STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AF-0017	A. BUILDING _____ B. WING _____	03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS CHURCH HEALTHCARE CENTER	900 SOUTH WASHINGTON ST SUITE 300 FALLS CHURCH, VA 22046

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{T 000}	12VAC5-412 Initial Comments An unannounced Revisit Inspection to the Biennial Licensure Inspection conducted 11/14/16 through 11/17/16, was conducted 3/1/17 and 3/2/17 by two (2) Medical Facilities Inspectors from the Office of Licensure and Certification, Virginia Department of Health. The agency was not in compliance with 12 VAC-412 Regulations for the Licensure of Abortion Facilities. A repeat deficiency was cited in the area of Infection Prevention 12VAC 5-412-220B.	{T 000}	T 195 **12VAC5–412-220B** Infection Prevention PLAN OF CORRECTION: ***Corrective Action:*** A review and retraining of aseptic and clean techniques was done with the HCP. A retraining of safe injection, infusion, and medication vial practices, with attention to cleansing the ports with alcohol prior to puncturing the septum of the medication vials, was done by the Nursing Administrator who is trained in infection control. Review of site specific, practitioner specific injection techniques, and safe injection practices and standards was completed. No patients were affected evidenced by no increase in adverse events.	3/21/17
{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;	{T 195}	A review and retraining of safe handling and cleaning of reusable, non-critical medical equipment was completed. The cleaning of the EKG screen with an Opticide wipe was added to the routine environmental cleaning in between patient care. No patients were affected evidenced by no increase in adverse events. A review of CDC and WHO guidelines on appropriate hand hygiene practices was done with HCP. Direct observation reminds people to wash their hands and over time this reinforcement has an impact on the number of people who do hand hygiene. Infection control is a behavioral science and by encouraging people to practice the five moments of hand hygiene outlined by WHO then we will have accomplished our goal in hand hygiene. Verbal reminders will be given to HCP by the Nursing Administrator and the Surgical Wing Coordinator. No patients or staff were affected evidenced by no increase in adverse events. We will continue to provide sufficient and appropriate PPE for our HCP. A review of CDC's Standard Precautions and the Osha Blood Borne Pathogens Standard emphasizing changing gloves and performing hand hygiene between patient encounters. No staff member was affected evidenced by no increase in adverse events.	3/7/17

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

Administrator 3-28-17

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{T 195}	Continued From Page 1 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 observation and interview, it was determined the facility staff failed to ensure that safe injection practices were followed, that correct hand-washing technique was utilized by staff, that PPE (personal protective equipment) was properly utilized, and that critical multi-use equipment was sanitized between patients. Findings include: A surveyor observed a surgical procedure on 3/2/17 between 10:30 AM and 10:45 AM, and observed the following: Staff Member #3, a CRNA (Certified Registered Nurse Anesthetist), obtained a vial of Propofol from a multi-dose box, and placed a vial of Fentanyl on a cart beside the door. Staff Member #3 then donned gloves and used an alcohol prep pad to clean the patient's right arm. Staff Member #3 pulled tape from a roll, placed it on the the table, started the IV (intravenous line), and taped it	{T 195}	As defined by WHO guidelines a safe injection does not harm the recipient, does not expose the provider to any avoidable risk, and does not result in waste that is dangerous for the community. A review of OSHA's needle stick safety and sharps injury prevention, that includes no recapping of needles, was done with the HCP. No staff member was affected evidenced by no increase in adverse events. ***Measures to prevent recurrence:*** The Surgical Coordinator will continue to monitor and train staff on current best practices: for injection safety, for hand hygiene, for safe handling of potentially contaminated non-critical equipment and for maintaining clean environmental surfaces in the patient environment. This includes practices intended to prevent transmission of infectious disease between one patient and another, or between a patient and a HCP during preparation and administration of parental medications. These steps are in practice now and will continue to be reinforced in our staff trainings. Ongoing education and training on best practices to protect HCP will continue to be provided to prevent recurrence. Cleaning and disinfecting of environmental surfaces will continue to be monitored and assessed by the surgical coordinator. An annual OSHA retraining for certification of all personnel in infection control methods will continue. ***Measures implemented to maintain compliance:*** Continued ongoing education and training for the HCP will maintain up to date best practices and compliance with current safe injection practices. Ongoing staff education of appropriate selection and use of PPE for infection control for outpatient settings continues. Ongoing education for surface disinfection to meet infection prevention guidelines continues. Ongoing education for hand hygiene best practices to minimize transmission of infectious diseases and ensure patient health continues.	

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{T 195}	Continued From Page 2 into place. Staff Member #3, while wearing the same gloves, reached around his/her PPE (personal protective equipment) gown, and removed alcohol prep pads from his/her scrub pocket. Staff Member #3 removed the top from both medication vials, and wiped each with an alcohol prep pad. Staff Member #3 left the procedure room wearing his/her PPE including gloves, gown, and shoe covers, then re-entered the procedure room still wearing PPE, and carrying more alcohol prep pads. Staff Member #3 drew up Propofol into a 30 cc (cubic centimeter) syringe without re-cleaning the vial top after it was left uncovered and unattended. Staff Member #3, without removing his/her PPE, and wearing the same gloves, left the room a second time, then returned wearing PPE, with several 3 cc syringes, and drew up Fentanyl into one of the syringes. Staff Member #3 did not re-clean the vial top, which was left unattended and uncovered, prior to withdrawing the medication from the vial. The unused syringes were placed in a box of supplies being used for multiple procedures/patients. Staff Member #3, while still wearing the same gloves, reached into an open box of EKG (electrocardiogram) electrodes which were loose in the box, removed 3 electrodes, and placed them on the patient. After cleaning the IV medication port with alcohol, Staff Member #3 administered the IV Fentanyl. Without first re-cleaning the medication port, Staff Member #3 administered IV Propofol through the medication port. After administering Fentanyl and Propofol, Staff Member #3 re-capped each syringe prior to disposal in the sharps container.	{T 195}	***Attachments for this response:*** 1. Sign in sheet for Aseptic Techniques/Safe injection, Infusion, and Medication Vial Practices 03/21/2017 a. APIC Position Paper (2016) b. Safe Injection Practices The One and Only Campaign c. Blood borne Pathogens Training Activity 2. Sign in sheet for Hand Hygiene Guidelines 03/07/2017 a. WHO/Evidence for Hand Hygiene b. Importance of Hand Hygiene Infectious Disease News, 2014 RECEIVED MAR 31 2017 VDH/OLC	

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{T 195}	Continued From Page 3 After the procedure was complete, Staff Member #3 silenced the EKG monitor after the electrodes and pulse oximeter (placed on the finger to monitor the patient's oxygen levels) were removed. Staff Member #3 helped the Recovery Room nurse and the Surgical Assistant move the patient onto the stretcher, still wearing the same gloves he/she had put on prior to starting the patient's IV. Staff Member #3 then picked up his/her clipboard and a box of Propofol which still contained 5 unopened and unused vials of medication available for use for other procedures, moved into the recovery room to write his/her note. After the note was written, Staff Member #3 returned to the procedure room, removed PPE, and left the room with the box of Propofol and clipboard without washing or sanitizing his/her hands. On 3/2/17 between 10:45 AM and 10:55 AM, a surveyor observed Staff #5 cleaning the procedure room between patients. Staff #5 cleaned the BP (blood pressure) cuff, pulse oximeter, and tubing; however, he/she did not clean the EKG monitor, which had been touched by Staff Member #3 with contaminated gloves. These findings were discussed with Staff Members #2 and #3 on 3/2/17 between 11:00 AM and 11:30 AM.	{T 195}		