STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SA000017	A. BUILDING _____ B. WING _____	10/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCE GEORGES REPRODUCTIVE HEALTH S	7411 RIGGS RD, SUITE 300 HYATTSVILLE, MD 20783

(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
A 000	Initial Comments	A 000		

A relicensure survey of Prince Georges Reproductive Health Services was conducted on October 15, 2015. The survey included: interview of the staff; an observational tour of the physical environment; observation of reprocessing of surgical equipment; review of the policy and procedure manual; review of clinical records; review of professional credentialing; review of personnel files and review of the quality assurance and infection control programs.

The facility included two procedure rooms.

A total of five patient clinical records were reviewed. The procedures were performed between July 2014 and September 2015.

A key code for the patients and staff was provided to the facility staff.

Findings in this report are based on data present at the time of review. The agency's staff was kept informed of the survey findings as the survey progressed. The agency staff was given the opportunity to present information relative to the findings during the course of the survey.

A 380 .05 (A)(1)(a) .05 Administration — A 380

(a) Consulting with the staff to develop and implement the facility ' s policies and procedures in accordance with §C of this regulation;

This Regulation is not met as evidenced by:
Based on review of the policy and procedure manual, review of staff credentialing files for five of six staff, interview of staff #7 and review of QA (quality assurance) / Staff Meeting Minutes, it was

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A 380	Continued From page 1	A 380		

determined that the administrator did not implement policies and procedures for infection control measures and disaster/fire (emergency) drills. Staff: 1, 2, 3, 5, and 6

The findings include:

1) Review of the policy and procedure manual on 10/15/15 at 12:00 PM revealed, "The hepatitis B vaccination series is available at no cost after training and within 10 days of initial assignment to employees identified in the exposure determination section of this plan. Vaccination is encouraged unless: 1) documentation exists that the employee has previously received the series, 2) antibody testing reveals that the employee is immune, or 3) medical evaluation shows that vaccination is contraindicated. However, if an employee refuses to decline vaccination, the employee must sign a declination form. ...Documentation of refusal is kept at Prince Georges Reproductive Health."

There was no policy and procedure regarding TB (tuberculosis) screening for staff.

Review of Staff 3 and 6's credentialing files on 10/15/15 at 10:00 am revealed no documented evidence that they had ever been vaccinated for Hepatitis B, or had been offered the Hepatitis B vaccination by the facility. Additionally, there was no documented evidence that Staff 1, 2, 3, 5, and 6 had ever been tested for TB (tuberculosis).

Interview of Staff 7 on 10/15/15 at 1:00 PM revealed that s/he acknowledged s/he did not have documented evidence for hepatitis B for these staff. Tuberculosis testing is mandatory for all staff who provide clinical care to patients in the facility.

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A 380	Continued From page 2	A 380		

2) Review of the policy and procedure manual on 10/15/15 at 12:30 PM revealed "Disaster and Safety Drills...In order to maintain a safe facility and a well-trained staff, disaster/safety drills will be held at least quarterly. The clinical administrator will plan these events during staff meetings and/or as surprise events to test the employees skills in coping with the situation presented. It is the responsibility of the clinical administrator to document these events in the QA/Staff Meetings file in the front office."
Review of the QA/ Staff Meeting Minutes on 10/15/15 at 10:30 am revealed a fire drill was conducted on 4/2/15, a disaster/fire drill was conducted on 6/12/13, and fire drill training was conducted on 4/27/13.
Interview with the administrator on 10/15/15 at 1:00 PM revealed that s/he acknowledged disaster/fire and safety drills were not being conducted on a quarterly basis.

A1150 .09(C)(5) .09 Emergency Services — A1150

(5) Suction equipment; and

This Regulation is not met as evidenced by:
Based on a tour of the facility and interview of staff #7, the administrator did not ensure that specified emergency equipment was available at the facility. The findings include:

A tour of the facility on 10/15/15 at 12:00 PM revealed that the facility did not have an airway suction machine and necessary supplies required to perform oral airway suction in an emergency.

Interview of Staff #7 on 10/15/15 at 1:30 PM

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A1150	Continued From page 3 revealed that s/he acknowledged that a suction machine and necessary supplies were not available. S/he was unaware that this equipment was necessary to have available at the facility.	A1150		
A1270	.11 (A)(2) .11 Pharmaceutical Services (2) Develop and implement policies and procedures for pharmacy services in accordance with accepted professional practice. This Regulation is not met as evidenced by: Based on review of the policy and procedure manual, tour of the facility and interview of Staff 7, it was determined that the agency staff did not account for controlled medications. The findings include: Review of the policy and procedure manual revealed "In order to ensure proper counts of narcotic we keep an excel log of all medications received and given to patients. At the beginning of every week the Registered Nurse counts all narcotics and a second count is done by the Clinical Administrator to ensure the count matches. This is also done at the end of every week. Once the counts are completed it is the responsibility of the Assistant Manager to input the patient names and amount of narcotics administered. The total of narcotics given to each patient is added up from the medication administration page and documented by the physician on the surgical end sheet within the patients chart. This is where the Assistant Manager will get the totals to input in the log." A tour of the facility on 10/15/15 at 12:30 PM revealed there was one medication cabinet	A1270		

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A1270	Continued From page 4	A1270		

hanging on the wall located in the ultra sound room. This cabinet was locked and contained 32 vials of Midazolam (schedule IV controlled substance), and 150 ampules of Fentanyl (schedule II controlled substance). Review of the spread sheet on the computer used for tracking Midazolam and Fentanyl revealed that a daily am (morning/beginning of shift) and PM (evening/end of shift) count was not performed and documented by two licensed staff for these two (Midazolam and Fentanyl) controlled substances.

Interview of Staff 7 on 10/15/15 at 1:00 PM revealed that at the beginning of the week one registered nurse (RN) counts the Midazolam and Fentanyl. The RN documents these counts on a scrap piece of paper, and gives it to Staff 7 for review. The Medical Assistant (MA) reviews the patient chart, and records the amount of a controlled substance (Midazolam and Fentanyl) given to the patient on the spread sheet on the computer. Then, on a weekly basis, Staff 7 compares the count documented on the scrap paper by the RN to the spread sheet on the computer for accuracy of the controlled substance count. The scrap paper is then discarded.

The total amount of each controlled substance medication must be counted, documented, and signed by two licensed health care providers at the facility twice daily (am/beginning of shift and PM/end of shift) whenever those medications are accessed. This count must be performed before the first patient of the day receives any of the controlled medication, and after the last patient of the day receives any of the controlled medication.

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A9999	Continued From page 5	A9999		
A9999	Final Comments	A9999		

An exit conference was conducted with the administrator on October 15, 2015.

The survey findings were reviewed. The facility staff was directed to submit a written plan of correction in response to the 2567 form and following the attached guidelines, within ten days. Failure to submit an acceptable plan of correction may result in revocation of license from the Surgical Abortion Facilities program.