State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AF-0005	A. BUILDING _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A CAPITAL WOMENS HEALTH CLINIC	1511 STARLING DRIVE HENRICO, VA 23229

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T 000	12VAC5-412 Initial Comments An unannounced Licensure Revisit inspection to the Biennial Licensure inspection, which was completed September 28, 2016 through September 30, 2016, was conducted January 25, 2017 by two (2) Medical Facilities Inspectors from the Virginia Department of Health, Office of Licensure and Certification. The facility was not in compliance with the State Board of Health 12 VAC5-412, Regulations for Abortion Facilities. The report contains two (2) deficiencies which were previously cited at the time of the Biennial inspection. A new deficient practice was identified in the area of Administration.	T 000	RECEIVED FEB 24 2017 VDH/OLC	2/27/17
T 045	12VAC5-412-170 A Administrator The governing body shall select an administrator who shall be responsible for the managerial, operational, financial, and reporting components of the abortion facility including but not limited to: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including patient rights; 2. Employing qualified personnel and ensuring appropriate personnel orientation, training, education, and evaluation; 3. Ensuring the accuracy of public information materials and activities; 4. Ensuring an effective budgeting and accounting system is implemented; and 5. Maintaining compliance with applicable laws	T 045	12VAC5-412-220 B Effective 2/27/17, staff member #3 has taken and completed a current and outside infection control course. Evidence of successful completion has been placed on file for review. Further, effective 2/27/17 the facility medical director has conducted hands on observation/training of staff member #3 in medication handling and preparation and approved said member for such. Documentation of this approval has been placed on file for review. Further, staff member #3 has undergone numerous episodes of observation/Q&A with the facility infection control officer. Documentation of these sessions with signatures of both parties is on file for review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 2-24-17

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T 045	Continued From Page 1 and regulations and implementing corrective action. This RULE: is not met as evidenced by: Based on observation, staff interview, facility document review and review of facility personnel and training records, the facility Governing Body and the facility Administrator, who was responsible for the management of the facility, failed to ensure the appropriate orientation, training and education was provided for staff. The findings included: During a review of the facility Plan of Correction (POC) credible evidence regarding staff training and education for safe injection practices, appropriate methods of handling, preparing, and storing of medications and cleaning procedures, the surveyor reviewed the personnel records for all staff employed at the facility. The surveyor was unable to determine from the personnel records evidence of training for the staff related to the Plan of Correction. The surveyor requested information and evidence for the training from Staff Member #2 (facility Administrator) on 1/25/17 at 10:00 a.m. On 1/25/17 at 10:35 a.m., Staff Member #2 provided the surveyor with a typewritten document which included the facility name and address at the top and the date 12/10/16. Review of this document revealed the following: "On Saturday, December 10th, Administrator and Infection Control Officer (name of Staff Member #2) held a staff inservice to ensure proper protocol was being followed for infection control. (Name of Staff Member #2) discussed extensively the acceptable standards of practice for safe injections, and	T 045		

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T 045	Continued From Page 2 further demonstrated appropriate methods of handling, preparation, and storing of medications. The newly detailed policy for cleaning and disinfection of procedure rooms was discussed, All staff were re-trained on infection control techniques. Staff were quizzed randomly and given the opportunity to ask questions. The meeting also served as our 4th quarter staff meeting." This document did not list names of any staff who attended. There was no "sign-in" log for this training. The personnel records for all staff were reviewed and no evidence of this training was included in the personnel files. The surveyor requested evidence of staff attendance, a sign in log, or other evidence of who attended the meeting. Staff Member #2 stated, "I don't think I had anyone sign in." The surveyor requested a schedule of staff who were working that day (12/10/16) to evidence who was on duty and may have attended the inservice. Staff Member #2 stated, "I don't know if I have a schedule because we have such a small staff." The surveyor again reviewed the credentials and training for Staff Member #2. Staff Member #2, who conducted the training last had documented infection control training with a "Certificate of Completion" on 5/1/2012. There was no evidence from the personnel record training record or credentials that Staff Member #2 had any training regarding handling, storage, or preparation of medications. Staff Member #2 did not hold a license as a medical professional or any health care associated training which would qualify Staff Member #2 to be able to inservice staff regarding medication handling, storage, or preparation. When interviewed as to whether the Medical Director was available to in-service staff or provide	T 045		

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T 045	Continued From Page 3 training, Staff Member #2 stated, "(He/she) is available to answer questions..." There was no evidence the Medical Director participated in the training or in-services for staff. The concerns were discussed with Staff Member #2 on 1/25/17 at 7:15 p.m. No further evidence was presented by the end of the inspection. Please Refer to 12VAC 5-412-220B (195) and 12VAC 5-412-220C for further information.	T 045		
{T 195}	12VAC5-412-220 B Infection Prevention 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-borne pathogen requirements of the U.S. Occupational Safety & Health Administration; 6. Use of personal protective equipment; 7. Use of safe injection practices;	{T 195}	RECEIVED FEB 24 2017 VDH/OLC 12VAC5-412-170 A Effective 2/27/17, The Administrator will ensure that all staff in-services and trainings will be documented with any/all employees in attendance's signature and a copy of such documentation will be placed in any/all attending employee's file. Effective 2/27/17, Staff member #2 has taken and successfully completed a current edition of infection control training. Documentation of this outside training is available for review. Further, the facility medical director has documented individual training with staff member #2 regarding handling, storage, and/or preparation of medications. With the refresher course, hands on observation/training with the medical director, and 18 years experience in successful infection control management, it was established by the Governing Authority that Staff member #2 is qualified to conduct staff in-services regarding medication handling, storage, and preparation, and notation to that effect has been placed on record for review. Further, effective 2/27/17 policy has been established that no staff member shall conduct preparation of any medications without hands on training by the medical director. Documentation of such training will be kept in the employee file for review.	2/27/17

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{T 195}	Continued From Page 4 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 observation and staff interview, the facility staff failed to ensure that injectable medication was handled in a manner to prevent contamination for 17 Lidocaine filled syringes available for use during abortion procedures, and facility staff failed to implement their Plan of Correction in regards to staff training in infection control measures, and proper handling and storage of medications. Findings include: 1. Between 4:40 PM and 5:00 PM on 1/25/17, the Inspector observed Staff Member #3, a Licensed Practical Nurse (LPN), draw up 1 % (one percent) Lidocaine for the scheduled procedures that evening. Staff Member #3 opened a 10 ml (milliliter) syringe and an 18 gauge needle, attached the needle to the syringe, wiped off the bottle of lidocaine with an alcohol soaked cotton ball, inserted the needle, drew up 10 ml of Lidocaine, aseptically capped the needle, removed the needle placed it in the sharps container, then put the uncapped Lidocaine filled syringe into a plastic box containing extenders,	{T 195}		

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{T 195}	Continued From Page 5 which had been sterilized and were wrapped in blue paper. This process was repeated until Staff Member #3 had filled 17 syringes with Lidocaine, and 17 uncapped syringes were lying together in the plastic box. Staff Member #3 then carried the plastic box into the room where the autoclave machine sat, stating he/she would "put the extenders on the syringes when the physician arrived at the facility, and someone else would get them and put them in the room". The surveyor discussed the potential for contamination of the medication because of the uncapped syringes with Staff Member #3 on 1/25/17 at 5:40 PM, and he/she stated "Yes, I can see how that could be an issue, thank you for sharing that with me". The surveyor asked Staff Member #3 about the training he/she had received at the facility. The LPN responded that at the time of hire, he/she had a one day orientation with a Licensed Practical Nurse. Since that time the administrator and alternate administrator had been precepting him/her. Neither the administrator or alternate administrator are licensed in the healthcare field. The findings were discussed with Staff Member #2, the administrator, on 1/25/17 at 7:15 PM. 2. During a review of the facility Plan of Correction (POC) credible evidence regarding staff training and education for safe injection practices, appropriate methods of handling, preparing, and storing of medications and cleaning procedures, the surveyor reviewed the personnel records for all staff employed at the facility. The surveyor was unable to determine from the personnel records evidence of training	{T 195}		

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{T 195}	Continued From Page 6 for the staff related to the Plan of Correction. The surveyor requested information and evidence for the training from Staff Member #2 (facility Administrator) on 1/25/17 at 10:00 a.m. On 1/25/17 at 10:35 a.m., Staff Member #2 provided the surveyor with a typewritten document bearing the facility name and address at the top and the date 12/10/16. Review of this document revealed the following: "On Saturday, December 10th, Administrator and Infection Control Officer (name of Staff Member #2) held a staff inservice to ensure proper protocol was being followed for infection control. (Name of Staff Member #2) discussed extensively the acceptable standards of practice for safe injections, and further demonstrated appropriate methods of handling, preparation, and storing of medications. The newly detailed policy for cleaning and disinfection of procedure rooms was discussed, All staff were re-trained on infection control techniques. Staff were quizzed randomly and given the opportunity to ask questions. The meeting also served as our 4th quarter staff meeting." This document did not list names of any staff who attended. There was no "sign-in" log for this training. The personnel records for all staff were reviewed and no evidence of this training was included in the personnel files. The surveyor requested evidence of staff attendance, a sign in log, or other evidence of who attended the meeting. Staff Member #2 stated, "I don't think I had anyone sign in." The surveyor requested a schedule of staff who were working that day (12/10/16) to evidence who was on duty and may have attended the in-service. Staff Member #2 stated, "I don't know if I have a schedule because we have such a small staff."	{T 195}		

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{T 195}	Continued From Page 7 The surveyor again reviewed the credentials and training for Staff Member #2. Staff Member #2, who conducted the training, last had documented infection control training with a "Certificate of Completion" on 5/1/2012. There was no evidence from the personnel record training record or credentials that Staff Member #2 had any training regarding handling, storage, or preparation of medications. Staff Member #2 did not hold a license as a medical professional or any health care associated training which would qualify Staff Member #2 to be able to in-service staff regarding medication handling, storage, or preparation. When interviewed as to whether the Medical Director was available to in-service staff or provide training, Staff Member #2 stated, "(He/she) is available to answer questions..." There was no evidence the Medical Director participated in the training or in-services for staff. The concerns were discussed with Staff Member #2 on 1/25/17 at 7:15 p.m. No further evidence was presented by the end of the inspection.	{T 195}		