infections	yes		
Diarrhea-Acute stage	no		Until symptoms resolve & infection w/
(diarrhea w/other symptoms			*Salmonella is ruled out*
Diarrhea-Convalescent stage	yes	personnel should not take care of high	Until stool is free of the infecting or-
Salmonella(nontyphoidal)		risk patients	ganism on 2 consecutive cultures not
			less than 24 hours apart
Other enteric pathogens	yes		
Enteroviral infections	yes	personnel should not take care of	Until symptoms resolve
		infants and newborns	
Group A streptococcal dis.	no		Until 24 hours after adequate treat-
			ment is started
Hepatitis, viral hepatitis A	no		Until 7 days after onset of jaundice
Hepatitis B, acute	yes	personnel should wear gloves for	Until antigenemia resolves
		procedures that involve trauma to	
		tissues or contact with mucous mem-	
		branes or non-intact skin	
Chronic antigenemia	yes	same as acute illness	Until antigenemia resolves
Hepatitis C	yes	same as hepatitis B	
Hepatitis non-A, non-B	yes	same as acute hepatitis B	Periodic infectivity has not been
			determined
Herpes Simplex (genital)	yes	**NOTE: It is not known whether**	
Herpes Simplex (hands)	no	**gloves prevent transmission--- personnel should not take care of high-risk patients**	Until lesions heal
Herpes Simplex (orofacial)	yes		Until lesions heal
HIV-Ab positive	no		Until their job activities have been
			reviewed to determine under what
			circumstances,if any, they may con-
			tinue to perform exposure-prone
			procedures
Measles (active)	no		Until 7 days after the rash appears
Measles (post-exposure--			
susceptible personnel)	no		From the 5th through the 21st day
			after exp. And/or 7 days after rash
			appears
Mumps (active)	no		Until 9 days after onset of parotitis
Mumps (post-exposure)	no		From the 12th through the 26th day
			after exp. Or until 9 days after onset
			of parotitis
Pertussis (active)	no		From the beginning of the catarrhal
			stage through the 3rd week after
			onset of paroxysms or until 7 days
			after start of effective therapy
Pertussis (post-exposure-			
asymptomatic personnel)	yes		

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DISEASE PROBLEM	PT CARE	WORK RESTRICTION	DURATION
Pertussis (post exposure-			
symptomatic personnel)	no		Same as active pertussis
Rubella (active)	no		Until 5 days after the rash appears
Rubella (post-exposure			
(asymptomatic personnel)	no		From the 7th day through the 21st day
			after the exposure and/or 5 days after
			rash appears
Scabies	no		Until treated
Staphylococcus aureus(skin			
lesions)	no		Until lesions have resolved
Tuberculosis, pulmonary	no		Until receiving adequate therapy, proof
			of three consecutive daily negative
			acid-fast bacilli smears, cough is
			resolved
Upper respiratory tract			
infections (high risk patients)	no	personnel with U.R.I. Should not take	Until acute symptoms are resolved
		care of high-risk patients	
Zoster (shingles)-active	yes	appropriate barrier desirable; per-	Until lesion dry and crust
		sonnel should not take care of high-	
		risk patients	
Zoster (shingles) post-exp.			
asymptomatic personnel	no		From the 10th through the 21st day
			after exposure or,if varicella occurs,
			until all lesions dry and crust
Varicella (chicken pox)			
active	no		Until all lesions dry and crust
Varicella (chicken pox)			
post-exposure	no		From the 10th through the 21st day
			after exposure or, if varicella occurs,
			until all lesions dry and crust

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Reviewed: Date & Initial										

Peninsula Medical Center for Women
Policy and Procedure Manual

Department: Infection Prevention	**Policy Description:** Hand Hygiene
Page: 1 of	**Replaces Policy Dated**:
Effective Date:	**Reference Number:**
Approved:	

Scope:	All facility personnel.
Purpose:	To both protect personnel from infection, and to prevent personnel from spreading infections among patients.
Policy:	Good hand hygiene, including use of alcohol-based hand rubs and hand washing with soap and water, is critical to reduce the risk of spreading infections.
Procedure:	Key situations where hand hygiene should be performed include but are not limited to: • Before touching a patient, even if gloves will be worn • Before exiting the patient's care area after touching the patient or the patient's immediate environment • After contact with blood, body fluids or excretions, or wound dressings • Prior to performing an aseptic task (e.g., placing an IV, preparing an injection) • If hands will be moving from a contaminated-body site to a clean-body site during patient care • After glove removal Use soap and water when hands are visibly soiled (e.g., blood, body fluids), or after caring for patients with known or suspected infectious diarrhea (e.g., *Clostridium difficile*, norovirus). Otherwise, the preferred method of hand decontamination is with an alcohol-based hand rub. Clinical staff will not use artificial nails. All staff will be provided with initial training on proper hand hygiene, including hand washing and glove removal and disposal. Yearly training, whether in service or online, will include hand hygiene. All trainings will be documented in personnel files. Soap and working sinks with hot and cold running water and disposable paper towels will be available near any patient area involving body fluids. Alcohol-based hand rubs will be present at patient areas.
Reference:	**12VAC5-412-220-B** Guideline for Hand Hygiene in Health-Care Settings (available at: http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf).

Revised: Date & Initial										
Reviewed: Date & Initial										

Peninsula Medical Center for Women

Clinical Policies and Procedures Manual

Department: Infection Control	**Policy Description:** Spore testing for Autoclaves
Page: 1 of 2	**Replaces Policy Dated:**
Effective Date:	**Reference Number: 12VAC5-412-220C7**
Approved:	

Scope:	Utility Room Staff
Purpose:	To ensure that the autoclave is operating in a manner that materials being placed in the autoclave are being sterilized
Policy:	Weekly spore testing will be conducted on each autoclave in operation
Procedure:	Spore testing will be conducted weekly. Label the ampule with location including which autoclave the ampule will be sterilized in if more than one autoclave at that location. ProTest ampule will be placed in a horizontal position in the most difficult to sterilize location. Run the regular cycle of the autoclave. Remove unit and verify that the chemical indicator on the ampule label has change color. HANDLE WITH CARE AFTER STERILIZATION. Allow sufficient cooling time (10 to 15 minutes) to reduce risk of the ampule bursting. ALWAYS WEAR GLOVES AND SAFETY GLASSES WHEN HANDLING STERILIZED UNITS. After the unit has cooled, place unit in a pouch to send to lab in Richmond office for incubation. Activate the ampule by using the designated crusher. Place the activated ampules and a control ampule in the incubator at 55 to 60 C for 24 hours. Begin monitoring the incubated units after 12-24 hours. Record observations. All positive units should be recorded and disposed of immediately. Interpretation: Control: The control unit should exhibit turbidity and/or a color change to or toward yellow. If the control unit does not show signs of growth, consider the test invalid. Test: A **failed sterilization cycle** is indicated by turbidity and/or a color change to or toward yellow. That autoclave must be taken out of service until repairs can be made. Record in the Preventive Maintenance Manual for that piece of equipment. A test unit that retains its original color indicates that sterilization parameters have been met.

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Reviewed: Date & Initial										

	Record test results on the report form and fax to the appropriate location. Also record in the log book for spore testing results. Immediately notify the site administrator in the event of a failed sterilization cycle.
Reference:	**12VAC5-412-220C7; CDC Guide to Infection Prevention in Outpatient Settings: Minimum Expectations for Safe Care; CDC Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008; ProTest Steam, Healthlink**

Revised: Date & Initial:										
Reviewed: Date & Initial										

Peninsula Medical Center for Women
Policy and Procedure Manual

Department: Infection Prevention	**Policy Description:** Personal Protective Equipment
Page: 1 of	**Replaces Policy Dated**:
Effective Date:	**Reference Number: 12VAC5-412-220-B**
Approved:	

Scope:	All facility personnel.
Purpose:	To both protect personnel from infection, and to prevent personnel from spreading infections among patients.
Policy:	Personal Protective Equipment (PPE) will be worn to protect staff from exposure to or contact with infectious agents.
Procedure:	All staff will receive training on proper selection and use of PPE. At the start of each shift, clinical staff will assure that sufficient and appropriate PPE is available and readily accessible. Remove and discard PPE before leaving the patients' area. Wear gloves for potential contact with blood, body fluids, mucous membranes, non-intact skin or contaminated equipment. • Do not wear the same pair of gloves for the care of more than one patient • Do not wash gloves for the purpose of reuse • Perform hand hygiene immediately after removing gloves Wear a gown to protect skin and clothing during procedures or activities where contact with blood or body fluids is anticipated. • Do not wear the same gown for the care of more than one patient Wear mouth, nose and eye protection during procedures that are likely to generate splashes or sprays of blood or other body fluids. Wear a surgical mask when placing a catheter or injecting material into epidural or subdural space.
Reference:	**12VAC5-412-220-B** 2007 Guideline for Isolation Precautions (available at: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf).

Revised: Date & Initial										
Reviewed: Date & Initial										

Peninsula Medical Center for Women
Policy and Procedure Manual

Department: Infection Prevention	**Policy Description:** Injection Safety
Page: 1 of 1	**Replaces Policy Dated**:
Effective Date:	**Reference Number:** 12VAC5-412-220B7
Approved:	

Scope:	Clinical Staff
Purpose:	Injection safety includes practices intended to prevent transmission of infectious diseases between one patient and another, or between a patient and healthcare provider during preparation and administration of parenteral medications. DEFINITIONS: • Aseptic technique- the manner of handling medications and injection equipment to prevent microbial contamination.
Policy:	All healthcare workers will adhere to the safe injection practices by following aseptic technique and infection prevention when handling or preparing parenteral medications, administering injections and procurement and sampling of blood.
Procedure:	Dispose of used syringes and needles at the point of use in a sharps container that is closable, puncture-resistant, and leak-proof. **ASEPTIC TECHNIQUE** All parental medications should be accessed in an aseptic manner. Proper hand hygiene should be performed before handling medications, and if a medication vial has already been opened, the rubber septum should be disinfected with alcohol prior to piercing it. The use of a new sterile syringe and needle should be used to draw up medications while preventing contact between the injection materials and the non-sterile environment. Syringes and needles should be used for a single patient only and for a single procedure. The storage and preparation of medications and supplies should be performed in a designated "clean" area that is not adjacent to areas where potentially contaminated items are placed. Never store needles and syringes unwrapped as sterility cannot be assured. **IV SOLUTIONS** A single use parenteral medication should be administered to one patient only. Single-use IV solutions should be administered to one patient only, during one treatment. Never use intravenous solution containers (i.e. bags or bottles) to obtain flush solutions for more than one patient. Initiate administration of IV solutions within one hour of preparation or spiking, otherwise discard prepared IV solution and tubing **FLUSHING** Use single dose containers for flush solutions whenever possible. Ideally the safest practice is to restrict each medication vial to a single patient, even if it's a multi-dose vial. However, if a multi-dose medication vial must be used for more than one patient, the vial should only be accessed with a new unused sterile syringe and needle even if the vial is dedicated to a single patient.
Reference:	**12VAC5-412-220-B7** http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf). (http://www.cdc.gov/injectionsafety/)

Revised: Date & Initial										
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Peninsula Medical Center for Women

Clinical Policies and Procedures Manual

Department: Quality Assurance	**Policy Description:** Quality Assurance and Process Improvement, QAPI
Page: 1 of 2	**Replaces Policy Dated:** 4/1/12
Effective Date: 6/5/2012	**Reference Number:** 12 VAC5-300-A, B, C, D, E
Approved:	

Scope:	All facility personnel
Purpose:	To establish a QAPI program to achieve optimal care for the consumer as well as provide for patient and employee safety.
Policy:	QAPI is a program which allows both administrative personnel and staff to identify real or potential problems, document findings, and use methodology to improve processes to improve outcomes in various areas as noted below.
Procedure:	A. QAPI for the facility serves as an ongoing, comprehensive, integrated, self-assessment program of the quality and appropriateness of care or services provided, including services provided under contract or agreement. The program includes process design, data collection/analysis, assessment and improvement and evaluation. The findings are used to correct identified problems and revise policies and practices. B. To ensure adequacy and appropriateness of services, and to identify unacceptable or unexpected trends or occurrences the following shall be evaluated: 1. Staffing patterns and performance, done annually and as needed. 2. Supervision appropriate to the level of service, done annually and with position vacancies. 3. Patient records; with one record checked weekly by site administrator; and full audit of all records current with procedure day every other month; and as determined by chart errors found through audits. 4. Patient satisfaction; through patient satisfaction queries in a format ensuring privacy of responses. 5. Complaint resolution; through audits for trends. See also policy on patient rights (12VAC5-412-210, B, C, & D.) 6. Infections, complications and other adverse events; audits done and occurrences sent to Regional Director for trending. 7. Staff concerns regarding patient care. 8. Periodic safety checks on all equipment C. The quality improvement (QI) committee is responsible for the oversight and supervision of the program and shall consist of: 1. A physician 2. A non-physician health care practitioner 3. A member of the administrative staff 4. An individual with demonstrated ability to represent the rights and concerns of patients. This may be a member of the facility's staff. 5. There may be coordination between the Regional Director's multiple sites of responsibility to provide a range of insight helpful to the improvement process.

Revised: Date & Initial:										
Reviewed: Date & Initial										

	D. When problems are identified measures shall be implemented to resolve the problems and concerns that have been identified. E. Results of the quality improvement program will be reported 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 corrections actions shall be documented. Identified deficiencies that jeopardize patient safety shall be reported immediately in writing to the licensee by the quality improvement committee.
Reference:	12 VAC5-300-A, B, C, D, E

Revised: Date & Initial:										
Reviewed: Date & Initial										

Peninsula Medical Center for Women

Clinical Policies and Procedures Manual

Department: Facilities & Environment	**Policy Description:** Fire Plan/ Evacuation
Page: 1 of 3	**Replaces Policy Dated:**
Effective Date: 01/12	**Reference Number:** 12VAC5-412-150
Approved:	

Scope:	All Personnel
Purpose:	To provide an evacuation plan for the facility in the event of a fire
Policy:	The Center shall use this plan to guide staff members in the event of a fire to protect the health and safety of patients, family members, and PSC personnel. The personnel of PMCW will practice RACE (***R***escue, ***A***larm, ***C***ontain, and ***E***xtinguish) in the event of a fire. When using the fire extinguisher PASS (***P***ull, ***A***im, ***S***queeze, and ***S***weep) is practiced.
Procedure:	A. **<u>For plan of action</u>** 1. Anyone detecting a fire will initiate the fire plan by calling "Code Red (location of the fire) and calling 911. Any employee may activate the fire pull station alarm. 2. The front desk will notify the upstairs office if occupied. 3. In the event of a fire, the Administrator or designated charge person will direct the evacuation of patients, family and auxiliary personnel. All fire doors will be shut. Patients may be evacuated via the reception area or back door as dictated by the fire situation. Patients may be evacuated by whatever means necessary (stretcher, wheelchair, etc.) The designated charge persons will notify the Administrator that their area has been evacuated by "all clear". 4. Responsibility will be transferred to the fire department upon arrival. 5. Once adequate provisions have been made for evacuation of the facility, any available personnel may use the fire extinguishers to attempt to put out the fire. 6. Fire drills will be conducted at least 4 times a year and more often as desired. Simulating an evacuation of patients will be practiced. In the event of an actual evacuation all occupants will meet in the parking lot. 7. The Administrator or her designee will evaluate fire drills with recommendations of corrective action as needed. 8. No Smoking is allowed in the Peninsula Medical Center for Women Center. 9. Inspection of the smoke detectors will be completed every six months. 10. The fire extinguishers will be inspected on a regular basis in compliance with current codes by a contracted service. 11. Fire drills will be observed by a member of the Quality Assurance Committee who will evaluate any problems and report them to the Quality Assurance Committee. The committees will recommend corrective action if needed. 12. The Quality Assurance Committee will review the fire and disaster plans annually and recommend any needed changes. B. **<u>To establish a plan of action in the event of evacuation</u>:** All available personnel shall report to the Administrator for assignment. You may be called upon to assist in the evacuation. 1. Remove any persons that may be in immediate danger to the safe area in the parking lot. . 2. Confine the fire-Shut the door!

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Reviewed: Date & Initial										

3. Activate the paging system, signal "Code Red" and give the location of the fire.
4. The front desk will call 911.
5. Close all other doors in your area to prevent the spread of fire and smoke.
6. Return to the fire area and use available fire extinguishing equipment on the fire. CAUTION: Feel the outside door to the fire area before entering. If the door is hot, STAY OUT. Get some linen, wet it thoroughly and place it around the crack at the bottom of the door.
7. Evacuate patients and others as necessary. The Administrator may authorize evacuation of a single area. All staff members are to meet outside at the parking lot when they have secured their areas and all patients and families are gone from the building.
8. Evacuation of multiple areas or the building will be undertaken only upon authorization of the Administrator or the Fire Official in charge.

9. **Evacuation Equipment**

   a. Blankets and bed linens- of all possible equipment that can be used for evacuation, these are the most important. They can be used;
      - To smother the fire.
      - To help confine smoke to a room-by wetting them and placing them across the crack under the door.
      - To drag a non-ambulatory patient from a room.

D. **Area Responsibilities**

1. Front Desk:
   - Call 911.
   - Notify Administrator of the fire and its location.
   - Make any other necessary emergency phone calls.
   - Close all doors in the immediate area.
   - Offer reassurance and emotional support to visitors and family in the lobby.

2. Administrator
   - Close all doors in the immediate area.
   - Supervise and coordinate activities of Center.
   - Coordinate staff and family members - offer emotional support.
   - Interact with the fire official in charge.
   - If the Administrator is in a scrub/assistant role she will be relieved by RR. staff.

3. Recovery Room Staff:
   - Assist Administrator
   - Work closely with the front desk.
   - Close all doors in the immediate area.
   - Evacuate all patients when notified by the official in charge or the Administrator
   - Become pivotal members moving in and out of Center as safely necessary.

Revised: Date & Initial:										
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	• Do not take the code cart with stable patients if surgery is still underway. You may evacuate as far from the Center 4. <u>Counselors</u> • Take assignment from the Administrator • Care for the patients. Evacuate as needed upon the order of the official in charge or the management team of Center • Close all doors in the immediate area. • Assist with control and information to family members. • Assist RR with evacuation • At first announcement of the fire, check to see that the fire extinguisher was obtained and taken to the necessary area. • Retrieve needed supplies. • Assist with the evacuation of the patients in the facility 5. <u>Procedure and Utility Staff:</u> • Take assignment from the Administrator. • Continue surgical procedure until instructed to evacuate by the official in charge. Notify all members in the procedure room of possible need to evacuate and the location of the fire. • Close doors to Procedure. Check Utility area for staff members. Close all doors in immediate area that can be safely shut. After the Center has been evacuated, a head count of all staff and patients present will be done to ensure that everyone has been evacuated by use of patient charts to account for patients and visitors, and by use of the payroll listing to account for staff. After the "all clear" signal has been given, all members of PMCW shall assist in the return of the patients and the families to the center.
Reference:	

Revised: Date & Initial:										
Reviewed: Date & Initial										

Peninsula Medical Center for Women

Clinical Policies and Procedures Manual

Department: Maintenance of Facility	**Policy Description:** Local and State Codes
Page: 1 of 1	**Replaces Policy Dated:**
Effective Date: 1/1/12	**Reference Number:**
Approved:	

Scope:	Entire facility
Purpose:	To ensure that the facility is in compliance with local and state codes, zoning and building ordinances, and the Uniform Statewide Building Code.
Procedure:	The facility will comply with local and state codes, zoning and building ordinances, and the Uniform Statewide Building Code. Full compliance with 2010 Guidelines for Design and Construction of Health Care Facilities of the Facilities Guidelines Institute will take precedence of the code within two years of the date of licensure
Reference:	**12VAC5-412-380**

Revised: Date & Initial:										
Reviewed: Date & Initial										

Disaster Preparedness at Peninsula Medical Center for Women

Satisifies: 12VAC 5-412, 150, 350

This document is a summary outline of Peninsula Medical Center for Women disaster preparedness (DP) contained in our Readiness Notebook which is part of our procedural manual. In order to maintain the safety and security of our center, staff and patients the full plan is not disclosed herein because of concerns for breach of security with a FOIA request. These general guidelines are based on suggestions contained in the Security Resource Manual, Legal Remedies to Address Violence and Harassment and the Field Guide to Anti-Abortion Extremists handbooks of the National Abortion Federation (NAF), FBI FACE Task Force and our assigned FBI agent, Virginia Department of Health Pandemic Preparedness and NAF and from various FEMA and CDC publications.

Routine Preparation for Anti-Choice Violence and Natural Disasters

- Emergency Contact list with phone numbers of staff, volunteers, and law enforcement readily accessible. Appoint Staff Security Agent to coordinate DP.
- Communicate regularly with Newport News City police, the FBI Domestic Terrorism and FACE Task Force. Contact chain to alert of impending Anti-Choice threats and actions is established and implemented with threats.
- Phone tree implemented so that everyone knows who is responsible for calling each member of the staff and patients in case of an emergency closures or reschedules.
- Copies of the Emergency Contact list, phone tree, and emergency vendor list kept at an offsite locations.
- Emergency assembly point designated, which is a safe distance from Peninsula Medical Center, staff is aware and trained to location, law enforcement and fire and rescue notified.
- Fire extinguishers are current and functioning through annual certified inspection.
- Staff trained on the proper shut off of utilities, evacuations with and without patients
- Staff trained and aware of the location of first aid kits and supply kit and use of safe room.

Preparation of a Basic Disaster Supply Kit

A basic emergency supply kit appropriate for the facility is stored in our Safe Room. The kit could include the following items appropriate from http://www.ready.gov/basic-disaster-supplies-kit:

- Water: 2 gallons of water for drinking and sanitation. Food: an emergency supply of non-perishable food.
- Flashlights, hand crank or battery-powered with extra batteries,
- Basic First aid kit
- Basic tools including: wrench, pliers, screwdrivers, snips
- Emergency contact list

Recommendations for Anti Choice Domestic Terrorist Attacks more at NAF's, FBI and ATF

Before Anti-Choice Violence and Disruption Incidents:

- Annually Practice the survey techniques for bomb threats
- Implement the FBI and City of Peninsula Police recommendations as fully as possible
- Secure the Facility with appropriate surveillances and Key Control
- Follow Opening and Closing Procedures and staff policies for knowing who is on site
- Conduct Employment Background Checks as needed for verification and require Confidentiality agreements for all non-patient visitors.
- Train Staff how to use the Phone Threat and Harassment Reports and the Violence and Disruption Reports

During Anti-Choice Violence and Disruption Incidents:

- Implement the Violence and Threat plan. Evacuate to the Safe Room immediately if a domestic terrorist trespasses with gun, bomb or device. If a telephone threat or warning of Bomb or biological agent implement the Threat plan and evacuate if or as advised.
- CALL 911. Alert to incident those individuals or agencies on Emergency Contact list.
- Identify who and where fellow staff or patients are. Check for injuries. Do not attempt to move seriously injured people unless they are in immediate danger of further injury.
- Remain in Safe Room and keep doors locked. Do not attempt to evacuate unless so instructed by Police, FBI or ATF.
- Once staff is secure make mental or written notes of description, time etc. to further assist law enforcement.

After Anti-Choice Violence and Disruption Incidents:

- Once released by law enforcement survey your work space for damage, things out of place, etc. and advise attending officers
- Complete the Disruption or Threat Report
- Staff Security Agent is to notify all the appropriate agencies; verify that the facility security measures are functional. As needed locksmiths notified to change locks; patients to be rescheduled as needed.

Recommendations for Fire Procedures Additional at NAF's or at http://www.ready.gov/fires.

Before a Fire:

- Annually practice our fire escape plan with our staff.
- Peninsula Fire and Rescue train as needed for a second way out. A secondary route might be a window with a collapsible ladder for escape from upper story designated window.
- Practice feeling your way out of the building in the dark or with your eyes closed.
- At closing each day, close all interior doors to contain any fire occurring after hours.

During a Fire:

- Implement the fire evacuation plan.
- CALL 911 immediately if you discover fire or smoke. Look for and extinguish small fires.
- When the alarm sounds, get out fast. You may have only seconds to escape safely. Stay where you are and signal for help at the window with a light-colored cloth or a flashlight if you cannot evacuate.
- Identify who and where fellow staff or patients are. Check for injuries. Do not attempt to move seriously injured people unless they are in immediate danger of further injury.
- If you can't get to someone needing assistance, leave the building and call 911 or the fire department. Tell the emergency operator where the person is located.
- Remember the evacuation methods:
    - Crawl low under any smoke to your exit - heavy smoke and poisonous gases collect first along the ceiling.
    - If there is smoke blocking your door or first way out, use your second way out. Smoke is toxic. If you must escape through smoke, get low and go under the smoke to your way out.
    - Before opening a door, feel the doorknob and door. If either is hot, leave the door closed and use your second way out.
    - f there is smoke coming around the door, leave the door closed and use your second way out.
    - If you open a door, open it slowly. Be ready to shut it quickly if heavy smoke or fire is present.
    - If you can't get out, close the door and cover vents and cracks around doors with cloth or tape to keep smoke out. Call 9-1-1 or your fire department.
- If your clothes catch fire, stop, drop, and roll – stop immediately, drop to the ground, and cover your face with your hands. Roll over and over or back and forth until the fire is out. If you or someone else cannot stop, drop, and roll, smother the flames with a blanket or towel. Use cool water to treat the burn immediately for three to five minutes. Cover with a clean, dry cloth. Get medical help

After a Fire:

- Check with the fire department to make sure your building is safe to enter. Be watchful of any structural damage caused by the fire. Return only when authorities say it is safe.
- The fire department will advise if utilities are either safe to use or are disconnected before they leave the site. DO NOT attempt to reconnect utilities yourself.
- Conduct an inventory of damaged property and items. Do not throw away any damaged goods until after an inventory is made.
- Try to locate valuable documents and records.
- Staff Security Agent is to notify all the appropriate agencies; verify that the facility security measures are functional. As needed locksmiths notified to change locks; patients to be rescheduled. Begin saving receipts for any money you spend related to fire loss. The receipts will be needed later by the insurance company for verifying losses.

Recommendations for Earthquake Procedures visit http://www.ready.gov/earthquakes

During an Earthquake:

- Drop, cover, and hold on. Minimize your movements to a few steps to a nearby safe place and if you are indoors, stay there until the shaking has stopped and you are sure exiting is safe.

- Stay away from glass, windows, outside doors, walls, and anything that could fall, such as lighting fixtures or furniture.
- **DO NOT** use the elevators.
- Be aware that the electricity may go out or the sprinkler systems or fire alarms may turn on.

After the tremors have stopped:

- Look around to make sure it is safe to move, and then exit the building. Identify who and where fellow staff or patients are. Check for injuries. Do not attempt to move seriously injured people unless they are in immediate danger of further injury.
- Expect aftershocks. These secondary shockwaves are usually less violent than the main quake but can be strong enough to do additional damage to weakened structures and can occur in the first hours, days, weeks, or even months after the quake.
- Help injured or trapped persons. Give first aid where appropriate. Do not move seriously injured persons unless they are in immediate danger of further injury. Call for help.
- Look for and extinguish small fires. Fire is the most common hazard after an earthquake.
- Listen to a hand crank or battery-powered radio or television for the latest emergency information.
- Use the telephone only for emergency calls.
- Stay away from damaged areas unless your assistance has been specifically requested by police, fire, or relief organizations. Return only when authorities say it is safe.
- After it is determined that it's safe to return, your safety should be your primary priority as you begin clean up and recovery.
- Staff Security Agent is to notify all the appropriate agencies; verify that the facility security measures are functional. As needed locksmiths notified to change locks; patients to be rescheduled. Check for gas leaks. If you smell gas or hear a blowing or hissing noise, open a window and quickly leave the building.

Recommendations for Flood, Hurricane and Heavy Rains Procedures For more visit http://www.ready.gov/floods

Flooding can occur from storms or equipment failure.

Before a Flood or water incident:

- Identify storm drains, streams etc. in the area that could flood and impede evacuation.
- Power down all computers. Unplug power strips and store as high as possible.
- Remove or relocate computers if possible.
- Shut off power to phone system.
- If you need to evacuate, be aware that flash flooding can occur. If there is any possibility of a flash flood, move immediately to higher ground.

During a Flood or water incident:

- Listen to the radio or television for information.
- Be aware of streams, drainage channels, and other areas known to flood suddenly.

If you must prepare to evacuate, you should do the following:

- Secure the building.
- Do not walk through moving water. Six inches of moving water can make you fall. If you have to walk in water, walk where the water is not moving. Use a stick to check the firmness of the ground in front of you.
- Do not drive into flooded areas. If floodwaters rise around your car, abandon the car and move to higher ground if you can do so safely. You and the vehicle can be swept away quickly.
- Do not park your vehicle along streams, rivers, or creeks, during threatening conditions.

After the flood:

- Use local alerts and warning systems to get information and expert informed advice as soon as available. Identify who and where fellow staff or patients are. Check for injuries. Do not attempt to move seriously injured people unless they are in immediate danger of further injury.
- Avoid moving water.
- Stay away from damaged areas unless your assistance has been specifically requested by police, fire, or a relief organization. Emergency workers will be assisting people in flooded areas. You can help them by staying off the roads and out of the way.
- Play it safe. Additional flooding or flash floods can occur. Listen for local warnings and information. If your car stalls in rapidly rising waters, get out immediately and climb to higher ground.
- Return only when authorities indicate it is safe.

Recommendations for Tornado Procedures For more visit http://www.ready.gov/tornadoes

At the time of a tornado warning:

- Go to a pre-designated shelter area on a lower floor basement or the lowest building level. Alternatively go to the center of an interior room or interior hallway away from corners, windows, doors, and outside walls. Put as many walls as possible between you and the outside. Get under a sturdy table and use your arms to protect your head and neck.
- Do not open windows.

After the tornado has passed:

- Identify who and where fellow staff or patients are. Check for injuries. Do not attempt to move seriously injured people unless they are in immediate danger of further injury.
- Get medical assistance immediately. If someone has stopped breathing, begin CPR if you are trained to do so.
- Be aware of hazards from exposed nails and broken glass.
- Continue to monitor hand crank or battery-powered radio or television for emergency information.
- Hang up displaced telephone receivers that may have been knocked off by the tornado, but stay off the telephone, except to report an emergency. After a tornado, be aware of possible structural, electrical, or gas-leak hazards.
- In general, if you suspect any damage to your facility, have the Fire and Rescue assist. If you smell gas or suspect a leak, turn off the main gas valve, open all windows, and leave the building immediately. Do not turn on the lights, light matches, smoke, or do anything that could cause a spark. Do not return to your building until you are told it is safe to do so. If you see frayed wiring or sparks, or if there is an odor of something burning, you should immediately shut off the electrical system at the main circuit breaker if you have not done so already, code is in Emergency kit..
- Staff Security Agent is to notify all the appropriate agencies; verify that the facility security measures are functional. As needed locksmiths notified to change locks; patients to be rescheduled. If it is dark when you are inspecting the center, use a flashlight rather than a candle or torch to avoid the risk of fire or explosion in a damaged building.

Peninsula Medical Center for Women

Clinical Policies and Procedures Manual

Department: Personnel	**Policy Description:** Administrator Position
Page: 1 of 1	**Replaces Policy Dated:**
Effective Date: 1/1/12	**Reference Number: 12VAC5-412-160, -170F**
Approved:	

Scope:	Administrator
Purpose:	To provide for continued quality of care in the facility.
Policy:	Governing authority shall select an administrator whose qualifications, authority and duties will allow for the best patient care
Procedure:	1. Governing authority selects an administrator having evaluated her qualifications. 2. Governing authority will review job performance annually. 3. Any outlying patient outcomes will be reported to the governing authority. Any actions of the administrator which contributed to the outcome will be addressed by the governing authority. 4. The administrator is responsible for appointing an individual to act in her absence.

Revised: Date & Initial:										
Reviewed: Date & Initial										

Peninsula Medical Center for Women
10758A Jefferson Avenue
Newport News, Virginia 23601
(757) 599-6389
(757) 599-0347 – fax

Orientation Checklist

Employee _____

Job Title(s) _____

Hire Date _____

	Emp Initials	Trainer init	Date	
1.	_____	_____	_____	Confidentiality Statement
2.	_____	_____	_____	Tour of Building
3.	_____	_____	_____	Job Description
4	_____	_____	_____	Signature Log
5	_____	_____	_____	Emergency Contact List
6	_____	_____	_____	Biweekly payday
7	_____	_____	_____	License if app
8	_____	_____	_____	Criminal Background Check if app
9	_____	_____	_____	CPR Training if app
10	_____	_____	_____	Policy and Procedures Manual
11	_____	_____	_____	Organizational Chart
12	_____	_____	_____	Disaster Preparedness
13	_____	_____	_____	HIPAA Training
14	_____	_____	_____	Bloodborne pathogen training
15	_____	_____	_____	Infection Control training
16	_____	_____	_____	Fire safety training
17	_____	_____	_____	Employee Health packet
18	_____	_____	_____	Keys

I have received the following keys: _____

_____

Signature of Employee Date

T 065 / T070

Peninsula 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. 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:	6/12									
Reviewed: Date & Initial										

Job Description

Front Desk

Front Desk responsibilities include, but are not limited to:

- Greeting Patients and guests
- Answering phones and Scheduling appointments
- Checking over patient paperwork
- Putting together charts (Patient information, consents, FDC's)
- Accepting and documenting payment
- Disinfect work area as needed
- Monitor work area for any need for repairs and advise administrator

Qualifications

1. Must be pro-choice.
2. Ability to multitask
3. Ability to maintain professional demeanor in high-stress environment.
4. Must be flexible.

Training

All staff will be trained in infection control and fire safety initially and annually

Signed _____

Date _____

Job Description

Counselors

Qualifications:

- Must be Pro-Choice
- Knowledge of the Abortion Process, reproduction and birth control

The Abortion Counselor interacts with patients requesting pregnancy information in the following manner:

1. Interviewing each patient with respect to her motivations for seeking an abortion. The interview process should enable the counselor to determine if the patient has considered other options and feels secure with her decision, and if a support network exists.
2. Discussing any emotional or physical problems resulting from and associated with, this pregnancy or previous pregnancies and abortions.
3. Corroborating physician's impression as to whether continuation of the pregnancy will impair or jeopardize the patient's health.
4. Explaining in detail the contemplated surgical and non-surgical procedure, as well as any restrictions and potential after effects.
5. Discussing contraception extensively and comprehensively, and documenting contraceptive history and post-operative birth-control choice.
6. Informing patient of the availability of post abortion counseling
7. Reviewing consent forms and answering questions.
8. Following patient through surgical procedure, if necessary.
9. Checking patient in recovery, post-operatively for further counseling, if necessary.
10. Disinfect work area as needed
11. Monitor work area for any need for repairs and advise administratror

Training

All staff will be trained in inflection control and fire safety initially and annually as well as the training needed for her position.

Signed_____ Date_____

Job Description

Lab Assistant

Qualifications:

- Must be pro-choice
- Must have previous medical experience

Under the general supervision of the clinic coordinator, the lab assistant is responsible for the daily operation of the laboratory including:

1. Drawing blood
2. Rh typing
3. Hemoglobin
4. Running pregnancy tests
5. Maintain patient test results log
6. Disinfect laboratory and reusable equipment after each clinic day
7. Inventory supplies and request restocking from clinic Administrator when necessary
8. Adhere to universal precautions per OSHA guidelines
9. Monitor work area for any need of repair and advise administrator
10. Cross train for other tasks where applicable
11. Other duties as assigned by clinic Administrator

Training: All staff will be trained in infection control and fire safety as well as training for her position. Training will be initially and annually.

Signed _____ Date _____

Job Description

Procedure Room

Staff responsible for assisting the Physician during the abortion procedure and reports directly to the physician and the Administrator.

Qualifications:

1. Must be pro-choice.
2. Must be appropriately trained by existing procedure room staff and then cleared for working.
3. Must be able to take direction.
4. Must be CPR certified

Responsibilities:

1. Act as physician's assistant and patient support person.
2. Proficient with sterile technique
3. Keep procedure room stocked
4. Cross train for recovery and other patient care areas.
5. Per physician instruction, assist in any emergency that may arise and get help immediately.
6. Disinfect procedure room at end of each procedure day
7. Disinfect reusable equipment per policy
8. Monitor work area for need for repairs and advise administrator
9. Other duties as assigned by the nursing supervisor or Administrator.

Training:

All staff will be trained in infection control and fire safety initially and annually

Signed _____Date_____

Job Description

Recovery Room Staff

Qualifications:

- Must be pro- choice
- Must have previous experience with patient care
- Must be certified in CPR
- Nurse must be licensed as licensed or registered nurse
- Nurse must have a criminal background check obtained

Recovery room staff is responsible for:

1. Emotional and physical support of each patient.
2. Meeting patient's needs during post-op observation.
3. Verification of patient identity.
4. Taking and recording vital signs.
5. Recording pertinent information on patients chart
6. Knowledge of sterile technique.
7. Assisting the physician in procedures if necessary.
8. Reporting changes in the patient's condition to person in charge or to the physician.
9. Maintenance and knowledge of use emergency equipment and medications.
10. Cleanliness and disinfection of assigned area.
11. Giving post-op care instructions.

Training: All staff will be trained in infection control and fire safety initially and annually

Signed _____ Date _____

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

Granting of Privileges

W.K.G. and J., Incorporated hereby appoints [redacted] M.D., M.P.H. to the clinical staff of:

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

William G. Fitzhugh, M.D. is approved to:

- Perform 1st trimester abortions including medical abortions
- Direct treatment in any emergency arriving from performance of abortions
- Diagnose and treat ectopic pregnancy
- Perform follow-up examinations
- Perform routine gynecology exams
- Prescribe medications deemed necessary
- Insert and remove IUDs
- Insert and remove Implanon
- Perform biopsy of the cervix
- Perform biopsy of the vagina and vulva
- Perform biopsies of any abnormal tissue
- Perform endometrial sampling
- Perform ultrasound for dating and placement of pregnancy
- Supervise CRNA's\
- Administer IV sedation

T. 105 501

[redacted], President Date

[redacted] M.D. Date

Peninsula Medical Center for Women
Policy and Procedure Manual

Department: Quality of Care	**Policy Description:** Physician Competency
Page: 1 of	**Replaces Policy Dated:**
Effective Date:	**Reference Number:** 12VAC5-412-180
Approved:	

Scope:	Physicians
Purpose:	To provide for exceptional quality of patient care at this facility.
Policy:	Abortion is a safe procedure when performed by compassionate qualified practitioners.
Procedure:	• Abortion procedures will be performed by licensed Obstetricians and/or Gynecologists trained in the provision of abortion care, in accordance with governmental law. • All personnel performing abortions must receive training in the performance of abortions and in the prevention, recognition and management of complications. • When practicable, physicians performing abortions will train appropriate medical students, residents and interns in the performance of abortions and in the prevention, recognition and management of complications. • A copy of the most recent medical license of all physicians with clinical privileges will be prominently posted in each center in which they provide care. • Personnel files of physicians will include clinics in which they have clinical privileges, hospitals at which they have admitting rights, documentation of training hours, and CME's, as well as copies of any awards or Board of Medicine admonitions. • Privileges will be granted by the Governing Authority • CPR Certification and Criminal Background Checks will be on file • The physician will treat each patient with dignity and respect, greeting each patient individually, introducing themselves, and clarifying whether they have questions and understand the procedures as explained to them. • The physician shall remain on the premises until all patients are medically stable, sign the discharge orders, and will be available and accessible until the last patient is discharged. • The administrator and medical director jointly will have final approval of physician hires and clinical privileges.
Reference:	12VAC5-412-180

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Revised: Date & Initial										
Reviewed: Date & Initial										

Peninsula Medical Center for Women

Clinical Policies and Procedures Manual

Department: Patient Care	**Policy Description:** Minors
Page: 1	**Replaces Policy Dated:**
Effective Date: 6/22/12	**Reference Number: 12VAC5-412-200**
Approved:	

Scope:	All patients under the age of 18
Purpose:	To ensure no abortion procedure is performed on a minor unless informed written consent is obtained from the minor and the minor's parent, guardian or other authorized person
Policy:	No person may perform an abortion upon an unemancipated minor unless written consent is obtained from the minor and the minor's parent, guardian or other authorized person.
Procedure:	- If person is under the age of 18, a parent, guardian, or other authorized person must accompany the minor and provide identification - Parent, guardian, or other authorized person must sign a parental consent form consenting to abortion services being provided to the minor. This form will be notarized - If the minor elects not to seek the informed written consent of an authorized person, a copy of the court order authorizing the abortion entered pursuant to the 16.1-241 of the Code of Virginia shall be obtained prior to the performance of the abortion
Reference:	**12VAC5-412-200**

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Revised: Date & Initial:										
Reviewed: Date & Initial										

Peninsula Medical Center for Women

Clinical Policies and Procedures Manual

Department: Patient Care; Infection Prevention	**Policy Description:** Pre-screening
Page: 1 of 1	**Replaces Policy Dated:**
Effective Date: 1/1/12	**Reference Number: 12VAC5-412-150, -220**
Approved:	

Scope:	All patients and visitors
Purpose:	To provide for continued quality of care in the facility; to reduce infection spread among patients and visitors
Policy:	Patients and visitors will be screened for acute illness prior to receiving care
Procedure:	All staff are responsible for visually screening patients and visitors who exhibit symptoms of acute illness, especially: Cough Sore throat Severe widespread muscle aches Extreme fatigue Diarrhea Undiagnosed rash or skin lesions Febrile state If possible, patient or visitor will be isolated in a private room. The physician will be consulted about the symptoms and if advised, the patient or visitor will be sent to their own physician or hospital
Reference:	**12VAC5-412-150, -220**

Revised: Date & Initial:										
Reviewed: Date & Initial										

Peninsula Medical Center for Women

Clinical Policies and Procedures Manual

Department: Infection Control	**Policy Description:** Infection Control Monitoring
Page: 1	**Replaces Policy Dated:**
Effective Date: 6/21/12	**Reference Number: 12VAC5-412-220B**
Approved:	

Scope:	Infection Control Officer; All Staff
Purpose:	To provide a tool to monitor the Center's infection control plan and to monitor compliance of the staff throughout the Center
Policy:	The Infection Control Officer shall use the Infection Control Survey quarterly to identify need for changes and corrective action.
Procedure:	Each quarter, the Infection Control Officer will conduct the Survey. Compliance issues will be identified and appropriate changes made. Findings will be reported to the Quality Assurance Committee. Retraining of staff will be performed as indicated by the survey.
Reference:	**12VAC5-412-220B**

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Revised: Date & Initial:										
Reviewed: Date & Initial										

	Yes	No
Are items allowed to dry before use?		
Are sani-wipes used?		
Is Cavicide or equivalent used?		
Are timers used ?		
Environmental Infection Control		
Are procedure rooms terminally cleaned daily?		
Are all surfaces in procedure cleaned and disinfected with the proper approved disinfectant?		
Does the staff know the procedure to decontaminate gross blood spills?		
Are there rust spots or tears on equipment?		
Are chemicals stored AWAY from clean supply room?		
Program, System, Education		
Does the center have an explicit infection control program?		
Does the infection control follow national recognized infection control guidelines?		
Is there a person trained for infection control?		
Is there a complication log?		
Is there inservice or computer based infection control training for the staff?		
Does all of the staff receive infection control training?		
Is training conducted initially?		
Is training conducted annually?		
Is training documented?		
Hand Hygiene		
Do all areas have soap and water available to wash hands?		
Is there alcohol based hand rub available?		
Does staff perform hand hygiene after removing gloves?		
After direct patient contact?		
Before starting in IV?		
After removing gloves after contact with blood, body fluids, or contaminated surfaces?		
Does the staff wear gloves for procedures that might involve contact with blood or body fluids?		
Does staff wear gloves when handling contaminated patient equipment?		
Does staff remove gloves before moving to the next task and/or patient?		

INFECTION CONTROL SURVEY

TO BE PERFORMED QUARTERLY TO MONITOR STAFF ADHERENCE TO INFECTION CONTROL PRACTICES

Performed by: Date:		
	YES	NO
Injection Practices		
Are needles used for only one patient?		
Are syringes used for only one patient?		
Are medication vials always entered with a new needle?		
Are medication vials always cleaned with alcohol before they are used?		
Are medications that are pre-drawn labeled with the medication name, initials of the person drawing, expiration date and time?		
Are single dose medication vials used for only one patient?		
Are bags of IV solutions used for only one patient?		
Is administration tubing an connectors used for only one patient?		
Are multi-dose vials dated and initialed when opened?		
Are they discarded according to manufacturers' recommendations?		
Are multi-dose vials stored away from immediate areas of direct patient contact?		
Are all sharps disposed in a puncture-resistant container?		
Are all sharps containers secure?		
Are all sharps containers replaced when the fill line is reached?		
Sterilization		
Is pre-cleaning always performed prior to sterilization?		
Does the staff use steam sterilization?		
Are all instruments inspected visually for proper cleaning prior to packaging and sterilization?		
Is there autoclave indicator tape or other indicator on each item?		
Is documentation of preventive maintenance present and up to date?		
Are all items contained and handled so as to assure sterility is not compromised?		
Are all instruments stored in a clean designated area?		
Are sterile packages inspected for tears, cracks, or damage prior to use?		
If a sterile package is compromised, are items resterilized prior to use?		
Are all packs initialed and dated?		

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Problems or issues		

Peninsula Medical Center for Women
Policy and Procedure Manual

Department: Quality of Care	**Policy Description:** PATIENT COUNSELING AND EDUCATION
Page: 1 of	**Replaces Policy Dated**:
Effective Date:	**Reference Number:** 12VAC5-412-240B
Approved:	

Scope:	All facility personnel.
Purpose:	Patient Education and/or Counseling is a discussion of the feelings and concerns expressed by the patient which may include help with decision making and contraceptive choices, values clarification, or referral to other professionals.
Policy:	The facility shall offer each patient appropriate counseling and instruction in the termination procedure.
Procedure:	• Each patient will have a private opportunity to discuss issues and concerns about her abortion with a trained staff member who offers her the time needed to address such. • Information about clinical procedures, aftercare and birth control must be reviewed with the patient during her visit to the facility. In addition, she will be given a hard copy of aftercare and birth control information. • Each patient shall be made aware of the availability of post-abortion counseling • If the patient is torn about her decision to terminate, she will be offered VDH referrals to local resources suited to help her continue the pregnancy, she will also be offered another appointment at a later date, giving her more time to work through her decision. • A referral to community services should be available if that becomes necessary or the needs of the patient are outside the scope of training of clinic staff. • If concerns of safety arise in counseling- sexual abuse, child abuse, domestic violence, coercion, etc- staff may temporarily stop counseling, offering the patient appropriate reading material, while staff consult with the manager on duty. • All reasonable precautions must be taken to ensure the patient's confidentiality, in accordance with Federal and State guidelines. When any third party is involved with payment for abortion, certain protected information will be given to that entity. Depending on applicable laws and regulations, the patient may need to be informed and authorization obtained for the communication of this information.
Reference:	12VAC5-412-240B

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Reviewed: Date & Initial										

Expiration Date Log

Location: _____

Date: _____

Item	Expiration Date	Initials

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Date	Versed	Fentanyl	Xanax 0.5 mg	Xanax 1 mg	T-3	Name	Initials

	1 mg/ml Versed	Fentanyl	Xanax 0.5 mg	Xanax 1 mg	Tylenol 3	Signature and Date
Count in						
Dispensed						
Received						
Count out						
Diff						
Count in						
Dispensed						
Received						
Count out						
Diff						
Count in						
Dispensed						
Received						
Count out						
Diff						
Count in						
Dispensed						
Received						
Count out						
Diff						
Count in						
Dispensed						
Received						
Count out						
Diff						

Peninsula Medical Center for Women

Clinical Policies and Procedures Manual

Department: Pharmaceutical Services	**Policy Description:** Use of Multidose Vials
Page: 1 of 1	**Replaces Policy Dated:**
Effective Date: 6/12	**Reference Number:** 12VAC5-412-260
Approved:	

Scope:	All nursing, allied health and medical staff.
Purpose:	To determine the procedures for multi-dose vials.
Policy:	The following guidelines shall be followed with regard to the use of multi-dose vials at the Center.
Procedure:	Guidelines: A) Multi-dose vials are to be opened/penetrated using strict aseptic technique. B) Unless contamination of a multi-dose vial is apparent or suspected, the vial may be used for 30 days for opened or entered vials unless otherwise specified by the manufacturer. C) All multi-dose vials will be dated and initialed when opened. If a vial is found to be opened and not dated and initialed, it is to be discarded. D) Single use vials are opened and discarded after one time use. E) Recommended discard times for: 1) IV tubing 24 hours 2) IV sets 24 hours 3) Irrigating solutions 24 hours
Reference:	12VAC5-412-260

T 285

Revised: Date & Initial	06/14/99	05/12/00	12/19/06	4/5/10						
Reviewed: Date & Initial	09/01/03	12/06/04	10/09/07	12/31/08	11/09/09					

Peninsula Medical Center for Women

Clinical Policies and Procedures Manual

Department: Quality Assurance	**Policy Description:** Quality Assurance and Process Improvement, QAPI
Page: 1 of 2	**Replaces Policy Dated:** 4/1/12
Effective Date: 6/5/2012	**Reference Number:** 12 VAC5-300-A, B, C, D, E
Approved:	

Scope:	All facility personnel
Purpose:	To establish a QAPI program to achieve optimal care for the consumer as well as provide for patient and employee safety.
Policy:	QAPI is a program which allows both administrative personnel and staff to identify real or potential problems, document findings, and use methodology to improve processes to improve outcomes in various areas as noted below.
Procedure:	A. QAPI for the facility serves as an ongoing, comprehensive, integrated, self-assessment program of the quality and appropriateness of care or services provided, including services provided under contract or agreement. The program includes process design, data collection/analysis, assessment and improvement and evaluation. The findings are used to correct identified problems and revise policies and practices. B. To ensure adequacy and appropriateness of services, and to identify unacceptable or unexpected trends or occurrences the following shall be evaluated: 1. Staffing patterns and performance, done annually and as needed. 2. Supervision appropriate to the level of service, done annually and with position vacancies. 3. Patient records; with one record checked weekly by site administrator; and full audit of all records current with procedure day every other month; and as determined by chart errors found through audits. 4. Patient satisfaction; through patient satisfaction queries in a format ensuring privacy of responses. 5. Complaint resolution; through audits for trends. See also policy on patient rights (12VAC5-412-210, B, C, & D.) 6. Infections, complications and other adverse events; audits done and occurrences sent to Regional Director for trending. 7. Staff concerns regarding patient care. 8. Periodic safety checks on all equipment C. The quality improvement (QI) committee is responsible for the oversight and supervision of the program and shall consist of: 1. A physician 2. A non-physician health care practitioner 3. A member of the administrative staff 4. An individual with demonstrated ability to represent the rights and concerns of patients. This may be a member of the facility's staff. 5. There may be coordination between the Regional Director's multiple sites of responsibility to provide a range of insight helpful to the improvement process.

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	D. When problems are identified measures shall be implemented to resolve the problems and concerns that have been identified. E. Results of the quality improvement program will be reported 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 corrections actions shall be documented. Identified deficiencies that jeopardize patient safety shall be reported immediately in writing to the licensee by the quality improvement committee.
Reference:	12 VAC5-300-A, B, C, D, E

Revised: Date & Initial:										
Reviewed: Date & Initial										

Peninsula Medical Center for Women

Clinical Policies and Procedures Manual

Department: Functional Safety and Maintenance	**Policy Description:** Preventive Maintenance
Page:	**Replaces Policy Dated:**
Effective Date: 5/1/12	**Reference Number:**
Approved:	

Scope:	All patient monitoring equipment and electrical equipment
Purpose:	To ensure that all equipment is in good working condition for the safety of the patient as well as the staff operating the equipment
Policy:	Equipment shall be checked and/or tested in accordance with manufacturer's specifications at least annually. After repairs and/or alterations are made, the equipment shall be thoroughly tested for proper operation before it is returned to service. Records shall be maintained on each piece of equipment to indicate its history of testing and maintenance
Procedure:	An annual schedule will be maintained in which each piece of patient monitoring equipment and other electrical equipment will have a preventive maintenance review. Records will be kept for each piece of equipment to indicate its history of testing and maintenance. Stickers will be placed on each piece of equipment when the PM has been conducted. The administrator will oversee the scheduling of the preventive maintenance program.
Reference:	**12VAC5-412-360**

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Reviewed: Date & Initial										

The finding of deficiency for noncompliance with 12VAC5-412-380 is inappropriate because Peninsula Medical Center for Women (PMCW) 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 PMCW a variance. The plan that PMCW 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 14, 2012 – Brought in an architect to do an assessment of PMCW's facility for compliance with 12VAC5-412-380.

May 9. 2012 – Fire marshal conducted inspection and found facility in compliance with fire code.

July-Oct. 2012

- Identify mechanical engineer and schedule inspections or evaluation visits as appropriate to obtain information on insulation rating and HVAC/ ventilation requirements. To write report and design system to come into compliance
- Identify electrician able to inspect electrical system and evaluate compliance. Perform upgrades as necessary.
- Building owner to 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.

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 PMCW 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 PMCW in the long run. Consult with Department of Health concerning timeline.

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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.