

COMMONWEALTH of VIRGINIA

Department of Health

Marissa J. Levine, MD, MPH, FAAFP State Health Commissioner

Office of Licensure and Certification

TYY 7-1-1 OR 1-800-828-1120

9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1485 FAX: (804) 527-4502

January 8, 2015

Administrator Alexandria Women's Health Clinic 101 S. Whiting Street - Suite 215 Alexandria, Virginia 22304

RECEIVED
JAN 22 2015
VDH/OLC

RE: Alexandria Women's Health Clinic - Alexandria, VA
Abortion Facility Biennial Licensure Inspection

Dear Administrator:

An unannounced, Abortion Facility biennial licensure inspection of the above facility was conducted December 8, 2014 through December 9, 2014 by two (2) Medical Facilities Inspectors from the Virginia Department of Health's Office of Licensure and Certification.

Enclosed is the Biennial Licensure Inspection. The facility was not in compliance with 12VAC5-412 regulations for the Licensure of Abortion Facilities, effective June 20, 2013. This document contains a listing of deficiencies found at the time of this inspection.

You are required to submit a plan for correcting the deficiencies cited. Your statements shall reflect the specific detailed actions you will take to correct deficiencies, prevent a recurrence of the deficiencies, and measures implemented to maintain compliance. You must also give the expected completion date of each deficiency.

Completion of corrective actions shall not exceed 45 working days from the last day of the inspection.

After signing and dating your Plan of Correction, retain one copy of the report for your files and return the original to OLC within 15 (fifteen) working days of receipt of the inspection report. The Administrator shall be notified whenever any item in the plan of correction is determined to be unacceptable. Failure to submit an acceptable plan of correction may result in a penalty in accordance with the Code of Virginia §32.1-27 or in denial, revocation or suspension of a license in accordance with 12VAC5-412-130.



Administrator Alexandria Women's Health Clinic - Alexandria, VA January 8, 2015

Page 2

A copy of the completed form will be kept on file in this office and will be available for public review. The Virginia Department of Health – Office of Licensure and Certification is required to make copies of this report available to other Federal and State regulatory or reimbursement agencies upon request.

Thank you for the cooperation that was extended to our inspectors during this investigation. If you should have any question or concerns regarding this report or the report findings, please contact me at (804) 367-4877.

Sincerely,

Anne Sparkman Tuck, Supervisor Division of Acute Care Services

Enclosure

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1 030	B. Any change in administrator shall the licensee to the This RULE: is no Based on intervie determined the agrelated to reporting administrator. The findings including Review of the agreement of 12/08/policy requiring the Office of Licensus	the position of the ll be reported immedice department in writing the met as evidenced by and document revigency failed to develong changes of the positions.	edure e was no notify the notify gof a		The governing body develop a policy an for reporting any char writing of any char position of the adr to the Office of Lic and Certification.	vinistrator	12/30/14
Т 060	approximately 6:0 there was no polichanges in the polichanges in the polichanges. 12 VAC 5-412-17 A. Each abortion adequately trained.	ew conducted on 12/00 PM, Staff #2 acknown cy related to notifying osition of administrate of A Personnel of facility shall have a led and capable of process of the conduction of supervision to the conduction of the conduction o	owledged g the OLC of or. staff that is oviding	T 060	FEB 02 VDH/C	2015	
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approximately 12:40 PM, Staff #4 stated that he/she had trained Staff #6 how to perform vital signs. A review of the employee file of Staff #6 did		administrator will be responsible that the employe training is documented and filed. RECEIVED	e
not include supporting documentation of training for performing vital signs.		VDH/OLC	
T 095 12 VAC 5-412-170 H Personnel	T 095	T095	12/30/14
H. Personnel policies and procedures shall include, but not be limited to: 1. Written job descriptions that specify authority, responsibility, and qualifications for each job classification; 2. Process for verifying current professional licensing or certification and training of employees or independent contractors;		3. A policy and procedure will be developed for annual evaluation of employees. There will be an annual self-evaluation documentation of employee performance in each	

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Т 095	performance and 4. Process for veremployees meet to the facility; and 5. Process for rephealth care practitionsing or certification appropriate board Health Profession This RULE: is not Based on docume was determined to annual employee seven (7) employer #3). The findings inclusion and to include data surveyor to review records on 12/08/contain evidence staff (Staff #3) haperformance evaluation members had been appropriately was p.m., with Staff #1 requested docume would have an an performances. Strunsure if the facility procedures to refire requirements for experformance evaluations.	nually evaluating emploompetency; rifying that contractors the personnel qualificationers for violations of cation standards to the within the Departments. It met as evidenced by the facility failed to perperformance for one the survey same	s and their ations of sertified of their ent of staff of their ent of sertified on nel ed to seven (7) annual staff et (1) year.	T 095	employee file. The process for evaluating employees' annual performed competency will be reviewed by the Quality Assurance. Program and Governing Body providing report of review, resultations, if an arecommendations, if an arecommendations.	the ga sand	12/30/14

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	reviewed on 12/08 "The facility staff's information on the training, experience licensure, if application personal backgro The review of the on 12/08/2014 at for evaluating emplo#1 and Staff #2 of #2 acknowledged process to comple performance evaluating en personnel file she documents but facility.	cy titled, "Credentialires/2014. The policy reshall obtain and verify application as to educe, appropriate profescable, and the health und of each staff method of each staff and not included to implementing the each of the employee annual staff although the agreement of the employee annual staff and have contained to do so. Staff annual ersonnel file until it was by the surveyor.	ead in part: / ucation, ssional and mber." i procedures lude policies annually. the policy for with Staff pency has a / w the these //2 reported al evaluation				
	During the exit in acknowledged the obtain an annual evaluation, but fa	aterview on 12/09/201 nat the facility has a p lemployee performan ailed to maintain the f anner required by this	rocess to nce facility's		T170		12/30/1
T 170	12 VAC 5-412-2	20 B Infection preven	ntion	T 170		de reminded	1201
	procedures shal 1. Procedures for and visitors for a applying approp	tion prevention policient include, but not be list or screening incoming acute infectious illnes riate measures to precommunity acquired	imited to: g patients ses and event		All employees will to a staff meeting infection prevention regarding the use of precautions and conversing technique	<u>ು</u>	ation sheet 4 c

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within 2. To prev 3. Condice alcoods. U. 5. Condice alcoods. U. 7. U. 8. Pointer and 10. retrain previous This Basinevial 1. Expense colonic transition and	ention technique torrect hand-wations for use hol-based hands of standard ompliance with irements of the lath Administrates of personalise of safe injection prevention prevention procedures for mmended inferention practices. RULE: is not each on observation, when was mission of missio	ersonnel in proper infues; ashing technique, income soap and water and rubs; diprecautions; hiblood-bourne pathole U.S. Occupational sion. Il protective equipmentation practices; al retraining of all person methods; monitoring staff adhesection prevention practice ar documenting annualif in recommended in	cluding nd use of gen Safety & nt; sonnel in erence to ctices; al nfection cument ailed to: ons by ent	T 170	TIFO continued. The facility will requisive standard precautions of followed by all employ and medical staff car patients to prevent transfirstents to prevent transfirstents to prevent transfirstents associated infections by the transmission of michanimate surfaces to thank hygene shall be before and after each contact as well as afremoval and before onew gloves.	ire jees ing for ismission codoces noare- preventing croorganisi and from patients. practiced patient ter glove	S
whe The It wa 12/9 #2 c chai	n donning glover findings includes as observed in 1/2014, at appro- lid not performages. At appro-	/es	n that Staff en glove staff #6 did		A healthcare profession (physician, RN, etc. be responsible for the ongoing education region feetion prevention to	kl	5.

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T 170	Continued From P	age 5	1	T 170			
	approximately 12:: that hands should changes and state interview on 12/09 Staff #6 acknowle	w on 12/09/2014, at 20 PM, Staff #2 ackn be cleaned between ed, "I guess I forgot." 1/14, at approximately dged that hands are onning gloves with so	glove During an / 12:25 PM, to be				£9
	cleaning room on 11:00 AM, that Sta	the tissue exam and 12/09/2014, at appro aff #3 did not perform glove changes follow	ximately hand				
	approximately 11: hands before I co leave the room, a Staff #3 acknowle	w on 12/09/2014, at 20 AM, Staff #3 state me into the room and fter all procedures aredged he/she would reall procedures were on the state of the st	d when I e done." not leave the				
	(CDC), Guide To Outpatient Setting performed: 1. Before touchin worn 2. Before exiting	Center for Disease C Infection Prevention gs, hand hygiene sho g a patient, even if gl the patient's care are ent or the patient's im-	For ould be loves will be a after				
	Review of the agmanual on 12/09 policy related to figloves. During an interview	ency policies and pro /2014, revealed there nand hygiene when w ew on 12/09/2014, at 00 PM, Staff #2 ackn	e was no vearing				
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T 170	Continued From P	age 6		T 170			
	there was no polic hygiene before do removal.	y related to performir nning gloves and afte	ng hand er glove		en e		
T 175	12 VAC 5-412-220	C Infection preventi	on	T 175	T175		12/30/14
	management of th supplies shall add 1. Access to hand adequate supplies hand rubs, dispos 2. Availability of u and other materia storage and trans 3. Appropriate sto locked cabinets o cleaning) and prouse of cleaning adtime, managemer 4. Procedures for transporting clear and equipment; 5. Procedures for and transporting in accordance with a 7. Procedures for and transporting in accordance with 7. Procedures for eusable medical different patients. (i) the level of commended le has been achieve reference the materials.	s and procedures for the facility, equipment the facility sinks, cleaning is lightly sinks, cleaning is lightly sinks, cleaning is lightly sinks, cleaning agone for cleaning agone for cleaning agone for cleaning agone for chemical duct-specific instructions (e.g., dilution, control of accidental expositions of the faccidental exposition	and t and -based r dryers); supplies sal, id supplies; gents (e.g., is used for ions for contact sures); id supplies rocessing aste in s; each type of uses on Il address: sterilization t, iical erilization hall nendations		The vinyl padding in table will be replaced decontaminate between use. The administrator designee (assistant surgical coordinate will be responsible replacement of any in order to be in	and veen patient or administration of the for the	tor

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	non-reusable equip 9. Policies and promaintenance/repair with manufacturer 10. Procedures for surfaces with approximate approx	appropriate disposa oment; ocedures for ir of equipment in a recommendations; r cleaning of enviro opriate cleaning pro- est control program, local health and ulations; and n prevention procedent/control transmis the facility as recom-	ccordance nmental oducts; , managed lures sion of an nmended by: document failed to eaning				
	The findings include	led:					
	12/08/2014, at app was a tear in vinyl	iring a tour of the fa roximately 2:00 PM padding of a structu e, above the head o	i, that there are adjoining	п.	*		**

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During an interview conducted on 12/08/2014, at approximately 2:00 PM, Staff #1 stated that this portion of the table was used by a clinician to make notes during the procedure. Staff #1 stated,

A tear in vinyl inhibits the ability to disinfect the surface of microorganisms. Agency policy and procedures state "Stretcher mattresses, gurneys, wheel chairs and chairs will be examined first

"We can get rid of this."

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NO PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUI		1, , ,	vG	COMPLE	TED	
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T 175	Continued From P	age 8		T 175		'		
	thing in the morning and between patients for tears. If there is any damage to any mattress, gurney or chair it will be removed from use and reported to the Director of Nursing." 12 VAC 5-412-220 D Infection prevention							
T 180	T 180 12 VAC 5-412-220 D Infection prevention		on	T 180	T180	15	12/30/14	
	program that incluing 1. Access to record 2. Procedures for communicable disprevented from we transmission to oth 3. An exposure compathogens; 4. Documentation immunizations offer accordance with serecommendations including document tuberculosis and a 5. Compliance with Cocupational Safe reporting of workpexposure to infect This RULE: is not Based on document the facility failed to program that docummunizations off accordance with secommendations	mmended vaccines, assuring that employeeases are identified a per personnel or patie on trol plan for blood-to of screening and ered/received by emptatute, regulation or of public health authoration of screening forcess to hepatitis Both requirements of the trological that the trological endings are associated injurtion. It met as evidenced be the treview and staff in the public health authoration of screenings are ered/received by emptatute, regulation or of public health authoration (7) employees and is	vees with and d result in ents; bourne bloyees in orities, or vaccine; e U.S. ration for ies or y: htterviews health and bloyees in porities for another in the continuous for the conti		The facility will imple policy and procedure employee health procedure program will consist be limited to: Education of person recognize and protection of indicate and other personnel. Provision of indicate all employees (included in the communicable diseased with infection preventation of the communicable diseased in the control of	nram. This of, but not nuel to t against themselves aked vaccination uding physicia uding physicia ste in Conjuct tion. enance of and personal ovision of with work-	øs on	
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	summary strach deficience of the risk cate to be given its eview of the risk cate to be given it	AF-0014 OR SUPPLIER DMEN'S HEALTH CLINIC SUMMARY STATEMENT OF DEFICIENCIE ACH DEFICIENCY MUST BE PRECEDED BY GULATORY OR LSC IDENTIFYING INFORMA nued From Page 9 oyee files #1-#7) and five (5) cred nnel records (Credentialing Emplo yees were offered/received scree culosis annually. One (1) of sever nnel records (Employee #4) and file of credentialing personnel records entialing Employees #1, 2, 3 and in evidence verifying employees he ceived on 12/08/2014. The polic "Each staff member whose position fied them as being at risk of contri- is reasonable anticipation that the sed to Hepatitis B Virus (HBV) will BV vaccination series free of char ne will be available within 10 days by ment or assignment of a new por the risk category. This vaccination to be given if; the employee has provided the complete HBV vaccination and the vaccine is contraindicated cal reasons, or the employee refuse the vaccine is contraindicated cal reasons, or the employee refuse the vaccine is contraindicated cal reasons, or the employee refuse the vaccine is contraindicated cal reasons, or the employee refuse the vaccine is contraindicated cal reasons, or the employee refuse the vaccine is contraindicated cal reasons, or the employee refuse the vaccine is contraindicated cal reasons, or the employee refuse the vaccine is contraindicated cal reasons, or the employee refuse the vaccine is contraindicated cal reasons, or the employee refuse the vaccine is contraindicated cal reasons, or the employee refuse the vaccine is contraindicated cal reasons, or the employee refuse the vaccine is contraindicated cal reasons, or the employee refuse the vaccine is contraindicated cal reasons, or the employee refuse the vaccine is contraindicated cal reasons, or the employee refuse the vaccine is contraindicated cal reasons. Staff #2 reported m contraint is the process of the facility's policies and contraint is the process of the facility's policies and contraint is the process of the pr	AF-0014 TOR SUPPLIER DMEN'S HEALTH CLINIC SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) DOUGH From Page 9 Oyee files #1-#7) and five (5) credentialing movel records (Credentialing Employees) failed to contain evidence verifying evides annually. One (1) of seven (7) movel records (Employee #4) and four (4) of containing Derivation of the entialing Employees had access to attits B vaccine. Gency's policy titled, "Hepatitis B Vaccine" evidence verifying employees had access to attits B vaccine. Gency's policy titled, "Hepatitis B Vaccine" eviewed on 12/08/2014. The policy read in "Each staff member whose position has fied them as being at risk of contracting, or is reasonable anticipation that they may be sed to Hepatitis B Virus (HBV) will be offered BV vaccination series free of charge. The me will be available within 10 days of expensive to the given if; the employee has previously and the risk category. This vaccination does not to be given if; the employee has previously and the complete HBV vaccination series, only testing has revealed the employee is not the read signs the Informed Refusal Form." Eview of the facility's policies and procedures to the employee of the facility's policies and procedures and signs the Informed Refusal Form."	AF-0014 AF-0014 STREET ADDRESS, CITY, 101 S. WHITING ST. 3 ALEXANDRIA, VA 22 SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) TO failed to contain evidence verifying or sulosis annually. 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The new will be available within 10 days of contracting or is reasonable anticipation that they may be used to enjoyee has previously ved the complete HBV vaccination does not to be given if, the employee has previously ved the complete HBV vaccination series, odly testing has revealed the employee is ne, the vaccine is contraindicated for call reasons, or the employee refused the enjoyees is one, the vaccine is contraindicated for call reasons, or the employee refused the enjoyees with Staff #2 on 12/08/2014 at 2.30 p.m. did not include policies indings related to having screening and mizations offered/received by employees discussed with Staff #2 on 12/08/2014 at p.m. Staff #2 acknowledged the facility does a process for offering employees screening mmunizations, including Hepatitis B an	AF-0014 STREET ADDRESS, CITY, STATE, ZIP CODE 101 S. WHITTING ST. SUITE #215 ALEXANDRIA, VA 22304 SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL JULATORY OR LSC IDENTIFYING INFORMATION) THE APPROVINCE ST. SUITE #215 ALEXANDRIA, VA 22304 SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL JULATORY OR LSC IDENTIFYING INFORMATION) THE APPROVINCE ST. SUITE #215 ALEXANDRIA, VA 22304 PROVIDERS PLAN OF CORRECT ALEXANDRIA PROVIDERS PLAN OF CORRECT ALEXANDRIA PROVIDERS PLAN OF CORRECT ALEXANDRIA PROVIDER	A BUILDING AF-0014 AF-0014 STREET ADDRESS, CITY, STATE, ZIP CODE 10 S. WHITING ST. SUITE #2215 ALEXANDRIA, VA 22304 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY SULATORY OR LSC IDENTIFYING INFORMATION) THE CORRECTION OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY JUST SAMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES A BUILDING 8. WING 12/09. 12/09. 10 S. WHITING ST. 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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE		1	PLE CONSTRUCTION	(X3) DATE SUI	
IND FERN OF CONNECTION				G	12/09/2014		
		AF-0014		B. WING _		12/05/	2014
NAME OF PR	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
ALEXAND	RIA WOMEN'S HEA	LTH CLINIC		ITING ST, S RIA, VA 22	SUITE #215 304		
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T 275	Continued From P	age 11		T 275			
	Nursing, under the Director is responsitocking, controlling controlled substant In accordance with dept on all ordering drugs." An interview was app.m. with Staff #1. the three (3) boxe #1 stated, "There just received this approximately one expired already. It this, but these box immediately from [According to www opioid medication narcotic. Fentanyles.]	lity's policy titled 'read in part: "The Description of the National sible for the orderinging, distributing and dinces and all other mental applicable laws, g, purchasing and disconducted on 12/08/2. Staff #1 verified the sof single use Fental is something wrong I shipment from the disconducted and it sham going to contact we should be discard this locked medication. An opioid is sometial is used as part of an after surgery or other	Medical , storing, isposing of edications. records are spensing of 2014 at 1:45 e date on anyl. Staff because we stributor houldn't be them about ded on cabinet." nyl is an mes called a nesthesia to				
T 285	12 VAC 5-412-26 dispensing of dru	0 E Administration, s	torage and	T 285	T285		12/30/14
*	received, sold, ad otherwise dispose accordance with a include the invent of a theft or loss of the Drug Control. This RULE: is not Based on document.	drugs in Schedules Iministered, dispense ed of shall be mainta federal and state law tory and reporting record drugs found in 54. Act of the Code of Viet met as evidenced bent review, observaticility failed to keep record	ed or ined in s, to quirements 1-3404 of irginia.	The same of the sa	Only healthcare licens professional will keep of all drugs received, a dispensed or disposed. The medical director was responsible for ordering controlling, distribution disposing of controlled	administere ill be a.stocking	

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State of \			0.001.14	(X2) MI II T	IPLE CONSTRUCTION	(X3) DATE SI	
		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1	IG	COMPLE	TED
				A BUILDIN			10044
		AF-0014		B. WING		12/09	/2014
NAME OF F	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
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T 285	with federal and s	es I-V received in acco tate laws.	ordance	T 285	and other medications in the facility's police procedure manual.	s as stated and	12/30/14
	Note: This is a re	-cite from 2012.	:		1		4
	at approximately (Administrator). Stored in the doul Staff #1 confirme sedation have an inserted into the medications) star #1 confirmed he/professional. Stareceived by him/l medications are by the physicians anesthetist) and logs. Staff #1 ac accounted for by record and by the physicians and/o Medical Director are counted at the physicians prior the medication lot the narcotics may a separate ledge compare counts and Staff #2 are professionals. A review of the reconducted on 12 Medication logs and CRNA signed.	ity was conducted on 1:30 p.m. with Staff #1 reported all noble locked medication d only patients who really (intravenous line verified prior to the processhe is not licensed as aff #1 confirmed the nature from the vendor; it removed from the lock and CRNA (certified documented in the maknowledged all narcost documentation in ease medication logs sign CRNA, which is over the above named facility to each use and document the removed from the physicians. Staff #1 again confirmed the physicians of the confirmed as health with the physicians of the p	arcotics are cabinet. eceive which is or dure. Staff a health arcotics are edication atics are ch patient's ned by the erseen by		Monthly narcotic coundons by a healthcan professional and verifice director of nursing medical director.	t will be e lisensed fied by and for	

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T 285	Continued From	Page 13	1	285			
	Medical Director Staff #2 are not Staff #2 are not Market Proper author A review was described and proper author A review of the Substances) by allowance for nonarcotic medical supervision of a A review of the "Pharmaceutical Nursing, under Director is respected by a proper author and	one of the Code of Virgessional use (of contro Practitioners. There von-licensed persons to ations, even if under th	e/she and fessionals. #5 on Staff #5 e beginning medication e been no ere ould notify ector or report it ginia alled was no handle e e Director of Medical g, storing, disposing of hedications, records are dispensing of he Director of safe and s limited to anel. Jeration shall area to house d supplies." Inlicensed				

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FORM APPROVED State of Virginia (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING 12/09/2014 AF-0014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 101 S. WHITING ST. SUITE #215 ALEXANDRIA WOMEN'S HEALTH CLINIC ALEXANDRIA, VA 22304 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) T 285 Continued From Page 14 T 285 During a review of Staff #5's credentials file on 12/08/2014 it was noted the documentation indicated Staff #5's DEA (drug enforcement agency) number expires on 10/31/2016. A review of Staff #1 and Staff #2's employee file were conducted on 12/08/2014. Staff #1's date of hire was 07/01/2000. Staff #1 has no professional license which would allow him/her to handle controlled substances. Staff #1 has no evidence of training in medications in his/her employee file. Staff #1 has a job description for administrator. Staff #2's date of hire was 09/04/2004. Staff #2 has no professional license which would allow

An interview with Staff #1 and Staff #2 was conducted on 12/09/2014 in regards to the findings. Staff #1 acknowledged approximately two (2) years prior to the survey a staff Registered Nurse was responsible for the task of handling all medications. After the Registered Nurse left the facility, the medication task became the responsibility of the Administrator because the physicians were not in the office everyday. Staff #1 didn't want to add more responsibilities to the physicians so he/she took the duty of ordering. storing and stocking the controlled substances and all other medications. Staff #1 stated. "I didn't realize I couldn't receive, store and count the narcotics until it was brought to my attention by the

him/her to handle controlled substances. Staff #2 has evidence of attending nursing school and training in medications in his/her employee file. Staff #2 has job descriptions for alternate administrator and surgical and laboratory

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technician.

surveyor."

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State of Virginia	(X1) PROVIDER/SUPPLIE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	AF-0014		B. WING _		12/09	/2014	
NAME OF PROVIDER OR SUPPLIER		2.5		STATE, ZIP CODE			
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T 315 12 VAC 5-412-300) A Quality assurance	•	T 315	T315	8	12/30/14	
A. The abortion for ongoing, compreh self-assessment properties appropriateness of including services agreement. The design, data colled improvement, and be used to correct policies and practions. This RULE: is not Based on documing quality committee maintained an organized self-assessment.	acility shall implement hensive, integrated, program of the quality of care or services pro- program shall include ction/analysis, assess d evaluation. The find at identified problems a tices, as necessary. In the tas evidenced be ent review and intervi- te failed to ensure the fagoing, comprehensives ssessment program.	t an and ovided, ract or process, sment and dings shall and revise y: ew the facility		The avality Assurant Consists of: 1. Medical Director 2. Administrator (non healthcare practions). 3. Assistant Admir Comember of the content of the conditional with decapt ability to represent and concerns of patents.	CPhysician). n-physician troner). nistrator odministrativ ator (an mostrated the rights		
program was con p.m., with Staff # did not understate requirement of in comprehensive, program of the quare or services provided under of the review revenues. Meeting," which the facility's qual surveyor asked determined, which committee had to collected. Staff #	review of the facility's aducted on 12/09/2012. Staff #2 initially stand the State licensure applementing "an ongointegrated, self-assessuality and appropriate provided, including secontract or agreement aled documents titled listed items discusselity program meeting. Staff #2 how the quality chitems to discuss a formulated the items formulated the items formulated that data has basis for what was discontinuous discourse and the items of the standard that data has basis for what was discourse and the standard the items of the standard that data has basis for what was discourse and the standard that data has basis for what was discourse and the standard that data has basis for what was discourse and the standard that data has basis for what was discourse and the standard that data has basis for what was discourse and the standard that data has basis for what was discourse and the standard that data has basis for what was discourse and the standard that data has basis for what was discourse and the standard that data has basis for what was discourse and the standard that data has basis for what was discourse and the standard that data has basis for what was discourse and the standard that data has basis for what was discourse and the standard that data has basis for what was discourse and the standard that data has been discourse and the standard that data has been discourse and the standard that data has been discourse and the standard that the st	4 at 1:30 ated he/she bing, ssment eness of ervices t." "Quality d'as part of The ity committe nd if the from data ad been		The Quality Assure will implement a self-assessment pr quality care and of the services give This program will 1. Staffing patterns 2. Supervision appro- the level of serv 3. Patent records.	ance Committee comprehensive cogram of the appropriateue n to ourpatie consist of:	uls:	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE S COMPL	
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		committee's meetings	20		4. Patient Satisfacti suggestion box).	ion (surveys,	
	p.m., the surveyor	inquired if Staff #2 ha	ad i		5. Complaint (250lut	ion	
	reviewed the Regulations for the Licensure of Abortion Facilities Effective June 20, 2013. Staff #2 denied awareness of the updated State licensure regulations. Staff #2 stated, "We have not collected data or performed a program assessment." 320 12 VAC 5-412-300 B Quality assurance B. The following shall be evaluated to assure adequacy and appropriateness of services, and to identify unacceptable or unexpected trends or occurrences: 1. Staffing patterns and performance; 2. Supervision appropriate to the level of service; 3. Patient records; 4. Patient satisfaction; 5. Complaint resolution; 6. Infections, complications and other adverse events; and 7. Staff concerns regarding patient care.				b. Recording and reporting of infections, complications and other adverse events (monthly compilation).		
T 320				Т 320	7. Staff concerns rea care (staff suggest meetings). This program will a facility to correct (illow the and make	
				·	improvements to par and in our respective to better serve the our patients.	tient care le duties Care of	
	Based on docume quality committee the adequacy and required by the Standard Transfer of the stan	nis RULE: is not met as evidenced by: ased on document review and interview the uality committee failed to ensure an evaluation of e adequacy and appropriateness of services as equired by the State licensure regulations. ote: This is a re-cite from 2012 related to staff's illure to ensure all subjects of the quality approvement committee would be addressed. the findings included:			T320 The adequacy and of services will be a the Quality Assuranthis evaluation will unexpected or unaccounteres. This the following: 1. Staffing patterns of	evaluated by ce Committe identify the eptable trend will address	3
	An interview and r	eview of the facility's	quality		2 Supervision appropriate	c to the level of	Pervice
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State of Virginia (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING AF-0014 12/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 101 S. WHITING ST, SUITE #215 ALEXANDRIA WOMEN'S HEALTH CLINIC ALEXANDRIA, VA 22304 SUMMARY STATEMENT OF DEFICIENCIES X41 ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) T 320 Continued From Page 17 T 320 T320 Continued 12/30/14 3. Patient records. program documents were conducted on 12/09/2014 at 1:30 p.m., with Staff #2. Staff #2 4. Patient satisfaction (surveys, and the surveyor reviewed the facility's quality Suggestion box). program documentation. The facility's documentation did not include the required seven 5. Complaint lesolution (7) elements of: staffing patterns and 6-Recording and reporting of infections, complications and other performance; supervision appropriate to the level of service; patient records; patient satisfaction; complaint resolution, infections, complications and adverse events (monthly compilation) other adverse events; and staff concerns 7 Staff concern regarding pattent regarding patient care. Staff #2 reported the care (3taff suggestion blox, meetings) quality committee had collected data but had not evaluated data for the seven required areas or identified unacceptable or unexpected trends or All data collected will be evaluated occurrences. to correct and for make improvements During an interview conducted on 12/09/2014 at regarding patient care. 1:30 p.m. the surveyor inquired if Staff #2 had reviewed the Regulations for the Licensure of Abortion Facilities Effective June 20, 2013. Staff #2 denied awareness of the updated State licensure regulations. Staff #2 reported the quality. committee had collected data, but had not analyzed or trended data for the required areas to identify unacceptable or unexpected outcomes. 丁330 T 330 - 12 VAC 5-412-300 D Quality assurance T 330 12/30/14 The Quality Assurance Committee D. Measures shall be implemented to resolve with provide proper documentation problems or concerns that have been identified. of all data collected and will be This RULE: is not met as evidenced by: Based on document review and interview the evaluated to correct and/or make

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concerns.

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quality committee failed to ensure measures were

implemented to resolve identified problems and

Note: This is a re-cite from 2012 related to staff's failure to ensure how problems would be resolved

by the quality improvement committee.

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Care

improvements regarding patient

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tate of Virginia			OVEN MALINE	IPLE CONSTRUCTION	(X3) DATE SURVEY		
ATEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDENTIF		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IG	COMPLETE	
	AF-0014		1	B. WING _		12/09/2	014
I WE OF PE	ROVIDER OR SUPPLIER			RESS, CITY,	STATE, ZIP CODE		
	RIA WOMEN'S HEA	LTH CLINIC	101 S. WHI ALEXANDE	TING ST. SRIA, VA 22			
(X4) ID PREFIX TAG	JEACH DESIGIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE ∷ ((X5) COMPLETE DATE
T 330	Continued From F	'age 18		T 330	T330 Continued		430/14
	Continued From Page 18 The findings included: An interview and review of the facility's quality program was conducted on 12/09/2014 at 1:30 p.m., with Staff #2. Staff #2 initially acknowledged the quality improvement committee did discuss concerns/problems that had been identified by services provided, appropriateness of care including reports from staff, patients, performance, patterns, or any other sources of data collected. The review revealed documents titled "Quality Meeting," which listed items discussed as part of the facility's quality program meeting. Staff #2 identifies the items as concerns that were discussed during the meeting. The surveyor asked Staff #2 for documentation that measures were implemented to correct the concerns. Staff #2 reported the quality committee did not document any corrective actions that were implemented.			The Quality Assurance with hold meetings to concerns and problems been identified and an actions implemented to problems or concerns with documented. There will be a review complications and patien if any, from previous meeting and previous meeting and previous meeting.	that name y corrective resolve I be		
	approximately 1: findings were rev facility's quality p issues found by acknowledged the implement meas	conducted on 12/09 50 p.m., with Staff #2 riewed. Staff #2 report program needed to act the survey team. Sta ne quality program's to the survey team to resolve proble ave been identified.	2. The priced the difference the aff #2 failure to	And the second s			
T 335	5 2 VAC 5-412-30	0 E Quality assuranc	e	T 335	T335		12/30/14
	shall be reported and shall include recommendation improvements.	e quality improvement to the licensee at less the deficiencies idense for corrections and The report shall be a body and the facility	east annually ntified and d acted upon		All cesults from the 1 improvement program reported at least annures will be reported foverning Body and Lice	n will be vally. These I to the censee and	n sheel 19 of 2

STATE FORM

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						FORM	APPROVED
State of V	irginia			- _T			
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/SUPPL				A. BUILDING		(X3) DATE SURVEY COMPLETED	
		4	B. WING				
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	STATE, ZIP CODE		
	RIA WOMEN'S HEA	LTH CLINIC	101 S. WHI		SUITE #215 !304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCY MUST BE PRECEDED B SC IDENTIFYING INFORM	YFULL	ID PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
Т 335	corrective actions shall be documented. Identified deficiencies that jeopardize patient safety shall be reported immediately in writing to the licensee by the quality improvement committee.		Т 335	T335 Shall include any defound as well as the actions implemented problems or concerns.	ficien ci es Corregive	12/30/14	
	Based on docume quality committee deficient practices implemented to the Note: This is a refailure to ensure reimprovement proglicensee at least a identified, recommere being acted the facility. The findings include An interview and reprogram was concep.m., with Staff #2 the quality improvements or concerns/problem services provided including reports feathering, or any of the review reveal Meeting," which list the facility's quality in the services in the services of the review reveal meeting," which list the facility's quality in the services in the	cite from 2012 relatesults of the quality ram would be repor noually and deficient tendations and improper by the governing	ted to staff's ted to the ticles tovements ng body and the tallow the ticles tovements to the ticles		All corrective action documented. Deficiencies that may patient sately shall immediately in write Governing Body and	y yeopardize of reported ing to the	
	discussed during asked Staff #2 for were implemented #2 reported the qu	the meeting. The s documentation that d to correct the conductional dity committee did rective actions that	urveyor t measures cerns. Staff not				

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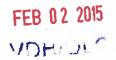
If continuation sheet 20 of 22

NO PLAN OF	OVIDER OR SUPPLIER	(2)			IPLE CONSTRUCTION		
NO PLAN OF	CORRECTION	IDENTIFICATION NUI			CIPLE CONSTRUCTION		
NAME OF PR	OVIDER OR SUPPLIER	45 0044	IDENTIFICATION NUMBER:		NG	(X3) DATE SURVEY COMPLETED	
NAME OF PR	OVIDER OR SUPPLIER	AF-0014				12/09	/2014
			STREET ADD	RESS, CITY,	STATE, ZIP CODE		
ALEXAND	RIA WOMEN'S HEAL	TH CLINIC	101 S. WH ALEXANDI		SUITE #215 2304		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
T 335	Continued From Pa	age 20	į.	T 335			
	committee did not of governing body to re An interview was co approximately 1:50 findings were review	#2 reported the qual compile a report for to review at least annual onducted on 12/09/20 p.m., with Staff #2, wed. Staff #2 reported gram needed to addi	he ally. 014 at The ed the			D.	ž Děl
	issues found by the	e survey team. Staff quality program's fail cies identified and	#2				
T 360	12 VAC 5-412-340	Policies and procedu	ures	T 360	T360		12/30/14
	The abortion facility shall develop, implement and maintain policies and procedures to ensure safety within the facility and on its grounds and to minimize hazards to all occupants. The policies and procedures shall include, but not limited to: 1. Facility security; 2. Safety rules and practices pertaining to personnel, equipment, gases, liquids, drugs, supplies and services; and 3. Provisions for disseminating safety-related information to employees and waste of the				A policy and procedure he developed to provide a healthy workplace for Visitors and employees. The facility shall protect	as been safe and all portions	
ā	Information to employees and users of the facility. This RULE: is not met as evidenced by: Based on interview and document review, it was determined the agency failed to develop policies related to safety within the facility and on the grounds. The findings included: Review of the agency policy and procedure				individuals from preven a ccupational injuries and as well as any situation may be hazardous or pothazardous to the environmenth or safety of the This policy and procedure include, but not be limit	d illnussel that entially muntal facility. shall	S

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State of Virginia	N .				FORM	APPROVE
TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLII		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	AF-0014	1	B. WING		12/09	/2014
NAME OF PROVIDER OR SUPPLIER			RESS, CITY	STATE, ZIP CODE	., .2.00	72014
ALEXANDRIA WOMEN'S HEA	ALTH CLINIC	101 S. WHI ALEXANDI		SUITE #215 2304		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIE OY MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
for employees and During an intervie approximately 6:0 facility had installe camera, and a pro ensure safety of s door to the buildin owners, as a safe acknowledged the	Page 21 w the agency provided patients within the factor of the patients of the patients of the patients within the patients of the pat	that the video ors to xterior PM by the	T 360	T360 Continued 1. Facility Security (secomera installed but glass at reception despossored on all door passocode on all door pertaining to personne gases, liquids, drugs, services (in-service, operio dic review). 3. Provisions for disse safety-related informal employees and overs of facility (in-service, disperiodic review).	ecurity illet proof sk school lettos el , equipmen applies and arills , minating ation to the	

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