State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-001	A. BUILDING _____ B. WING _____	05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF SOUTHEASTERN VIR	515 NEWTOWN ROAD VIRGINIA BEACH, VA 23462

(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 and Complaint Investigation (#2012-AC006) was conducted at the above referenced facility on May 1. 2012 by an Acute Care Supervisor and three (3) Medical Facility Inspectors from the Virginia Department of Health's, Office of Licensure and Certification. The complaint was not substantiated Planned Parenthood of Southeast Virginia which is located in Virginia Beach 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 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;	T 035	T 035 PPSEV personnel policies amended to state that in addition to the nationwide criminal background check conducted on all employees, employees not licensed by the Board of Pharmacy and whose job duties provides them access to controlled substances within our abortion facility will also have a criminal record report from the Virginia State Police. See Background Check Policy, Exhibit (A). The New Hire Checklist for All Employees was revised to include a provision for employees not licensed by the Board of Pharmacy and whose job duties provide them with access to controlled substances within our abortion facility needing a criminal	6/4/12

RECEIVED
JUN 05 2012
VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrick J. Hurd, Esq.	CEO	6/4/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-001	A. BUILDING _____ B. WING _____	05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF SOUTHEASTERN VIR	515 NEWTOWN ROAD VIRGINIA BEACH, VA 23462

(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 1 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	T 035 continued. record report from the Virginia State Police, in addition to the nationwide criminal background check performed on all new employees. For quality control of this policy, the Personnel File Maintenance Report has been revised to include the confirmation of the receipt of the criminal record report from the Virginia State Police for these specific employees, in addition to the nationwide criminal background check already included on the Report.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-001	A. BUILDING _____ B. WING _____	05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF SOUTHEASTERN VIR	515 NEWTOWN ROAD VIRGINIA BEACH, VA 23462

(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, review of 15 personnel files and policies, it was determined that the facility's personnel policies failed to include a statement about any compensated employee(s) not licensed by the Board of Pharmacy and whose job duties provides them access to controlled substances within the abortion facility must have a criminal record report form the Virginia State Police.

The findings include:
A) On May 1, 2012 between 2:45 PM and 4:36 PM, six (6) personnel files for employees whose job duties provide them access to controlled substances within the facility were reviewed in the facility's conference room. Employee's #9 and #14's personnel files failed to contain a criminal record report from the Virginia State Police.
B) On May 1, 2012 between 2:45 PM and 4:36 PM, an interview was conducted with employee #1 (Vice President of Operations), in the facility's conference room. Employee #1 acknowledged that two (2) employee's (#9 & 14) have job duties that provide access to controlled substances within the facility. Employee #1 also acknowledged that the personnel files of employee #9 and #14 failed to contain a criminal record report from the Virginia State Police
C) On May 1, 2012 between 2:00 PM and 5:30 PM the facility's polices were reviewed in the facility's conference room. The facility failed to have a personnel policy that stated any compensated employee not licensed by the Board of Pharmacy and whose job duties provide access to controlled substances within the facility are to have a criminal record report from the Virginia State Police.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-001	A. BUILDING _____ B. WING _____	05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF SOUTHEASTERN VIR	515 NEWTOWN ROAD VIRGINIA BEACH, VA 23462

(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 070	Continued From Page 3	T 070		
T 070	12 VAC 5-412-170 C Personnel C. Each abortion facility shall obtain a criminal history record check pursuant to 32.1-126.02 of the Code of Virginia on any compensated employee not licensed by the Board of Pharmacy, whose job duties provide access to controlled substances within the abortion facility. This RULE: is not met as evidenced by: Based on interview, review of fifteen (15) personnel files and policies, it was determined that the facility failed to have a criminal record report obtained through the Virginia State Police for two (2) out of six (6) compensated employee's whose job duties provide access to controlled substances (employee #'s 9 and 14). The findings include: A) On May 1, 2012 between 2:45 PM and 4.36 PM, six (6) personnel files of employees whose job duties provide access to controlled substances within the facility were reviewed in the facility's conference room. Employee's #9 and #14's personnel files failed to contain a criminal record report from the Virginia State Police. B) On May 1, 2012 between 2:45 PM and 4:36 PM an interview was conducted with employee #1 (Vice President of Operations), in the facility's conference room. Employee #1 acknowledged that two (2) employees (#9 & 14) personnel files have job duties that provide access to controlled substances within the facility. Employee #1 acknowledged that the personnel files for employee #9 and #14 failed to contain a criminal record report from the Virginia State Police. C) On May 1, 2012 between 2:00 PM and 5:30 PM, the facility's polices were reviewed in the facility's conference room. The facility failed to have a personnel policy that included the statement that compensated employee(s) not licensed by the Board of Pharmacy and whose job	T 070	T 070 Employees #9 and # 14 completed the Virginia State Police criminal record application and PPSEV filed the formal requests for the criminal record reports with the Virginia State Police, adding to the nationwide criminal background check already received and placed in the personnel files for employee #'s 9 and 14 pursuant to PPSEV personnel policies. See Background Check Policy, Exhibit (A).	6/4/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-001	A. BUILDING _____ B. WING _____	05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF SOUTHEASTERN VIR	515 NEWTOWN ROAD VIRGINIA BEACH, VA 23462

(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 070	Continued From Page 4 duties provide access to controlled substances within the facility are to have a criminal record report Virginia State Police report.	T 070		
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 observations and interviews it was determined that the facility's staff failed document refrigerator temperatures and therefore were unable to ensure the contents of the refrigerators were maintained at the correct temperature for two (2) of two (2) refrigerators observed in the	T 170	T 170 The refrigerator Temperature Logs for both refrigerators were modified to include instructions to record temperatures daily rather than only on days when the laboratory and recovery room were in use. See Refrigerator Temperature Log, Exhibit (B). This Refrigerator Temperature Log was also placed on the refrigerator in the recovery room. Staff assigned to the laboratory and to the recovery room were instructed and trained to record temperatures daily for each of these refrigerators and to enter the temperatures in the Refrigerator Temperature Log daily rather than only on days when the laboratory and recovery room are in use. The Laboratory Manual clearly states that daily temperatures must be recorded for the refrigerators. Periodic walk-through surveys and formal audits will be conducted to assure daily recording of temperatures for refrigerators.	6/4/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-001	A. BUILDING _____ B. WING _____	05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF SOUTHEASTERN VIR	515 NEWTOWN ROAD VIRGINIA BEACH, VA 23462

(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 5 facility. Specifically, the refrigerator in the laboratory did not have temperatures recorded each day the facility was open and the refrigerator in the facility's Recovery Room area, failed to have any temperatures recorded. The findings were: 1. During the initial tour of the facility on May 1, 2012 on or about 11 AM, a "REFRIGERATOR TEMPERATURE LOG" was noted on the front of the lab's refrigerator which is located in the lab. The log was for April of 2012 and had multiple days with no temperatures recorded. Days the facility was open and had no recorded temperature readings were: 4/9; 4/11; 4/16 - 18; 4/23; 4/25; 4/28 and 4/30/12. The VP (Vice President) of Operations who accompanied this writer during the tour was asked about the missing temperatures and stated, they only record temperatures on the days the lab is actually used. She went on to clarify that even though the facility is open everyday, they don't use the lab every day. 2. Also during the tour, a refrigerator was noted to be used in the Recovery Room area . No "REFRIGERATOR TEMPERATURE LOG" was used to record refrigerator temperatures on this refrigerator.	T 170		
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,	T 175	T 175 Bins of two different colors were obtained and staff instructed to use the gray color bin for instruments to be soaked and cleaned in the Alconox solution and the gold bin to hold instruments transferred from the Alconox solution bin to be transported to the	6/4/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-001	A. BUILDING _____ B. WING _____	05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF SOUTHEASTERN VIR	515 NEWTOWN ROAD VIRGINIA BEACH, VA 23462

(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 6 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 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.	T 175	T 175 continued. clean utility room for autoclaving. A Dirty Room Daily Process Flow Chart was created to appropriately display the correct flow, container usage, and proper decontamination in the dirty utility room; see Exhibit (C). This chart is visibly posted in the dirty utility room for all staff to see. Measuring containers were placed in the dirty utility room for staff access and accurate measurements. Staff members were trained in the proper measuring and use of the Alconox solution in strict adherence to the manufacturer's stated instructions and signs were posted in the dirty utility room. See Dirty Room Cleaning Agents, Exhibit (D). Periodic informal walk-through surveys will be conducted, as well as formal audits to assure that staff complies with the cleaning procedure and manufacturer's use instructions for the cleaning solution. At a minimum, annual training will be carried out or more frequently as needed based on the survey and audit results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-001	A. BUILDING _____ B. WING _____	05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF SOUTHEASTERN VIR	515 NEWTOWN ROAD VIRGINIA BEACH, VA 23462

(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 7	T 175		

This RULE: is not met as evidenced by:
Based on interviews and document reviews the facility staff failed to ensure they followed the manufactures directions when using a cleaning detergent that is used for the cleaning of reusable medical equipment that is used between patients.

The Findings Include:

On 5/1/12 during the initial tour of the facilty at approximately 11:45 the dirty utility room was observed. There were approximately 7 gray 12 quart plastic containers sitting on the counter top in the dirty utility room. There were no measuring instruments observed on the counters. There was a cup containing brushes sitting on the counter.

The Vice President of Operations (VPO) explained the dirty utility room was where the dirty instruments used in a procedure were cleaned prior to sterilization. Employee #4 was identified by the VPO as one of the employees who would be responsible for cleaning dirty instruments.

Employee #4 was asked to explain the process of how the instruments are brought into the dirty utility room and how the instruments are then cleaned. Employee #4 stated, "The doctor brings the instruments and the medical waste in the dirty utility room in one of those containers." Employee #4 pointed to the gray 12 quart (3 gallons) containers sitting on the counter. Employee #4 stated, "He (the doctor) removes the medical waste from the container and I fill it about half way full with water. I add about 1 (one) teaspoon of the Alconox (the detergent used for cleaning medical instruments). I then used those brushes (Employee #4 pointed to the brushes in the cup on the counter) to scrub the instruments then the instruments are rinsed. I place a towel in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-001	A. BUILDING _____ B. WING _____	05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF SOUTHEASTERN VIR	515 NEWTOWN ROAD VIRGINIA BEACH, VA 23462

(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 8 bottom of another container, put the the instruments in the container, cover them with another towel and carry them to the clean utility room were they get wrapped and sterilized. I will use the same water about 3-4 times before it is changed." Employee #4 was asked how she could tell which of the containers were dirty or clean. Employee #4 stated, "I can't I guess we need to have a different color to put the instruments in once they are clean." The instructions on the Alconox container states "Make a fresh 1% solution (2 and 1/2 Tbsp. (tablespoons) per gal. (gallon), 1 and 1/4 oz. (ounce) or 10 grams per liter) in cold, warm or hot water. If available use warm water.... RINSE THOROUGHLY- preferably with running water. For critical cleaning, do final or all rinsing in distilled, deionzied, or purified water..."	T 175		
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 and interviews the agency staff failed to ensure opened, accessed and available for use medications, syringes and sutures were not expired and were dated as to when they were opened.	T 275	T 275 The items identified in the findings were immediately removed from the exam room(s) and wasted/ disposed of in accordance with applicable PPSEV disposal policies and procedures. Staff members were retrained in PPSEV policy for proper labeling and disposal of medications, multi-dose and other reusable items. This was reinforced with the establishment of a written PPSEV policy, Handling and Expiration of Multi-Dose/Reusable Medical Items Policy,	6/4/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-001	A. BUILDING _____ B. WING _____	05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF SOUTHEASTERN VIR	515 NEWTOWN ROAD VIRGINIA BEACH, VA 23462

(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 9 The Findings Include: During the initial tour of the agency on 5/1/12 between 11 A.M. and 12 P.M. with the Vice President of Operations the following rooms contained the following items: Exam room #6: 1 container of Monocryl sutures expired 1/2011 Container of Baking Soda, no date 1 tube of Trimo San Vaginal gel expired 11/2008 Storage Room: 25 - 10 cc syringes with various expiration dates from 2006 to 2008 29 - 20 cc syringes with various expiration dates in 2010 Procedure Room #1: 4 - 50 ml bottles of Marcaine 0.5% had no date indicating when they were opened and accessed Procedure Room #2: 16 oz. bottle of Betadine with the expiration date of 2/12. The Vice President of Operations stated, "Those things should not be in here. You are correct. I know what they did with the Betadine. They poured it from the larger gallon bottle into the smaller bottle that looks like it is expired. We will have to do something else."	T 275	T 275 continued. which provides the written procedure for labeling, handling, and expiration of medications, multi-dose, and other reusable medical items. See Exhibit (E). Periodic informal and formal audits will be performed in the facility to verify compliance with this policy and procedure.	
T 345	12 VAC 5-412-320 Record storage Provisions shall be made for the safe storage of medical records or accurate and eligible reproductions thereof according to applicable federal and state law, including the Health Insurance Portability and Accountability Act (42 USC 1320d et seq.). In the event of closure of the facility, the facility shall notify OLC concerning the location where patient medical records are stored.	T 345	T 345 The PPSEV Medical Records Storage and Retention Policy was revised to include a statement that OLC shall be notified of the location of patient records storage if the facility were to close. See Medical Records Storage and Retention Policy, Exhibit (F).	6/4/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-001	A. BUILDING _____ B. WING _____	05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF SOUTHEASTERN VIR	515 NEWTOWN ROAD VIRGINIA BEACH, VA 23462

(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 345	Continued From Page 10 This RULE: is not met as evidenced by: Based on review of the facility's Policy and Procedure Manual and interview, it was determined the facility failed to have a policy that addressed, the Office of Licensure and Certification (OLC), would be notified of where records would be stored if the facility would close. The findings were: The facility's Policy and Procedure Manual was reviewed in the facility on May 1, 2012 between 2 and 5 PM. The manual failed to contain a specific policy that addressed the OLC being notified of the location of patient records if the facility were to close. The VP of Operations was asked if they had a policy that addressed the OLC being notified of where records would be stored if the facility closed and she stated, they did not have a policy addressing that.	T 345		
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 observations made during the initial tour of the facility it was determined that the facility failed to ensure the equipment was in good repair,	T 375	T 375 The 5 metal storage cabinets have been removed from use in the procedure rooms. Items previously stored in the cabinets have been relocated to proper storage cabinets in the abortion facility. Items for use during patient procedures on a given day in each procedure room shall be placed upon stainless steel rolling trays.	6/4/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-001	A. BUILDING _____ B. WING _____	05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF SOUTHEASTERN VIR	515 NEWTOWN ROAD VIRGINIA BEACH, VA 23462

(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 375	Continued From Page 11 free of hazards or maintain infection control precautions for the cleaning and disinfection of all surfaces. More specifically, five (5) of five (5) metal cabinets used in the procedures rooms could not be completely cleaned or sanitized due to multiple chips in the paint which were found on all cabinets. One cabinet also had what appeared to be a large area of tape residue on one side of the cabinet. The findings were: A tour of the facility was conducted on May 1, 2012 beginning at approximately 11 AM. The facility has two (2) procedure rooms that are used to perform procedures on patients. Procedure room #1 has three (3) green metal storage cabinets in it. All the cabinets had scratches and or chips of paint missing on the front, the sides and several legs. Procedure room #2 had two (2) metal storage cabinets in it. Both cabinets had chips and scratches. The taller cabinet also had a large area (approximately 10 inches wide by 1 inch tall of what appears to be a tape residue.	T 375		
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	T 380	T 380 The specific equipment items delineated were inspected and safety checks performed and stickers applied with the date, technician and company performing the inspection/ safety check. In addition, the technician conducted a walk-through survey of the entire facility and performed an inspection and safety check of all	6/4/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-001	A. BUILDING _____ B. WING _____	05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF SOUTHEASTERN VIR	515 NEWTOWN ROAD VIRGINIA BEACH, VA 23462

(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 12 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 and interview, it was determined that the facility failed to maintain a preventative maintenance program at least annually on all equipment. Specifically no preventative and or safety checks were documented for eight (8) heating pads, a microscope or a doppler. A preventative maintenance sticker was found on a blood typing machine (for Rh factors) but it was older than 12 months. The findings were: During a tour of the facility beginning at 11 AM on May 1, 2012 the following pieces of equipment failed to have any documented evidence of being inspected for safe use or preventative maintenance being conducted on them or, were inspected more than 12 months ago. Eight (8) heating pads, six (6) of which were in the Recovery Room for patient use and one in each of the two (2) exam rooms. The heating pads found in the exam rooms were used to warm instruments that are used to exam patients with. The microscope and the blood typing machine are both used in the lab to examine specimens. The microscope did not have any documented evidence of being inspected and the blood typing machine had a sticker saying it was inspected 8/20/10 which is greater than 12 months ago The lab has been in operation for greater than 12 months.	T 380	T 380 continued. equipment and affixed inspection tags to each item inspected with the date, technician and company performing the inspection. Each item has been added to the list of items to be inspected at least annually by the company. This list is inspected by staff at the abortion facility to ensure each item has received preventive maintenance following the annual inspections. New equipment purchased and leased for use in the facility shall also be inspected and a tag affixed with the date, technician and company performing the inspection/ safety check.	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-001	A. BUILDING _____ B. WING _____	05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF SOUTHEASTERN VIR	515 NEWTOWN ROAD VIRGINIA BEACH, VA 23462

(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

Exhibits

1. Exhibit A: Background Check Policy (ID Prefix Tags T 035 & T 070)
2. Exhibit B: Refrigerator Temperature Log (ID Prefix Tag T 170)
3. Exhibit C: Dirty Room Daily Process Flow Chart (ID Prefix Tag T 175)
4. Exhibit D: Dirty Room Cleaning Agents (ID Prefix Tag T 175)
5. Exhibit E: Handling and Expiration of Multi-Dose/Reusable Medical Items Policy (ID Prefix Tag T 275)
6. Exhibit F: Medical Records Storage and Retention Policy (ID Prefix Tag T 345)

BACKGROUND CHECK POLICY

I. PURPOSE

A. FUNCTION

PPSEV conducts background investigations to support the safety and security of the organization, patients, employees, trainees, and visitors, and in accordance with PPFA, federal and state rules and regulations. Generally, the background investigation, conducted by an external security company, will be completed within the first week of hire.

The CEO, Vice President of Operations, and Finance department ensures policy implementation.

B. CIRCUMSTANCES

1. All employees and volunteers must undergo a criminal background check within the first week of hire.
2. In addition, all employees who oversee financial systems must undergo a financial credit check within the first week of hire, in addition to the extensive background check in 1.
3. In addition, all employees not licensed by the Board of Pharmacy, whose job duties provide access to controlled substance at PPSEV must undergo a *criminal history check by the Virginia State Police through the Virginia Central Criminal Records Exchange,* in addition to the extensive background check in 1.

II. RESPONSIBLE STAFF

A. The CEO, Vice President of Operations, and Finance department ensures policy implementation.

B. The Supervisor, Vice President of Operations, Finance Controller, or their designees provides the New Hire paperwork for new employees. The Volunteer Coordinator handles background checks for internal volunteers. See the Volunteer Handbook for information on background checks for volunteers.

C. These individuals are responsible for having the new employees fill out the appropriate background check(s).

D. The Vice President of Operations and Finance is responsible for submitting the paperwork to the external security company, Sterling Infosystems, Inc.

E. All new employees must denote their understanding with the Background Check Policy and sign the policy. A copy of the signed signature page must be maintained in the personnel file.

III. POLICY

A. It is the policy of PPSEV to assure that criminal background checks are performed on all employees, volunteers, trainees, or contractors as applicable, within the first week of hire.

B. PPSEV reserves the right to process supplemental background checks on any employee, volunteer, trainee, and contractors during the course of their relationship with PPSEV.

C. It is the policy of PPSEV that all employees in who oversee financial systems shall undergo a financial credit check within the first week of hire, in addition to the extensive background check

D. It is the policy of PPSEV that all employees that are not licensed by the Board of Pharmacy and whose job duties provide access to controlled substances at PPSEV shall undergo a criminal history check by the Virginia State Police through the Virginia Central Criminal Records Exchange, in addition to the extensive background check.

E. Background checks and investigations performed for PPSEV may include the use of consumer reporting agencies, which may gather and report information to PPSEV in the form of consumer or investigative consumer reports. Such reports, if obtained, may contain, but are not limited to, information concerning an applicant's or employee's credit standing, credit capacity, character, or general reputation.

F. Employees are expected to cooperate fully with the background check policy. Such cooperation includes, among other things, providing truthful and complete information in response to inquiries made by PPSEV or third-party investigations during the course of investigations in a timely manner and providing appropriate written authorizations that may be required by law so that PPSEV may obtain complete investigation reports. Failure to cooperate with these checks or investigations, or any attempt to interfere with PPSEV's attempts to obtain relevant information, will result in disciplinary action, up to and including termination or withdrawal of employment offer. Furthermore, employees are encouraged to notify their supervisor if they expect negative findings.

G. It is the policy of PPSEV to maintain a copy of all background checks carried out in each employee's personnel file.

IV. PROCEDURE

A. Supervisors

1. Provide each employee with a New Hire Packet, which includes applicable background check(s) and advise the employee to complete the documents.
2. Forward the completed background check(s) to the Vice President of Operation, who will then forward the document(s) to the Finance Controller to submit to the external security company, VA State Police, or other agency, as applicable.
3. New employees may begin working while the background check is in progress, if not prohibited by law. Negative findings on the background check(s) may result in termination or withdrawal of employment offer.

B. CEO, Vice President of Operations, and Finance Department

1. Review the application for omissions and determine the scope of the background check required.
2. Applicants who were formerly employed, contracted and/or volunteered with PPSEV within the last month and were in good standing, are exempt from completing the background check.
3. Background process will be considered completed if a Memorandum of Understanding or Agreement (MOU or MOA) between PPSEV and a Medical training program is established and the Medical training program has a process for background screenings at the respective institution. Said background screening and background screening process must be successfully completed, evidencing good-standing for all relevant standards.
4. Submit candidate's information to PPSEV's authorized vendor for:
   a. Social Security verification
   b. Identify aliases and residential history
   c. National Criminal, State Criminal
   d. Motor Vehicle record
   e. Credit History (if applicable to position)
5. If applicable, verify professional licenses and education. Physicians and other licensed staff that are subject to the processes outlined in the Clinician Credentialing Policy and Non-Clinician Licensing Policy as applicable.
6. If applicable (employee not licensed by the Board of Pharmacy and whose job duties provide access to controlled substances), an additional criminal history check must be carried out through *criminal history check by the Virginia State Police through the Virginia Central Criminal Records Exchange.* The form can be obtained from the Virginia State Police website: http://www.vsp.state.va.us/downloads/SP167.pdf. The applicant fills out part of the form, a notary fills out part of the form, and the Finance Controller fills out the payment portion of the form and encloses the necessary payment on behalf of PPSEV. Once completed the Finance Controller mails the form to:

Virginia State Police
Central Criminal Records Exchange-NF
P.O. Box 85076
Richmond, VA 23261-5076

7. When the returned background check(s) are received, the Finance Controller delivers them to the Vice President of Operations for review and placement into the employee's personnel file.
8. In the event of an unfavorable background report, the Vice President of Operations, the CEO, and hiring supervisor will meet to discuss the report and take appropriate action as necessary.
9. In accordance with the Fair Credit Reporting Act, if the applicant is denied employment based on a report obtained by a consumer reporting agency such as a credit report, the applicant or individual will be given the opportunity to refute the information provided by the credit reporting agency.
10. If the candidate does not refute the findings and PSEV takes adverse action based on a consumer report, PPSEV will provide the candidate with:
    a. A copy of the credit report
    b. An adverse action letter
    c. A Summary of Rights

C. Background Check Components

1. All Staff
    a. Social Security Trace/Verification
        - Address and names history to include Aliases, Aka's, and Maiden Names
    b. Unlimited County Level Searches
        - Going back 7 years based off of the names and addresses developed in the SS Trace
    c. National and State Criminal Database Search
    d. Motor Vehicle Record
2. Staff who oversee financial systems
    a. In addition to the above
    b. Credit Check
3. Staff with Access to controlled substances and not licensed by the Board of Pharmacy
    a. In addition to the above
    b. Criminal History Check through the Virginia Central Criminal Records Exchange

D. Volunteers

1. All internal PPSEV volunteers must have a criminal background check carried out. Health center volunteers must have the extensive background check

through Sterling that all staff have at PPSEV, while other PPSEV internal volunteers will have a state criminal background check that is for non-profit volunteers. See the Volunteer Handbook for more information.

V. QUALITY CONTROL

A. The Vice President of Operations is responsible for monitoring compliance, review, and revision of this policy, in consultation with the Quality and Risk Management Committee.

B. The Vice President of Operations or designee will create a monthly "Personnel File Maintenance Report" displaying employee missing documents, in which any missed background checks would be noted. The Vice President of Operations will notify the supervisor of any employee with missing content that is to be resolved. This monthly Personnel File Maintenance Report will aid in quality control of this policy.

BACKGROUND CHECK POLICY

I have received a copy of Planned Parenthood of Southeastern Virginia's Background Check Policy. I understand that as a PPSEV employee, it is my responsibility to read and adhere to these guidelines and ask questions I may have regarding this information. Questions should be addressed to my supervisor, Vice President of Operations, and CEO.

Name (print)	Signature	Date

Planned Parenthood of Southeastern Virginia
Refrigerator Temperature L

ID Prefix Tag: T 170 Exhibit: B

Temperature must be taken daily, except on Sundays, holidays, or closures.

LOCATION: □ FP Lab □ Surgical Lab □ Recovery □ Pharmacy | **OFFICE:** □ Newtown □ Hampton

MONTH/YEAR: June 2012 **RANGE:** 2 to 8 degrees C **(celsius)**

Day of Month	Staff Initials	Time	<1	0	1	2	3	4	5	6	7	8	9	10	>11
1		am													
		pm													
2		am													
		pm													
3		am													
		pm													
4		am													
		pm													
5		am													
		pm													
6		am													
		pm													
7		am													
		pm													
8		am													
		pm													
9		am													
		pm													
10		am													
		pm													
11		am													
		pm													
12		am													
		pm													
13		am													
		pm													
14		am													
		pm													
15		am													
		pm													
16		am													
		pm													
17		am													
		pm													
18		am													
		pm													
19		am													
		pm													
20		am													
		pm													
21		am													
		pm													
22		am													
		pm													
23		am													
		pm													
24		am													
		pm													
25		am													
		pm													
26		am													
		pm													
27		am													
		pm													
28		am													
		pm													
29		am													
		pm													
30		am													
		pm													

Planned Parenthood® of Southeastern Virginia
Corrective Action Plan
ID Prefix Tag: T 170
Exhibit : B

DIRTY ROOM DAILY PROCESS FLOW CHART

Place one towel on the counter to the left of each sink

Place one GRAY BASIN on the top of each towel

Dump 2 ½ tablespoons of ALCONOX in each GRAY BASIN

Add 4 quarts of warm water to each GRAY BASIN

Put two small in the BLACK BUCKET

Put one large in the biohazard boxes (2)

Put on PPE

All CSR paper from jars & instruments are placed in a biohazard box

Dirty instruments are placed in the left GRAY BASIN & scrubbed in the sink

Dr places a paper towel on the far right side of the counter & places the jar on top

Jar lid & ring are placed in the right GRAY BASIN & scrubbed in the sink

Jar contents are examined & placed in the BLACK BUCKET

RInse jars with hot water

Spray with DISPATCH & let sit for one minute

Scrub & rinse

Dispose of PPE in biohazard box

Prepare biohazard boxes (see Waste Managment policy)

Make sure door is locked

Spray sinks and counters with DISPATCH let sit for one minute & wipe clean

Dump water from GRAY BASINS spray with DISPATCH and let sit for one minute

Scrub & use clean towel to dry

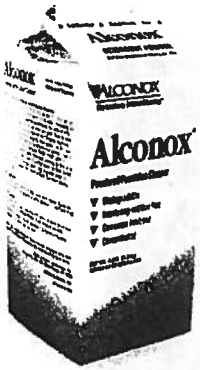
Wrap clean instruments in a towel and place in the GOLD BASINS outside the Dirty Room

Planned Parenthood of Southeastern Virginia

Planned Parenthood® of Southeastern Virginia
Corrective Action Plan
ID Prefix Tag: T 175
Exhibit : D

DIRTY ROOM CLEANING AGENTS

Manufacturer Instructions for Use



ALCONOX

Make a fresh 1% solution (2 ½ tbsp per gal) in cold, warm, or hot water. If available, use warm water. Use cold water for blood stains. For difficult soils, raise water temperature and use more detergent. Clean by soak, circulate, wipe, or ultrasonic method.

DISPATCH

Spray Method- Spray all surfaces of instruments with
Dispatch until thoroughly wet. Let stand for one minute. Wipe with a clean, damp cloth or paper towel & allow to air dry.

HANDLING & EXPIRATION OF MULTI-DOSE/REUSABLE MEDICAL ITEMS POLICY

I. PURPOSE

A. FUNCTION

To ensure safe and proper use of multi-dose and reusable medical items within PPSEV health centers

The Health Center Managers and Surgical Nurse Manager are responsible for policy implementation.

B. CIRCUMSTANCES

This policy applies to all PPSEV health centers.

II. STAFF TRAINING

A. The Surgical Nurse Manager, Health Center Managers, and designated staff are responsible for the training and implementation related to this policy.

B. Training regarding this policy is included for all clinical staff during the initial training period. Such training is documented on the *New Employee Orientation Checklist* and the *Clinician Orientation Checkoff List*, which are maintained in each staff person's personnel file.

III. POLICY

A. It is the policy of PPSEV to ensure safe and proper use of multi-dose and reusable medical items within PPSEV health centers settings.

B. Only items approved by the manufacturer for multiple uses and reuse are allowed to be used after opening, access, or use by PPSEV staff and in accordance with state, federal, and PPFA rules, regulations, and guidelines.

C. All multi-dose vials, reagents, and reusable medical items must be dated when opened in a clear and legible manner by the PPSEV staff personnel who opens or accesses the item.

D. In accordance with the CDC and United States Pharmacopeal (USP), when a multi-dose vial is opened or accessed (i.e. needle-punctured) the vial should be dated and properly discarded within 28 days unless specified otherwise (shorter or longer) by the manufacturer. The exceptions are vaccines, which are to be discarded according to the manufacturer's expiration date.

E. For other reusable or multi-use items, the manufacturer's instructions are followed to determine the date after which an opened item can no longer be used.

F. If a multi-dose vial or item has not been opened or accessed, it should be properly disposed of according to the manufacturer's expiration date.

G. In addition, multi-dose items should be properly disposed of if environmental conditions become detrimental to medication stability, the items are placed on a contaminated surface, aseptic technique is not adhered to, or the items become visibly contaminated, as applicable.

H. All multi-dose or reusable items that are discovered opened but unlabeled within the health center are disposed of in an appropriate manner.

IV. PROCEDURE

A. Multi-Dose/Reusable Medical Items

1. Multi-dose items or reusable medical items are indicated by the manufacturer. Single-dose items or non-reusable medical items may not be used after opening, access, or use.

B. Open Date

1. The health care staff member that personnel who initially opens or accesses a re-usable/ multi-dose vial, reagent, or medical item must add an "Open Label" to the item and fill out this label with the following information:
   a. Open Date
   b. Disposal Date
   c. Staff Initials
2. The label must be completed in a clear and legible manner with a permanent marker.
3. This ensures that all staff members will know the open date and disposal date of the item.
4. The rule of thumb is that any medical item with a cap must be properly dated.

C. Reusing or Re-accessing Multi-Dose or Reusable Medical Items

1. Prior to reuse or re-access a multi-dose or reusable medical item, the manufacturer's instructions should be followed for proper disinfecting of the item.
2. For multi-dose vials, the cover must be cleansed with an alcohol wipe prior to re-accessing the vial.

D. Discarding Items

1. All health center staff should look at the open and disposal dates on the label prior to utilizing a multi-dose vial or reusable medical items/reagent.
2. Multi-dose vials should be properly discarded after 28 days unless specified otherwise (shorter or longer) by the manufacturer. The exception is vaccines, which are to be discarded according to the manufacturer's expiration date.

3. For other reusable or multi-use items, the manufacturer's instructions are followed to determine the date after which an opened item should be used.
4. If a multi-dose vial or item has not been opened or accessed, it should be properly disposed of according to the manufacturer's expiration date.
5. In addition, multi-dose items should be properly disposed of if environmental conditions become detrimental to medication stability, the items are placed on a contaminated surface, aseptic technique is not adhered to, or the items become visibly contaminated, as applicable. All health center staff should briefly inspect the item before use to ensure the item is intact and the environmental conditions are adequate.
6. All multi-dose or reusable items that are discovered opened but unlabeled within the health center are disposed of in the appropriate manner.

V. QUALITY CONTROL

A. The Surgical Nurse Manager monitors compliance with this policy on the Surgical Center and the Health Center Managers monitor compliance with this policy at their respective health centers.

B. The Infection Prevention Audit includes several questions relating to the proper use, dating, and disposal of multi-dose and reusable items. This audit is carried out bi-annually and additionally, as needed.

C. Additional periodic audits should be carried out by the Managers and other assigned staff.

MEDICAL RECORDS STORAGE AND RETENTION POLICY

I. PURPOSE

A. FUNCTION

To establish proper medical records storage, how long medical records must be retained and the conditions and manner in which they can be destroyed.

The CEO, Vice President of Operations, and Director of Patient Services are responsible for policy implementation.

B. CIRCUMSTANCES

Destruction and storage of all medical records must be carried out in accordance with this PPSEV policy and in conformance with applicable PPFA Standards and Guidelines and Virginia law. This Policy supplements the records retention requirements in the PPSEV HIPAA Manual.

II. STAFF TRAINING

A. The Director of Patient Services is responsible for assuring staff training.

III. POLICY

A. PPSEV must maintain complete medical records for every patient in accordance with PPFA Medical Standards and Guidelines, accepted professional standards and applicable laws/regulations.

B. PPSEV must provide safe storage of medical records or accurate and eligble reproductions thereof according to applicable federal and state law.

C. The medical records of inactive patients shall be kept for a minimum of seven years, **except as follows**

1. Medical records of minor patients shall be kept until such minor patients reach the age of majority, plus seven years
2. Medical records of patients who received prenatal care shall be kept until the offspring reaches the age of majority plus seven years

D. The Director of Patient Services, in collaboration with the PPSEV QRM Committee, shall assure the appropriate and timely destruction of medical records in accordance with this policy.

E. In the event of closure, PPSEV must provide proper storage of medical records and must notify the Virginia Department of Health Office of Licensure and Certification (OLC) concerning the location where the medical records are stored.

F. In the event of closure, PPSEV shall notify patients by mail within 30 days with contact information for obtaining their medical records and comply with other applicable provisions of Virginia law.

IV. PROCEDURE

A. Storage

1. PPSEV maintains a medical record for each patient with staff encounter in accordance with PPFA Medical Standards and Guidelines, accepted professional stanadards and applicable laws/regulations.
2. Refer to PPFA Medical Standards and Guidelines, Clinical Program Structure, I-A-1, Section VI Maintaining Affiliate Medical Records for information regarding appropriate parameters and documentation required in medical records.
3. Safeguards against loss and use of medical records by unauthorized persons must be maintained, including proper and secure storage.
4. Paper charts must be secured by lock when unattended by personnel. Electronic health record systems must be consistent with HIPAA privacy regulations.

B. Purging

1. At the end of the year, designated clinical staff members carrying out purging of medical records. The medical records are reviewed for inactive patients (excluding exceptions, see below) whose medical records are approaching date of destruction. For example, the medical records of patients inactive for 6 years are placed in boxes and labeled with the date of destruction, which would be the next year, the seventh year, and kept in the secured medical records room.

C. Destruction

1. Upon expiration of the destruction date, boxes of medical records to be destroyed will be shredded by a contract medical record destruction company on-site. The contract medical record destruction company shall provide written documentation of the date and time of such shredding.

D. Procedure for Destruction of Records Described in IIIC of This Policy

1. An identifying sticker is placed on the medical records of both prenatal and minor patients. Each sticker is color coded, one color for prenatal and one for minor patients, and indicates the year the prenatal patient's offspring or minor will reach the age of majority plus seven years (age 25), respectively.
2. Prenatal records (indicated with the specific sticker displaying the date of destruction) are stored in a separate, specific location in the medical records room. These medical records are reviewed every year for any that have reached the date of destruction and are destroyed per the destruction procedure above.
3. The medical records of minors (indicated with the specific sticker displaying the date of destruction) are reviewed each year for any records that have reach the

date of destruction or are boxed if the date of destruction is nearing (box is labeled with the date of destruction and secured in the medical records room). The records are destroyed per the destruction procedure above.

E. Offsite Storage

1. If offsite storage of medical records is necessary, it shall only be done with the approval of the Vice President Operations, CEO or designee. Any such records stored offsite shall be indexed and a copy of the list of individual records stored maintained by the Vice President of Operations or designee. Such offsite storage facility shall preserve the confidentiality of all PPSEV medical records and comply with applicable provisions of federal and Virginia law.
2. These records stored offsite are secured in boxes labeled with the destruction date and are destroyed per the destruction procedure above.

F. Facility Closure

1. In the event of the closure of a health center, PPSEV must provide proper storage of medical records.
2. PPSEV must also notify OLC concerning the location where the medical records are stored. The CEO, Vice President of Operations, or designee should notify OLC. This contact must be appropriately documented, including the date, time, and the individual(s) at OLC reported to.
3. Contact Information (according to http://www.vdh.state.va.us/OLC/contacts.htm)
   a. OLC Main Number: 804-367-2102, 804-367-2103
   b. Acute Care: 804-367-2104
   c. Additional Contact: Kathaleen Creegan-Tedeschi 804-367-2156
4. In the event of closure, PPSEV shall notify patients by mail within 30 days with contact information for obtaining their medical records and comply with other requirements of applicable Virignia law.

V. QUALITY CONTROL

A. The CEO, Vice President of Operations, and Director of Patient Services are responsible for monitoring compliance, review, and revision of this policy, in consultation with the Quality and Risk Management (QRM) Committee.

B. Modifications to this policy must be reviewed and approved by the QRM Committee.

Planned Parenthood® of Southeastern Virginia

June 4, 2012

Erik Bodin, Director
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Richmond, Virginia 23233

Dear Mr. Bodin,

Enclosed is the Plan of Correction for Planned Parenthood of Southeastern Virginia (PPSEV) in response to the Abortion Facility Initial Licensure Survey of the PPSEV facility on 515 Newtown Road, Virginia Beach, VA 23462. The Plan of Correction details a list of corrective action items we have taken to address the deficiencies noted in the Licensure Inspection Report and to prevent recurrence of such deficiencies and maintain compliance. Please let us know if the Department has any questions.

Sincerely,

Patrick J. Hurd, Esq.
CEO
Planned Parenthood of Southeastern Virginia