

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		001 PROVIDER/SPILLER IDENTIFICATION NUMBER AF-0019	002 MULTIPLE CONSTRUCTION A. BUILDING _____ B. YEAR _____	003 DATE SURVEY COMPLETED 10/31/2014
NAME OF PROVIDER OR SUPPLIER PL PARENTHOOD METRO WASHINGTON FALLS C		STREET ADDRESS, CITY, STATE, ZIP CODE 309 E MAPLE AVE, SUITE 300 FALLS CHURCH, VA 22080		
004 ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LHA IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	005 COMPLETE DATE
T-009	12 VAC 5-412 Initial comment An unannounced Licensure Bureau survey was conducted 10/30/2014 through 10/31/2014. Two Medical Facilities Inspectors from the Office of Licensure and Certification, Virginia Department of Health conducted the survey. The agency was not in compliance with 12 VAC-412 Regulations for the Licensure of Abortion Clinics. (Effective 06/20/2013).	T-009		
T-130	12 VAC 5-412-208 Minor No person may perform an abortion upon an unaccompanied minor unless informed written consent is obtained from the minor and the minor's parent, guardian or other authorized person. If the unaccompanied 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. This RULE is not met as evidenced by: Based on interview and record review it was determined that the agency failed to provide evidence that a written consent was obtained from an authorized adult for a minor (Patient 08) in one (1) out of three (3) minors in a survey sample of three. (Patients 08)	T-130	Actions to correct the deficiency: Patient care is top priority. PPMW holds on the highest professional standards of care, and we follow all laws. During the site inspection, we became aware of one instance where our high standard was not met regarding our routine procedure of checking a minor's consent form. We have taken swift corrective action, including conducting an internal review to ensure that we are complying with all laws, retaining all staff, and instituting additional safeguards in our administrative and quality assurance systems. Actions to prevent a recurrence of the deficiency: To ensure the highest quality care, PPMW-Falls Church immediately implemented an expanded policy and additional procedures related to minor consent checking. The actions require daily checkpoints throughout a minor's visit to verify age and needed consent, a paperwork color coding system for minor patients, and expanded signing protocols for parents. Specifically, the expanded policy and procedures require the following: (1) the age of each patient will be reviewed at multiple steps of the visit; (2) determine if the patient is a minor; (3) when the patient is determined by the front desk staff to be a minor, a red folder will be used for that patient's records to indicate that the patient is a minor; and (4) the physician will document in the electronic health records that before beginning the procedure, he/she reviewed the age of the patient and determined that the necessary consents had been obtained. The initial training occurred in mid-November and all additional trainings will be in place fully by January 7, 2015. Actions to maintain compliance: All staff will be required to review the final policy and procedures and acknowledge that review on record by January 7, 2015.	
The findings included: Review of electronic patient records on 10/30/2014, revealed that a 17 year old patient (08) was admitted on 4/20/2014, and underwent an abortion on 5/2/2014. Review of the informed consent revealed that there was no signature of the parent or legal guardian.				

LABORATORY DIRECTOR OF PROVISIONS/SPILLER RESPONSIBILITY SIGNATURE: W. Meyer DATE: 12/17/14
 STATE FORM: _____ TITLE: CEO DATE: 12/17/14
 664011 (Revised 08/14)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		CPI PROGRAM/SP/PR/MLA IDENTIFICATION NUMBER		CPI MULTIPLE CONVICTIONS		CPI LICENSE STATUS	
		AFCWIS		A. NONE		10000000	
NAME OF PROVIDER OR SUPPLIER PL PARENTHOOD INC THE WASHINGTON FALLS C				THEIR ADDRESS CITY STATE ZIP CODE 202 S. MAPLE AVE. STATE ST FALLS CHURCH VA 22048			
CPI ID NUMBER	STATEMENT OF DEFICIENCIES (CPI MUST COMPLETE THIS SECTION BY FULL COMPLIANCE WITH ALL IDENTIFIED DEFICIENCIES)	CPI ID NUMBER	PROVIDER NAME OR COMPANY (CPI MUST COMPLETE THIS SECTION BY FULL COMPLIANCE WITH ALL IDENTIFIED DEFICIENCIES)	CPI ID NUMBER	PROVIDER NAME OR COMPANY (CPI MUST COMPLETE THIS SECTION BY FULL COMPLIANCE WITH ALL IDENTIFIED DEFICIENCIES)	CPI ID NUMBER	PROVIDER NAME OR COMPANY (CPI MUST COMPLETE THIS SECTION BY FULL COMPLIANCE WITH ALL IDENTIFIED DEFICIENCIES)
T 130	<p>Continued from Page 1</p> <p>An interview was conducted on 10/31/2014 at 10:15 AM with Staff #9. Staff #9 reviewed the electronic record for Patient #9 and acknowledged there was no signature of a parent or legal guardian on the informed consent. Staff #9 stated the agency had experienced a problem with the system capturing electronic signatures.</p>	T 130	<p>PPMH Falls Church Quality Risk Management program will review the status of all cases every 3 months to ensure that the medical documentation is complete. This review will also include a check of the physician's documentation that prior to beginning the procedure, the patient's copy and the consent documents were reviewed. This work will be recorded on the PPMH Schedule of FY 2015 QGRM Audit beginning on January 7, 2015.</p>				
T 135	<p>12 VAC 5-412-210 A Patient's rights</p> <p>A. Each abortion facility shall establish a protocol relating to the rights and responsibilities of patients consistent with the current edition of the Joint Commission Standards of Accreditation Care. The protocol shall include a process reasonably designed to inform patients of their rights and responsibilities in a language or manner they understand. Patients shall be given a copy of their rights and responsibilities upon admission.</p> <p>This RULE is not met as evidenced by: Based on document review and interviews the agency failed to provide documentation that patients received a copy of their rights and responsibilities upon admission for six (6) of six (6) patients included in the survey sample (Patient #1-6).</p> <p>The findings include:</p> <p>Review of six (6) patient records (#1-6) on 10/30/2014 at approximately 1:00 p.m. showed no evidence of patient signatures acknowledging receipt of a copy of their rights and responsibilities.</p> <p>A review of the facility's policy and procedure manual on 10/30/2014 revealed a policy containing a list of patient rights and</p>	T 135	<p>PPMH Falls Church practices at the time of the inspection were stated that staff has a patient sign in for electronic health records to acknowledge that the patient has received the informed copy of the Patient's Bill of Rights & Responsibilities that is provided upon admission. There are additional printed copies of the Patient's Bill of Rights & Responsibilities available in every procedure room and examination room to further review. Where patient information was in late hours, they received one from the Registration Desk, where there were copies of the document for the patient.</p> <p>Actions to correct this deficiency and prevent a recurrence: PPMH Falls Church implemented a new policy of printing of the Patient's Bill of Rights & Responsibilities which all patients will receive a paper copy to take home. A English and Spanish of the Patient's Bill of Rights and Responsibilities along with the other forms provided at the Registration Desk. This will be reviewed in the PPMH Desk Registration process. Further, all patients will sign a newly created form, the Form for consent, acknowledgment, confirming the patient's receipt of the copy.</p> <p>Staff will be required to provide these copies and all of these measures will be in place by January 7, 2015.</p> <p>Actions by compliance monitoring: PPMH Falls Church will monitor, as part of the Quality Risk Management program, records with a certain number of medical records to ensure that the Form (Informed Acknowledgment form) has been fully completed in all cases.</p> <p>This inspection will be recorded on the PPMH Schedule of FY 2015 QGRM Audit.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(C1) PROVIDER/PLP/LEADVA IDENTIFICATION NUMBER AF-0019	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(C3) DATE SURVEY COMPLETED 10/8/2014
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NAME OF PROVIDER OR SUPPLIER PL PARENTHOOD METRO WASHINGTON FALLS C	STREET ADDRESS, CITY / STATE / ZIP CODE 305 S. MAPLE AVE. SUITE 200 FALLS CHURCH VA 22024
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DIO 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)	DATE COMPLETE (DATE)
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T-130	Continued From Page 2 responsibilities and the Office of Licensure and Certification (OLC) Complete Unit toll-free complaint hotline and mailing address.	T-130		
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	<p>On 10/30/2014 at approximately 4:00 p.m., Staff #2 and Staff #6 were shown a patient rights and responsibilities documentation in the patient electronic record and policy and procedure manual. Staff were questioned about the process of providing the patients with a copy of this form on admission. Staff #2 acknowledged staff discuss with the patients their rights and responsibilities at admission, but the facility is not providing patients with a copy.</p> <p>During an interview on 10/31/2014 at approximately 1:30 p.m., Staff #2 acknowledged that the patient files did not have signatures on receiving a copy of patient rights and responsibilities on the admission dates. Staff #2 provided a copy of admission forms that are given to the patients on admission. This procedure could not be substantiated as the form did not designate an area for the patient's signature to acknowledge receipt. Staff #2 acknowledged he/she did not know the facility needed to provide a copy until it was brought to his/her attention by the surveyor.</p> <p>During the exit interview on 10/31/2014, Staff #1, Staff #2, Staff #6 and Staff #7 acknowledged the agency failed to provide documentation showing patients received their rights and responsibilities during admission in the manner required by the regulation and their own approved and established procedure.</p>			
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T-180	<p>12 VAC 5-412-210 D. Patient rights</p> <p>D. The patient shall be given a copy of the complete procedures, in a language or manner</p>	T-180	<p>PPRW Falls Church's practice mandated at the time of the inspection that any time a patient informs any staff member of a complaint, the patient received the form titled Complaint Handling Procedures form with the OLC Complete Unit contact information from the Reception Desk or the health care manager. When patients asked for a copy, they received one to take home.</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(A) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AF-0010	(C) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(D) DATE SURVEY COMPLETED 10/31/2014
NAME OF PROVIDER OR SUPPLIER PL PARISHOOD METHO WASHINGTON FALLS C		STREET ADDRESS, CITY, STATE, ZIP CODE 302 S. MAPLE AVE. SUITE 300 FALLS CHURCH, VA 22044		
(E) ID NUMBER T-100	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LAC IDENTIFYING INFORMATION)	(F) ID NUMBER T-100	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(G) COMPLETE DATE
T-100	<p>Continued From Page 3</p> <p>she understands, at the time of admission to service.</p> <p>This RULE is not met as evidenced by: Based on document review and interviews the agency failed to provide documented evidence that patients received complaint procedure information during admission for six (6) of six (6) patients included in the survey sample (Patient #1-#6).</p> <p>The findings included:</p> <p>Review of six (6) patient records (#1-#6) on 10/30/2014, beginning at approximately 1:00 p.m., showed no evidence of patient signatures acknowledging receipt of the Office of Licensure and Complaint (OLC) complaint information and telephone number, dated on patient admission. The six records also did not have complaint process and OLC information documented as given.</p> <p>A review of the facility's policy and procedure manual on 10/30/2014 revealed a policy containing a list of patient rights and responsibilities and the OLC Complaint Unit toll-free complaint hotline and mailing address.</p> <p>On 10/30/2014 at approximately 4:00 p.m., Staff #2 and Staff #6 were shown a complaint form taken from the waiting area. In the patient electronic record and policy and procedure manual. Staff was questioned about the process of providing the patients with a copy of this form on admission. The form reviewed in the policy and procedure manual included the OLC complaint information including the telephone number; however the form from the waiting area and electronic record showed no evidence the complaint procedures were given to the patient at</p>	T-100	<p>In the waiting room, the patients had access to a prominent box, with a sign on it indicating "Complaints and Compliments" where patients may fill out complaints to PPMW-Falls Church and deposit them in the box.</p> <p>Actions to correct the deficiency and prevent a recurrence: PPMW-Falls Church has expanded the complaint procedure protocol to ensure that patients receive a paper copy of the Complaint Handling Procedures form to take home, in English and Spanish, along with the other forms provided at the Registration Desk. This will be reflected in the Front Desk Registration protocols.</p> <p>Further, all patients will sign a newly created form, the Form Received Acknowledgment, confirming the patient's receipt of this copy.</p> <p>Staff will be retained to provide these copies and all of these measures will be in place by January 7, 2015.</p> <p>Actions to maintain compliance: PPMW-Falls Church will annually, as part of the Quality Risk Management program, randomly audit a certain number of medical records to ensure that the Form Received Acknowledgment form has been fully completed in all cases.</p> <p>This inspection will be recorded on the PPMW Schedule of FY 2015 CQRM Audit.</p>	

STATEMENT OF DEFICIENCY AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AF-0019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2014
NAME OF PROVIDER OR SUPPLIER PL PARENTHOOD METHOD WASHINGTON FALLS C			STREET ADDRESS, CITY, STATE, ZIP CODE 203 S. MAPLE AVE. SUITE 300 FALLS CHURCH, VA 22024		
OSR ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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)	OSR COMPLETE DATE	
T-150	Continued From Page 4 The time of admission. Staff #2 acknowledged patients are given information regarding how to file a complaint with the agency; however, the OLC's information is not provided to the patients. During an interview on 10/31/2014 at approximately 1:30 p.m., Staff #2 acknowledged that the patient files did not have signatures on a complaint process dated on the admission dates. Staff #2 provided a copy of admission forms that are given to the patients on admission. This procedure could not be substantiated as the form did not designate an area for the patients' signature to acknowledge receipt. Staff #2 acknowledged that the complaint procedure provided to six (6) patients, on the day of the procedure, did not have the information for contacting the OLC. During the exit interview on 10/31/2014, Staff #1, Staff #2, Staff #3 and Staff #7 acknowledged the agency failed to provide documentation that patients received the complaint procedure during admission in the manner required by this regulation and their own approved and established procedure.	T-150			
T-150	12 VAC 5-412-210 E Patients' rights E. The facility shall provide each patient or her designee with the name, mailing address, and telephone number of the: 1. Facility contact person; and 2. The OLC Complaint Unit, including the toll-free complaint hotline number. Patients may submit complaints anonymously to the OLC. The facility shall display a copy of this information in a conspicuous place.	T-150	PPMFC Falls Church's practice mandated at the time of the inspection that any time a patient informs any staff member of a complaint, the patient received the Internal Complaint Handling Procedure form with the OLC Complaint Unit contact information from the Reception Desk at the health center manager. When patients asked for a copy, they received one to take home. In the waiting room, the patients had access to a prominent box with a sign on it including, "Complaints and Concerns" where patients may file out complaints to PPMFC Falls Church and the post them in the box. In 2012, the complaint procedure was framed and mounted on the wall. After the walls were painted in May 2014, the complaint procedure was inexplicably not replaced along with the framed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AF-0010	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED 10/31/2014
NAME OF PROVIDER OR SUPPLIER PL PARENTHOOD METRO WASHINGTON-FALLS C		STREET ADDRESS, CITY, STATE, ZIP CODE 303 S. MAPLE AVE. SUITE 300 FALLS CHURCH, VA 22640		
(04) 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)	(05) COMPLETE DATE
T-155	<p>Continued From Page 5</p> <p>This RULE is not met as evidenced by: Based on observation and document review it was determined that the facility failed to display, in a conspicuous place, information on how to lodge a complaint with the facility contact person and the Office of Licensure and Certification (OLC) Complaint Unit.</p> <p>The findings included:</p> <p>On 10/30/2014 at approximately 9:00 a.m., a tour of the facility revealed a complaint box in the patient waiting area, but no postings in the facility with information for making a complaint to the OLC Complaint Unit, including the toll-free complaint hotline number or the facility contact person.</p> <p>A review of the facility's policy and procedure manual on 10/30/2014 revealed a policy containing a list of patients rights and responsibilities and the OLC Complaint Unit toll-free complaint hotline and mailing address.</p> <p>On 10/31/2014 at approximately 10:50 a.m., an interview was conducted with a patient in the recovery room. The patient revealed to the surveyor that the facility did discuss patient rights but a copy was not given to them on admission. The patient acknowledged if he/she had a complaint they would contact the agency directly; however the patient reported he/she did not know that a complaint could be made to the OLC or the OLC's contact information.</p> <p>During the exit interview on 10/31/2014, Staff #1, Staff #2, Staff #4 and Staff #7 acknowledged the agency failed to display information on how to make a complaint with the facility contact person and the OLC Complaint Unit in the manner</p>	T-155	<p>Patient Bill of Rights & Responsibilities and the internal complaint box.</p> <p>Actions to correct the deficiency and prevent a recurrence: PPMW-Falls Church will create a new framed copy of the Complaint Handling Procedures form, in English and Spanish, which includes the OLC hotline information. This form will be posted on the wall by January 7.</p> <p>Actions to maintain compliance: PPMW-Falls Church will mandate that monthly, the health center manager will check to make sure that the mounted Complaint Handling Procedures form is still present and is fully readable, and this inspection will be recorded on the Family Planning and Surgical Services Monthly Operational/Facility Survey.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		001. PROVIDER/FFL IDENTITY IDENTIFICATION NUMBER AE-0016	002 MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	003 DATE SURVEY COMPLETED 10/31/2014
NAME OF PROVIDER OR SUPPLIER PL PARENTHOOD METRO WASHINGTON FALLS C		STREET ADDRESS, CITY, STATE, ZIP CODE 305 S. MAPLE AVE, SUITE 200 FALLS CHURCH, VA 22046		
004 ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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)	005 COMPLETE DATE
T-166	Continued From Page 6 required by this regulation and their own approved and established procedure.	T-166		
T-170	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 exposure); 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.	T-170	Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care (CDC, 2014), Key Recommendations for Safe Injection Practices in Ambulatory Care Settings, page 11, the first two indicators state: "1. Use aseptic technique when preparing and administering medications 2. Cleanse the access diaphragm of medication vials with 70% alcohol before inserting a device into the vial?" At PPMH Falls Church, HCAs (Health Care Assistants) do not provide injections. HCAs do assist the providers who are wearing sterile gloves to draw up the local anesthetic into a syringe by picking and holding the multi-dose vial for the provider to insert the needle. Prior to insertion of the needle into the vial, the HCA will use aseptic technique and cleaned the diaphragm with 70% alcohol. Actions to correct the deficiency and prevent a recurrence: To ensure the CDC's recommendations for safe injection practices in ambulatory care settings are followed: 1. The Abortion Coordinator (Nurse Practitioner) will review the 9 recommendations with all staff involved in the provision of abortion and practice the techniques pertinent to their tasks. 2. Abortion procedure training for HCAs will include the step of cleaning all medication vials with 70% alcohol. 3. The Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care (CDC, 2014), page 11, Key Recommendations for Safe Injection Practices in Ambulatory Care Settings" will be included in the PPMH Health and Safety Manual, Blood Borne Pathogens Exposure Control Plan - Section E Actions to maintain compliance: PPMH's New Clinical Employee Orientation Checklist has been revised and under the "Infection Control" section a new indicator was added - Preparation of Injection Vials. In addition, annual observations will include aseptic techniques which includes preparation of multi-dose vials.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AF-0016	(OR) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(OR) DATE SURVEY COMPLETED 10/15/2014
NAME OF PROVIDER OR SUPPLIER PL PARENTHOOD METRO WASHINGTON FALLS C		STREET ADDRESS, CITY, STATE, ZIP CODE 345 S. MAPLE AVE. SUITE 300 FALLS CHURCH, VA. 22034		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REALITY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (ACTIONS CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE COMPLETE
T-178	<p>Continued From Page 7</p> <p>5. Procedures for appropriate disposal of non-reusable equipment.</p> <p>6. Policies and procedures for maintenance/repair of equipment in accordance with manufacturer recommendations.</p> <p>10. Procedures for cleaning of environmental surfaces with appropriate cleaning products.</p> <p>11. An effective pest control program, managed in accordance with local health and environmental regulations; and</p> <p>12. Other infection prevention procedures necessary to prevent/control transmission of an infectious agent in the facility as recommended or required by the department.</p> <p>This RULE is not met as evidenced by: Based on observation, interviews and review of CDC recommendation for Infection Protection for Outpatient Settings, it was determined that the facility failed to ensure infection prevention procedures necessary to prevent/control transmission of an infectious agent were followed. Note: This deficiency was previously cited in the Summary Statement of Deficiencies dated 6/29/2012, related to staff failure to clean the top of vial prior to a second puncture. The findings included: Observation of a procedure performed on 10/31/2014, revealed Staff #10 did not clean the top of a multi-use vial prior to the physician withdrawing medication for injection. According to the CDC Guide to Infection Prevention for Outpatient Settings dated September 2014: Key recommendations for safe injection practices in ambulatory care settings: 1) Use aseptic technique when preparing and administering medications; 2) Cleanse the access/discharge of medication vials with 70% alcohol before inserting a device into the vial. An interview with Staff #10 and Staff #11 was conducted on 10/31/2014 at approximately 1:10</p>	T-178		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AF-0018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2014
NAME OF PROVIDER OR SUPPLIER PE PARENTHOOD METRO WASHINGTON-FALLS CH		STREET ADDRESS, CITY, STATE, ZIP CODE 363 S. MAPLE AVE. SUITE 300 FALLS CHURCH, VA 22046		
(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 178	Continued From Page 8 PM Staff #10 stated her she only cleaned the vis after the top is originally removed, but not afterwards or between procedures. Staff #11 stated, "The vis need to be cleaned prior to each procedure."	T 178		
T 360	12 VAC 5-412-360 B Maintenance E. 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, document review and interviews the agency failed to ensure that all electrical equipment had been inspected as documented by proof of preventative maintenance per the manufacturer's recommendations as required in Section as required in Section 12 VACS-412-360. Note: This is a re-cite from 2012 related to staff's failure to ensure all electrical equipment had been inspected. The findings included: During the tour of the clinic conducted on 10/30/2014 at 9:25 a.m., the following was observed: Exam room #2 was designated as the	T 360 (T-350)	PPM-W Falls Church holds on the highest professional standards, including ensuring that an emergency generator is available for medical purposes when electricity is lost. PPM-W Falls Church and the medical maintenance company ensure that all electrical equipment is part of the annual preventative maintenance program. The T178 backup generator is included on the routine medical maintenance inspection report and was properly inspected on August 15, 2013. The audit found that although no backup generator was needed in 2014, a maintenance check on that piece of equipment did not occur in that year. A check for equipment preventative maintenance status is included as an additional indicator on the monthly compliance form, the Health Center Compliance Log, which is signed by staff. While the T178 backup generator's preventative maintenance status expired in February 2014, the Health Center Compliance Log for that room has been signed every month. Actions to correct the deficiency and prevent a re-occurrence: The medical maintenance company came to inspect the T178 generator on December 4, and the generator was fully functional, even though the required maintenance check had not occurred. PPM-W Falls Church took swift action to address the staff non-compliance and to ensure that this high standard is met in the future. Staff will be reminded to reemphasize that the Health Center Compliance Log checks must include all electrical equipment, including the backup generator, and a check of the status of each preventative maintenance status, and the new list of equipment for the medical maintenance company will be consistently reviewed. All of these measures will be in place by January 7, 2015. Actions to maintain compliance: PPM-W Falls Church will monitor this monthly; staff will check to ensure equipment compliance. An indicator was added to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(4) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AF-0010	(2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(3) DATE SURVEY COMPLETED 10/31/2014
NAME OF PROVIDER OR SUPPLIER PL PARENTHOOD METRO WASHINGTON-FALLS C			STREET ADDRESS, CITY, STATE, ZIP CODE 383 S. MAPLE AVE, SUITE 300 FALLS CHURCH, VA 22046		
(5) 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)	(6) COMPLETE DATE	
T-380	<p>Continued From Page 9</p> <p>Procedure Room. A Triplix back up generator failed to have an updated preventive maintenance sticker indicating it had been inspected for any potential electrical failures. The policy and procedure manual stated all equipment would be inspected annually.</p> <p>In an interview with Staff #3 during the tour of exam room #2, reported he/she was unable to answer the surveyor in regards to the expired maintenance sticker. Staff #3 stated the surveyor would need to verify with Staff #2, because he/she did not utilize exam room #2 because he/she did not perform abortion procedures.</p> <p>On 10/30/2014 at approximately 10:00 a.m., an interview was conducted with Staff #2. Staff #2 verified the generator's preventive sticker expired 02/2014 and would gather additional information. Staff #2 was asked to provide a list of annual equipment inspections for the surveyor to review.</p> <p>On 10/31/2014 at 9:00 a.m., Staff #2 presented the survey team the facility's medical equipment inspection reports. The review of the equipment inspection reports revealed a Triplix power supply on the report for 5/15/2013, but failed to be included on the inspection report dated 3/26/2014. Staff #2 confirmed the Triplix power supply was not inspected for 2014, but he/she was not able to provide evidence the reason it was left off the list.</p> <p>During the exit interview on 10/31/2014, Staff #1, Staff #2, Staff #5 and Staff #7 acknowledged that the facility failed to maintain the system in the manner required by the Virginia regulation.</p>	T-380	<p>Facility inspection portion of the Family Planning and Surgical Services Monthly Operational Facility Survey stated, "Medical Equipment including the power generator is compliant with inspection".</p> <p>Health center manager will do a random review every 6 months of all equipment to check for preventative maintenance stickers.</p>		