STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AF-0014	A. BUILDING _____ B. WING _____	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA WOMEN'S HEALTH CLINIC	101 S. WHITING ST. SUITE #215 ALEXANDRIA, VA 22304

(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 unannounced Revisit Licensure Abortion Facility inspection, following the facility's December 2014 Biennial Licensure inspection, was conducted on 03/17/2015. Two Medical Facilities Inspectors from the Office of Licensure and Certification, Virginia Department of Health conducted the survey. The agency remained out of compliance with 12 VAC- 412 Regulations for the Licensure of Abortion Clinics. (Effective 06/20/2013). Deficiencies were cited.	(T 000)	T000 Plan of Correction	
(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	(T 170)	T170 Immediate Corrective Action: ~~12/30/14~~ 3/20/15 A meeting was conducted on March 19, 2015 by the Medical Director/Director of Nursing about Infection Prevention regarding correct hand-washing techniques. (all staff attended). Staff #4 has been re-educated on March 20, 2015 (one-on-one) to wash hands prior to donning gloves, before touching a patient, before exiting the patient's care area and after touching the patient or the patient's immediate environment.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: DANIEL NOONAN MD — (X6) DATE: 4/28/15

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(T 170)	Continued From Page 1	(T 170)		

retraining of all staff in recommended infection prevention practices.

This RULE: is not met as evidenced by:
Based on observation and interview, it was determined the agency failed to ensure the use of standard precautions by clinicians, when wearing gloves to prevent transmission of microorganisms.

The findings included:

It was observed on 3/17/2015, at approximately 11:00 AM, that Staff #4 did not use standard precautions. Staff #4, who was assisting a post-procedural patient, proceeded to the recovery room and touched another patient, without changing gloves or performing hand hygiene per agency policy.

During an interview at 11:10 AM, Staff #4 acknowledged she had received training in hand hygiene.

At approximately 11:45 AM, Staff #4 performed hand hygiene prior to donning gloves to assist a post-procedural patient. Staff #4 picked up a crate with the belongings of a pre-procedure patient and placed the crate in the procedure room. Staff #4 proceeded to touch the post-procedural patient without first performing hand hygiene and changing gloves.

According to the Center for Disease Control (CDC), Guide To Infection Prevention For Outpatient Settings, hand hygiene should be performed:

1. Before touching a patient, even if gloves will be worn
2. Before exiting the patient's care area after touching the patient or the patient's immediate

Random monitoring for proper infection control procedures (hand-washing) will be done every two to three months for the next year and results will be reported to the Quality Assurance Committee.
Reporting shall continue if any compliance issues are found.

Measures to Maintain Compliance:
Staff retrained on March 19 and March 20, 2015. Training, In-services, and random monitoring will continue to ensure compliance.

Date of Completion:
March 20, 2015.

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	AF-0014	A. BUILDING _____ B. WING _____	03/17/2015

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{T 170}	Continued From Page 2	{T 170}		

environment
3. After glove removal

During an interview on 3/17/2015, at approximately 12:00 PM, Staff #1 stated that staff members were trained in standard precautions and hand hygiene and thought they were doing a good job of hand hygiene. Staff #1 and #2 acknowledged that although the staff had been trained, ongoing training and monitoring was needed and that this process would be implemented.

{T 180} 12 VAC 5-412-220 D Infection prevention {T 180}

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;
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 staff interviews, chart reviews and document review the facility failed to have an employee health program that documented screenings offered/received by employees in

Immediate Corrective Action: ~~12/30/14~~ 4/8/15

A review of all personnel records was done on March 19, 2015 to ensure records are complete, accurate easily accessible and organized.

All staff personnel records contain evidence verifying an annual tuberculosis screenings and/or tuberculin test or Purified Protein Derivative test (PPD).

This corrective Action includes all staff

Personnel # 1, 2, 3, 4 and 5

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(T 180)	Continued From Page 3	(T 180)		

accordance with statute, regulation or recommendations of public health authorities for five (5) of six (6) employees and three (3) of three (3) physicians.

The findings included:

A review of five (5) personnel records (Personnel #1, 2, 3, 4 and 9) and four (4) credentialing personnel records (Credentialing Personnel #5-#8) failed to contain evidence verifying employees were offered/received annual tuberculosis screenings. Personnel record #2 contained evidence a chest x-ray was performed on 03/07/2000, but no further evidence shown for an annual screening. Personnel record #3 contained no evidence of tuberculosis screenings or test being performed. Personnel record #4 contained evidence a chest x-ray was performed on 06/04/2012, but no further evidence of an annual screening. Personnel record #6 contained evidence of a negative tuberculosis test performed on 06/11/2012, but no further evidence of an annual screening. Credentialing Personnel record #7 contained evidence a chest x-ray was performed in 2011, but no further evidence of an annual screening. Credentialing Personnel record #8 and #9 contained no evidence of tuberculosis screenings or test being performed.

The agency's policy titled, "Employee Health" was reviewed on 03/17/2015. The policy acknowledged new staff members are required to have the tuberculosis skin test also known as the tuberculin test or Purified Protein Derivative (PPD) test upon hire or within five (5) days of employment. All staff will receive annually the PPD or chest x-ray if contraindicated.

An interview was conducted with Staff #1 on 03/17/2015 at approximately 11:00 a.m. The

PPD given on 3/20/15 and was read on 3/23/15.
Three out of five personnel had a positive result and were referred for chest x-rays (CXR). CXR results were negative on March 26, 2015.

Credentialing Personnel #5, 6, 7, 8 and 9.

PPD given on 3/20/15 and was read on 3/23/15.
There were no positive PPD results/no adverse effect on credentialing personnel.

TB Screening was done from March 20 - April 3, 2015 on all personnel.

Measures to maintain Compliance:
All personnel were administered PPD and read on day 3. The administration of annual PPD test/screening was completed on April 3, 2015. The governing body

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{T 180}	Continued From Page 4	{T 180}	will review all personnel and credentialing personnel records annually to ensure compliance. Completion Date: April 3, 2015	

findings related to having screening and immunizations offered/received by employees were discussed. Staff #1 acknowledged the facility does have a process for offering employees screening and immunizations, including Hepatitis B and the influenza vaccine. Staff #1 reported many employees refuse this offered service but are required to sign an "Informed Refusal Form" found in the employee personnel record. Staff #1 reported he/she was only aware that once a x-ray or PPD test was performed, that was it and no further screening was necessary. Staff #1 stated, "PPD test is only contraindicated in people who have had a severe reaction to a previous tuberculin skin test; if contraindicated a chest x-ray is ordered for that employee." The surveyor inquired if Staff #1 had documented the employee's refusal of a screening. Staff #1 stated, "We don't have anything about tuberculosis screening and we don't require it because we didn't know we needed to after an employee received an x-ray or a skin test."

An exit interview was conducted with Staff #1 and Staff #2 on 03/17/2015 at 12:15 p.m. Staff #1 stated, "Everyone here goes some where else to have their PPD test or x-ray done. We decided a day will be picked within the next month and everyone will bring in the documents needed to show each employee's skin test or x-ray has been done and placed in their personnel record."