

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AF-0009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/26/2016
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NAME OF PROVIDER OR SUPPLIER RICHMOND MEDICAL CENTER FOR WOMEN	STREET ADDRESS, CITY, STATE, ZIP CODE 118 NORTH BLVD RICHMOND, VA 23220
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T 000	<p>Initial Comments</p> <p>An unannounced Biennial State Licensure inspection was conducted 07/18/2016 through 07/20/2016 and 07/25/2016 through 07/26/2016 by two Medical Facilities Inspectors from the Office of Licensure and Certification, Virginia Department of Health.</p> <p>The facility was found not to be in compliance with the Regulations for the Licensure of Abortion Facilities 12 VAC5-412, (Effective 06/20/2013). Deficiencies were cited.</p> <p>One complaint (2016 -AC033) was investigated. Based on observation, staff interviews, document reviews, the complaint was substantiated with a deficient practice cited.</p>	T 000		
T 045	<p>12VAC5-412-170 A Administrator</p> <p>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:</p> <ol style="list-style-type: none"> 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 and regulations and implementing corrective 	T 045		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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T 045	<p>Continued From page 1</p> <p>action.</p> <p>This RULE: is not met as evidenced by: Based on interview and document review, it was determined the facility's administrator failed to ensure:</p> <ol style="list-style-type: none"> 1. Mandated employees were aware and trained on the requirement and how to report suspected child abuse or neglect for seven (7) of seven (7) employees; 2. Employees providing direct patient care had documented annual skills and competencies for two (2) of seven (7) employees (Staff #2 and #10); 3. Staff performing ultrasounds demonstrated the ability to conduct the procedure, analyze the results, identify the correct times and locations to record the images the physicians review for one (1) of two (2) employees trained to performed ultrasounds (Staff #2); <p>The findings included:</p> <ol style="list-style-type: none"> 1. During a review of staff employment/training records on 07/25/16, it was revealed seven (7) of seven (7) staff did not include documentation of training for reporting suspected child abuse or neglect. <p>Staff #4 (Administrator) was interviewed at 4:02 p.m., he/she acknowledged the findings and stated "I know we trained everyone because I trained them. We don't have those documents to show the training because it was done verbally."</p> <p>The policy titled "Required Reporting - Suspected Child Abuse or Neglect" was reviewed on 07/20/16 and read in part: "Scope: All facility</p>	T 045		

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T 045	<p>Continued From page 2</p> <p>personnel. Procedure: If any staff member observes a suspected situation of child abuse or neglect they will report this immediately to the administrator or her designee who will initiate the required reporting through the Department's toll-free child abuse and neglect hot-line." The policy failed to include training to ensure employees are trained on mandatory reporting for suspected child abuse or neglect to comply with the reporting requirements.</p> <p>The Administrator failed to ensure the facility had a policy that included the training of mandated employees to report suspected child abuse or neglect.</p> <p>2. Review of seven (7) personnel files (Staff #1-7) was conducted on 07/25/16 from approximately 11:30 a.m. to 1:00 p.m. The review revealed that there was no evidence of annual competency review for two (2) Registered Nurse (RN) employees (Staff #2 and #10). The folder did not contain an evaluation of how the RNs performed during training or the skills learned.</p> <p>During an interview with Staff #3 (Compliance Officer) on 07/25/16 at 12:25 p.m., the surveyor was told that "Registered Nurses are not reviewed for skills or competencies on a one on one basis." Staff #3 acknowledged on a quarterly basis, staff are audited and observed on how well they are doing on infection control practices and environmental care. Staff #3 stated, "I do not include the name of the staff member that is being observed and not each staff member is being captured annually."</p> <p>An interview was conducted on 07/25/16 at approximately 12:30 p.m., with Staff #3 and Staff</p>	T 045		

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T 045	<p>Continued From page 3</p> <p>#4. The findings were discussed in association with findings related to personnel competency review. Staff #3 verified annual competency audits would ensure the staff performing direct patient care had the correct required knowledge.</p> <p>The Administrator did not have a plan in place to implement the facility's policy regarding ensuring employees were evaluated for annual competencies.</p> <p>3. Review of seven (7) personnel files (Staff #1-7) revealed that there was no evidence of ultrasound training for one (1) of two (2) staff that perform the facility's ultrasounds which qualified him/her to perform ultrasounds for first trimester abortions (Staff #2).</p> <p>A review of the personnel record for Staff #2, an RN who works in the recovery room and performs the facility's ultrasounds, revealed no documentation for the training to perform ultrasounds. Staff #4 confirmed that Staff #2 was conducting ultrasounds and had received ultrasound training to demonstrate the ability to conduct the procedure, analyze the results, identify the correct times and locations to record the images the physicians review. Staff #4 acknowledged that the documentation for ultrasound training was not in the personal file for Staff #2.</p> <p>An interview was conducted on 07/25/16 at approximately 12:30 p.m., with Staff #3 and Staff #4. The findings were discussed in association with findings related to personnel having the proper ultrasound training. Staff #3 verified annual competency audits would ensure the staff performing direct patient care had the correct required knowledge. Staff #4 verified that Staff #2</p>	T 045		

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T 045	Continued From page 4 had been trained but the documentation failed to be in the personnel file. An exit interview was conducted on 07/26/16 at approximately 6:30 p.m., with Staff #4 and Staff #6. The findings were reviewed. Staff #4 reported the facility needed to address the issues found by the survey team.	T 045		
T 060	12VAC5-412-180 A Personnel Each abortion facility shall have a staff that is adequately trained and capable of providing appropriate service and supervision to patients. The abortion facility shall develop, implement and maintain policies and procedures to ensure and document appropriate staffing by licensed clinicians based on the level, intensity, and scope of services provided. This RULE: is not met as evidenced by: Based on interview and document review it was determined the facility staff failed to ensure: 1. Employees providing direct patient care had documented skills and competencies for two (2) of seven (7) employees (Staff #2 and #10); 2. Staff performing ultrasounds demonstrated the ability to conduct the procedure, analyze the results, identify the correct times and locations to record the images the physicians review for one (1) of two (2) employees trained to performed ultrasounds (Staff #2). The findings include: 1. Review of seven (7) personnel files (Staff #1-7) were conducted on 07/25/16 from approximately 11:30 a.m. to 1:00 p.m. The	T 060		

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T 060	<p>Continued From page 5</p> <p>review revealed that there was no evidence of annual competency review for two (2) Registered Nurse (RN) employees (Staff #2 and #10) and for one (1) of two (2) staff having ultrasound training which qualified him/her to perform ultrasounds for first trimester abortions (Staff #2).</p> <p>On 07/19/16 Staff #4 (Administrator) presented the surveyor with an employee list which included date of hire and job titles. Two (2) of seven (7) staff whose personnel records were reviewed did not include documentation of an annual competency review for Registered Nurses (RN).</p> <p>During an interview with Staff #3 (Compliance Officer) on 07/25/16 at 12:25 p.m., the surveyor was told that "Registered Nurses are not reviewed for skills or competencies on a one on one basis." Staff #3 acknowledged on a quarterly basis, staff are audited and observed on how well they are doing on infection control practices and environmental care. Staff #3 stated, "I do not include the name of the staff member that is being observed and not each staff member is being captured annually."</p> <p>2. A review of the personnel record for Staff #2 (RN) revealed no documentation for the training to conduct ultrasounds. Staff #4 confirmed that Staff #2 had received ultrasound training and that he/she was conducting ultrasounds. Staff #4 acknowledged that the documentation for ultrasound training was not in the personal file for Staff #2.</p> <p>An interview was conducted on 07/25/16 at approximately 12:30 p.m., with Staff #3 and Staff #4. The findings were discussed in association with findings related to personnel competency review and proper ultrasound training. Staff #3</p>	T 060		

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T 060	Continued From page 6 verified annual competency audits would ensure the staff performing direct patient care had the correct required knowledge. Staff #4 verified that Staff #2 had been trained but the documentation failed to be in the personnel file.	T 060		
T 135	12VAC5-412-200 A Patients' Rights Each abortion facility shall establish a protocol relating to the rights and responsibilities of patients consistent with the current edition of the Joint Commission Standards of Ambulatory Care. The protocol shall include a process reasonably designed to inform patients of their rights and responsibilities, in a language or manner they understand. Patients shall be given a copy of their rights and responsibilities upon admission. This RULE: is not met as evidenced by: Based on interview and document review it was determined the facility staff failed to ensure the patient had acknowledged receipt of rights information for one (1) of two (2) patients transferred from sister facilities. (Patient #16) The findings included: Review of Patient #16's medical record documented the patient had initially started her first trimester abortion process at a sister facility on 03/07/2016 by listening to the twenty-four (24) hour prior to procedure information. The sister facility faxed a copy of Patient #16's self-reported history to the facility. The facility staff stapled the faxed first page to a second form, providing an area for Patient #16 to document acknowledgement of patient rights and privacy information.	T 135		

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T 135	<p>Continued From page 7</p> <p>Patient #16 was scheduled for an intravenous (IV) sedation abortion on 03/08/2016 at the facility. Patient #16 was seen by the facility's counselor at 11:45 a.m. on 03/08/2016. The counselor completed the counseling notes, but did not have Patient #16 sign the top portion of the form documenting the patient's receipt of patient rights, privacy information, and an opportunity to discuss any issues.</p> <p>An interview was conducted on 07/27/2016 at 10:00 a.m., with Staff # 4. Staff #4 reviewed Patient #16's medical record. Staff #4 verified facility staff had failed to have Patient #16 sign and date her/his that she/he had received patient rights, privacy information and an opportunity to discuss any issues.</p>	T 135		
T 140	<p>12VAC5-412-200 B Patients' Rights</p> <p>The abortion facility shall establish and maintain complaint handling procedures which specify the:</p> <ol style="list-style-type: none"> 1. System for logging receipt, investigation and resolution of complaints; and 2. Format of the written record of the findings of each complaint investigated. <p>This RULE: is not met as evidenced by: Based on staff interview and document review the facility staff failed to implement their policies and procedures regarding maintaining a complaint log and documenting the investigation and resolution of complaints.</p>	T 140		

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T 140	<p>Continued From page 8</p> <p>The findings included:</p> <p>During the entrance conference on 07/18/16 at approximately 10:30 a.m. with Staff #3 (Compliance Officer), the surveyor requested to review the facility's complaint log. A second request for the facility's complaint log was made during the end of the day conference on 07/18/16 at 4:15 p.m., with Staff #3 and Staff #4. Staff #4 stated, "I will have that for you in the morning but we don't have many complaints."</p> <p>Review of the complaint log revealed one (1) documented complaint in the facility's complaint log. The log revealed the complaint was dated that it was received on 06/16/16, and had been filed regarding the "rudeness of an employee." The complaint log revealed a documented note that was not dated, only signed by Staff #4 (Administrator). The documentation revealed a discussion between the employee in question and Staff #4. Staff #4 revealed it was a miscommunication between the employee and the patient that filed the complaint.</p> <p>An interview was conducted with Staff #4 on 07/19/16 regarding the investigation and resolution of the complaint received on 06/06/16. Staff #4 stated, "This was the only complaint that was received in the past two years." Staff #4 verified the facility did not have documents related to the complaint investigation or resolution.</p> <p>A review on 07/19/16 of the policy and procedure titled "Patients' Rights: Grievance and Complaint Management" stated in part: "Patient grievances are to be addressed in a timely, reasonable, and consistent manner. Notification to the complainant of the proposed resolution will occur</p>	T 140		
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T 140	<p>Continued From page 9</p> <p>within 30 days from the date of the receipt of the complaint. The Facility Privacy Officer shall be responsible for overseeing the investigation and resolution of grievances..... D.1. A grievance/complaint log will be maintained by the Administrator or designated staff member. The documentation in the log will include date of complain/grievance, location, summary of issue, how the issue was addressed, date resolved and response to complainant, and the individual responding to the grievance. 2. Documentation of the resolution process will include: Name of person representing complaint/grievance and how to contact, Patient name, Nature of complaint/grievance, Date of service, Pertinent investigational information, Resolution/follow-up including written response for grievances, Signature of person addressing complaint/grievance."</p> <p>The findings were reviewed during the exit interview conducted on 07/26/16 at approximately 6:30 p.m. with Staff #4 and Staff #6.</p>	T 140		
T 170	<p>12VAC5-412-210 B Quality Management</p> <p>The following shall be evaluated to assure adequacy and appropriateness of services, and to identify unacceptable or unexpected trends or occurrences:</p> <ol style="list-style-type: none"> 1. Staffing patterns and performance; 2. Supervision appropriate to the level of service; 3. Patient records; 4. Patient satisfaction; 5. Complaint resolution; 	T 170		

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T 170	<p>Continued From page 10</p> <p>6. Infections, complications and other adverse events; and</p> <p>7. Staff concerns regarding patient care.</p> <p>This RULE: is not met as evidenced by: Based on interviews and document review it was determined the quality committee failed to evaluate four (4) of the seven (7) required components to identify appropriateness of services and unacceptable trends.</p> <p>The findings included:</p> <p>An interview and review of the facility's quality program documents were conducted on 07/25/16 at 12:40 p.m., with Staff #3 (Compliance Officer). Staff #3 and the surveyor reviewed the facility's quality program documentation. The facility's documentation did not include four (4) of the required seven (7) elements including: staffing patterns and performance; supervision appropriate to the level of service; complaint resolution; and staff concerns regarding patient care. Staff #3 reported the quality committee did not collect data or identify unacceptable or unexpected trends or occurrences for these four (4) elements. Staff #3 stated, "At one time, the Committee use to collect data for staff concerns regarding patient care as there is a section in the Quality notebook, but they no longer do this."</p> <p>An interview was conducted on 07/26/16 at approximately 1:30 p.m., with Staff #3. The findings were reviewed. Staff #3 reported the facility's quality program needed to address the</p>	T 170		

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T 170	<p>Continued From page 11</p> <p>issues found by the survey team. Staff #3 acknowledged the quality program's failure to report the deficiencies identified and recommendations for corrections and improvements regarding staffing patterns and performance; supervision appropriate to the level of service; complaint resolution; and staff concerns regarding patient care.</p> <p>The review revealed documents titled "Quality Meeting," which listed items discussed as part of the facility's quality program bi-monthly meeting. The surveyor asked Staff #3 how the quality committee determined, which items to discuss and if the committee had formulated the items from data collected. Staff #3 denied that data had been collected as the basis for what was discussed during the quality committee's meetings.</p> <p>A quality form documented no complaints had been received against the facility or the staff. A review of the facility's complaint log revealed one (1) documented complaint. The log revealed the complaint was dated it was received on 06/16/16, and had been filed against an employee. The surveyor failed to find evidence a complete investigation and resolution were documented being performed.</p> <p>An interview was conducted on 07/25/16 with Staff #3. The findings were reviewed. Staff #3 reported the facility's quality program needed to address the issues found by the survey team. Staff #3 acknowledged the quality program's failure to implement measures to resolve problems or concerns that have been identified.</p>	T 170		

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T 200	Continued From page 12	T 200		
T 200	<p>12VAC5-412-220 C Infection Prevention</p> <p>Written policies and procedures for the management of the abortion facility, equipment and supplies shall address the following:</p> <ol style="list-style-type: none"> 1. Access to hand-washing equipment and adequate supplies (e.g., soap, alcohol-based hand rubs, disposable towels or hot air driers); 2. Availability of utility sinks, cleaning supplies and other materials for cleaning, disposal, 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: <ol style="list-style-type: none"> (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 	T 200		

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(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 200	<p>Continued From page 13</p> <p>recommended level of disinfection/sterilization has been achieved.</p> <p>The procedure shall reference the manufacturer's recommendations and any applicable state or national infection control guidelines;</p> <p>8. Procedures for appropriate disposal of non-reusable equipment;</p> <p>9. Policies and procedures for maintenance/repair of equipment in accordance with manufacturer recommendations;</p> <p>10. Procedures for cleaning of environmental surfaces with appropriate cleaning products;</p> <p>11. An effective pest control program, managed in accordance with local health and environmental regulations; and</p> <p>12. Other infection prevention procedures necessary to prevent/control transmission of an infectious agent in the abortion facility as recommended or required by the department.</p> <p>This RULE: is not met as evidenced by: Based on observations, interviews and document review it was determined the facility staff failed to maintain processes for reducing the risk of spreading infectious agents by failing to:</p> <p>1. Perform hand hygiene before and between glove changes during direct patient care for two (2) of four (4) staff observed (Staff #2 and Staff #9);</p> <p>2. Follow manufacturer's directions for product</p>	T 200		

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T 200	<p>Continued From page 14</p> <p>used to disinfect transvaginal ultrasound probe.</p> <p>3. Discard expired supplies; and</p> <p>4. Clean contaminated surfaces- an ultrasound keyboard and blood splattered on the outside surface of a sharps container.</p> <p>The findings included:</p> <p>1. An observation was conducted on 07/25/2016 at 10:48 a.m., with Staff #2 during the ultrasound on Patient #28. Staff #2 performed Patient #28's abdominal ultrasound, cleaned the excess gel from the patient's abdomen with the head of the ultrasound scanning device, and used the sheet covering the patient to remove the excess gel from the head of the scanner. Staff #2 with the same contaminated gloves on touched the keyboard of the ultrasound equipment. Staff #2 removed her/his gloves and escorted Patient #28 to her/his office to discuss questions raised by the patient. Staff #2 and the surveyor returned to the ultrasound equipment at 11:15 a.m. on 07/25/2016. Staff #2 donned gloves without performing hand hygiene first. Staff #2 began the process of disinfecting the examination table.</p> <p>An observation was conducted on 07/27/2016 at 9:38 a.m., with Staff #2 during the ultrasound on Patient #27. Staff #2 performed Patient #27's abdominal ultrasound, cleaned the excess gel from the patient's abdomen with the head of the ultrasound scanning device, and used the sheet covering the patient to remove the excess gel from the head of the scanner. Staff #2 used the glove on her/his left hand to remove the contaminated glove on her/his right hand. Staff #2 initially used her/his left gloved hand, with potential contaminates, to retrieve a new glove</p>	T 200		

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T 200	<p>Continued From page 15</p> <p>from a box of gloves. Staff #2 accidentally dropped the glove on the floor. Staff #2 used her/his right hand to retrieve a new glove. Staff #2 used her/his contaminated left gloved hand to don the right glove; potentially introducing contaminates to the right glove. Staff #2 used her/his right gloved hand to touch the keyboard of the ultrasound equipment. Staff #2 did not remove her/his gloves prior to escorting Patient #27 to the waiting area. Staff #2 returned to the ultrasound room. Staff #2 did not change gloves prior to retrieving a disinfectant cloth from its container. Staff #2 used the same contaminated gloves to wipe the examination table. The surveyor inquired if Staff #2 had changed gloves after direct care of Patient #27 and prior to starting the cleaning process; Staff #2 stated, "No."</p> <p>An interview was conducted on 07/26/2016 with Staff #2 regarding her/his failure to perform hand hygiene prior to and between glove changes. The surveyor informed Staff #2 regarding the breaches in infection prevention/control practices. Staff #2 acknowledged she/he had not performed hand hygiene between glove changes. Staff #2 verified she/he had removed only the right glove that handled the ultrasound scanning head. Staff #2 reported she had only used her/his right hand in direct contact with the patient. Staff #2 acknowledged if there were contaminates on her/his left gloved hand any contaminates were potentially transferred to the new gloves.</p> <p>An observation was conducted on 07/26/2016 at 4:52 p.m., as Staff #4 and Staff #9 cleaned the procedure room after the termination of a pregnancy. Staff #9 donned and removed gloves three times without performing hand hygiene prior to or between glove changes. Staff #9 wore</p>	T 200		
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T 200	<p>Continued From page 16</p> <p>multiple wrist bracelets, which made contact with the environmental surfaces as Staff #9 cleaned equipment in the procedure room.</p> <p>An interview was conducted on 07/26/2016 at 4:56 p.m., with Staff #4. Staff #4 was informed of the findings.</p> <p>Review of the facility's policy titled "Environmental Surface Cleaning" read in part: "Purpose: To maintain a clean environment for patients and minimize the risk of patient and healthcare personnel exposure to potentially infectious microorganisms ... 7. Personnel responsible for cleaning must perform hand hygiene: a. Before initial patient environment contact ... b. After potential body fluid exposure ... c. After patient environment contact (e.g., after cleaning recovery or procedure room; after cleaning equipment such as stretchers; ...) d. ... Personnel must clean hands after removing gloves as gloves do not provide complete protection against hand contamination ..."</p> <p>2. Observations and interviews were conducted on 07/18/2016 at 11:59 a.m. in the ultrasound room with Staff #1, Staff #2 and the surveyors. Staff #2 described the process for cleaning the transvaginal ultrasound probe.. Staff #2 reported she/he would remove the condom that had been placed over the probe prior to use and discard it. Staff #2 stated, "I spray the probe with disinfectant spray we have a specific one for the probe. I spray it and wait two (2), maybe three (3) minutes then wipe the probe off." Staff #2 presented the disinfectant spray used specifically for the transvaginal ultrasound probe.</p> <p>Review of the manufacturer's label instructions read in part: "SPECIAL INSTRUCTIONS FOR</p>	T 200		
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T 200	<p>Continued From page 17</p> <p>CLEANING AND DECONTAMINATION AGAINST HIV-1 [Human Immunodeficiency Virus Type 1] OR HBV (Hepatitis [Sic] B Virus) OR HVC (Hepatitis C Virus) ON SURFACES / OBJECTS SOILED WITH BLOOD / BODY FLUID [Sic] ... Contact time: Leave surface wet for 1 minute (60 seconds) for HIV-1 and 10 minutes for HBV and HVC. Use a 10 minute contact time for disinfection against all other viruses, bacteria, and fungi claimed ..."</p> <p>The surveyor asked Staff #2 regarding the manufacturer's recommended contact time for viruses and bacteria. Staff #2 stated, "It maybe three (3) minutes." The surveyor asked Staff #2 to read the manufacturer's directions for contact time. Staff #2 read the product label and stated, "The label says leave wet for ten (10) minutes. I haven't done that." Staff #2 acknowledged it had not been her/his practice to ensure the transvaginal probe remained wet with the disinfectant for ten (10) minutes.</p> <p>3. Observations were conducted on 07/18/2016 at 11:36 a.m., with Staff #1 and Staff #2 in the Laboratory area. The observation revealed a box marked "Syringes 29 gauge x (times) 1/2 length exp. (expire) 2016-04." Staff #2 identified the syringes as insulin syringes. Staff #2 verified there were 59 syringes left in the box and available for use.</p> <p>4a. During the observation on 07/25/2016 at 10:48 a.m., Staff #2 performed Patient #28's abdominal ultrasound, cleaned the excess gel from the patient's abdomen with the head of the ultrasound scanning device, and used the sheet covering the patient to remove the excess gel from the head of the scanner. Staff #2 with the same contaminated gloves on touched the</p>	T 200		

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T 200	<p>Continued From page 18</p> <p>keyboard of the ultrasound equipment. Staff #2 escorted Patient #28 to her/his office to discuss questions raised by the patient. Staff #2 and the surveyor returned to the ultrasound room at 11:15 a.m. on 07/25/2016. Staff #2 donned gloves without performing hand hygiene first. Staff #2 began the process of disinfecting the examination table, the ultrasound scanner head and its cord. Staff #2 did not disinfect the ultrasound equipment's keyboard. Staff #2 removed her/his gloves and stated, "I'm done."</p> <p>When the surveyor asked if everything was completed, Staff #2 stated, "I forgot to wash my hands" and proceeded to wash her/his hands. Staff #2 left the ultrasound room. The surveyor asked Staff #2 if she/he had cleaned the keyboard of the ultrasound equipment; Staff #2 stated, "No, I didn't touch the keyboard. The surveyor inquired whether Staff #2 touched the keyboard in order to retrieve the patient's ultrasound images. Staff #2 reported she/he had touched the keyboard. The surveyor discussed the observation in which Staff #2 had not changed gloves or performed hand hygiene after providing direct patient care and prior to utilizing the keyboard. Staff #2 acknowledged this and stated the keyboard "needed to be disinfected."</p> <p>4b. Observations were conducted during a tour of the facility on 07/18/16 at approximately 12:15 p.m. with Staff #3 (Compliance Officer) and Staff #4 (Administrator). The observation was conducted in the Procedure Room. The surveyor observed a sharps container located in a corner on the floor with a large splatter of a red substance on the outside of the lid to the container. The areas were shown to Staff #3 and Staff #4. Staff #3 reported "That is expected to be cleaned between patients." The surveyor</p>	T 200		

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T 200	Continued From page 19 requested to see the policy and procedure for handling medical waste including environmental cleaning. On 07/19/16 at 1:50 p.m., Staff #4 presented the surveyor the facility's policy titled "Biomedical Waste Handling" and it read in part: "Purpose: To prevent contamination with any Biomedical waste. To be in compliance with the OSHA Bloodborne Pathogens Standard. Policy: The Center will follow procedures to ensure no accidental patient, employee, on-site contract personnel or visitor exposure to blood or other potentially infectious materials. 4) CONTAMINATED SHARPS, NEEDLES AND SYRINGES a) Waste from sites known to have an infectious agent are designated and handled as biomedical. 5) OTHER a) Any materials or items that have been contaminated or contain visible soiling by blood or other body fluids, including but not limited to sponges, suction canister contents, suction tubing, and/or draping materials."	T 200		
T 220	12VAC5-412-230 B Patient Services; Patient Counseling No person may perform an abortion upon an unemancipated minor unless informed written consent is obtained from the minor and the minor's parent, guardian or other authorized person. If the unemancipated minor elects not to seek the informed written consent of an authorized person, a copy of the court order authorizing the abortion entered pursuant to § 16.1-241 of the Code of Virginia shall be obtained prior to the performance of the abortion.	T 220		

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T 220	<p>Continued From page 20</p> <p>This RULE: is not met as evidenced by: Based on interview and document review it was determined the facility staff failed to document the proof of parentage or guardianship for one (1) of five (5) minors included in the inspection sample (Patient #4).</p> <p>The findings included:</p> <p>Review of Patient #4's medical record indicated she was 17 years old. Patient #4's medical record contained a signed consent for termination of pregnancy for a minor. The consent was notarized by facility staff. Patient #4's medical record did not contain documented proof; a copy of the person's driver's license /state identification card or birth certificate designating the person signing was Patient #4's parent or authorized guardian</p> <p>An interview was conducted on 07/20/2016 at approximately 11:00 a.m., with Staff # 3. The surveyor requested a copy of the facility's policy related to consent for terminating pregnancies for minors.</p> <p>Review of the policy titled "Patient Services - Minors" read in part: "Purpose: To ensure no abortion is performed on a minor unless informed written consent is obtained from the minor and the minor's parent, guardian or other authorized person ... Procedure: If the patient is under the age of 18, a parent, guardian, or other authorized person must accompany the minor and provide identification ..."</p> <p>An interview was conducted on 07/26/2016 at 10:09 a.m., with Staff #4. Staff #4 was informed of the findings. Staff #4 reviewed the medical records of Patient #4 and the four other minors</p>	T 220		

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T 220	Continued From page 21 included in the inspection sample. Staff #4 verified the four other medical records for minors included a copy of the parent's driver's license or state issued identification card. Staff #4 reported it was the facility's practice to obtain a copy of the authorizing person's picture identification. Staff #4 stated, "We look at their picture ID [identification] before we notarize the consent and we usually copy it." Staff #4 verified Patient #4's medical record did not contain documented proof for the person that signed Patient #4's informed consent.	T 220		
T 315	12VAC5-412-260 C Administration, Storage, Dispensing of Drugs Drugs maintained in the abortion 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, interviews and document review it was determined the facility staff failed to: 1. Discard expired medications and 2. Maintain refrigerator temperature logs for refrigerated medications. The findings included: 1. Observations and interviews was conducted on 07/18/2016 from 12:24 p.m. through 12:44 p.m., with Staff #3 and Staff #4 in the procedure room. An observation of the anesthesia cart bottom shelf revealed one (1) Ephedrine 5 mg	T 315		

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T 315	<p>Continued From page 22</p> <p>(milligram)/ml (milliliter) 25 mg/5 ml prefilled syringe with expiration date of "12-16-13" and one (1) Phenylephrine 40 mcg (microgram)/ml 0.4 mg/10 ml prefilled syringe with expiration date of "12-11-13." Staff #4 verified the expired medications were available for use. Staff #4 reported both medications should have been discarded in 2013.</p> <p>[According to www.ncbi.nlm.nih.gov "Ephedrine [t]reats low blood pressure caused by other medicines. Also used to improve breathing ... Ephedrine is a medication used to prevent low blood pressure during anesthesia."] [According to medical-dictionary.com Phenylephrine is "[a]n adrenergic drug, C9H13NO2, which is a powerful vasoconstrictor and is used to relieve nasal congestion, dilate the pupils, and maintain blood pressure during anesthesia."]</p> <p>An observation was conducted on 07/18/2016 at 1:03 p.m., with Staff #3 and Staff #4 in the Clean room. The Clean room was used for processing cleaned instruments, storage of sterilized procedure packs, and clean supplies. The observation revealed five (5) Providone iodine one fluid ounce solution multi-dose bottles in a small storage basket. One (1) of five (5) Providone iodine bottles had expired on "11/2014." Staff #4 verified the expiration dated and reported the expired Providone iodine should not have been available for use.</p> <p>2. Observations and interviews were conducted on 07/18/2016 from 12:47 p.m. through 12:59 p.m., with Staff #3 and Staff #4 in the Recovery room. A refrigerator in the recovery room contained medications Rhophylac [Rho (D) Immune Globulin Intravenous] and NuvaRing (etonogestrel/ethinyl estradiol vaginal ring). The surveyors requested the temperature log for the</p>	T 315		
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T 315	<p>Continued From page 23</p> <p>refrigerator. Staff #4 stated, "It's not up-to-date." The surveyor checked the thermometer within the refrigerator. Staff #4 reported the thermometer inside the refrigerator did not work and the facility staff was waiting for a thermometer to be installed on the outside of the refrigerator. The second surveyor asked when the log was last updated. Staff #4 pointed to the refrigerator log sheets in a basket on the wall. The sheets were dated 2015. The surveyor asked whether the refrigerator temperatures had been documented in 2016; Staff #4 stated, "No." The surveyors requested documentation the medications within the refrigerator had been stored at the proper manufacturer's directions. Staff #4 reported they did not have documentation. The surveyor requested the manufacturer's directions for storage for Rhophylac and NuvaRing. Staff #4 reported during recent storms the facility had been without power for "short periods of time." The surveyor had asked earlier in the inspection process (07/18/2016 at 11:36 a.m.) if the facility had a generator back up system in case of power outage and Staff #1 stated "No." The Rhophylac manufacturer's package insert was presented at 10:26 a.m. on 07/26/2016 by Staff #3 after the surveyor's third request. The manufacturer's package insert directions read in part: "Storage and Handling: Do No Freeze. Rhophylac contains no preservatives; do not store at room temperature. Store at 2 to 8 [degrees] C [Celsius] (36 to 46 [degrees] F [Fahrenheit] for a shelf life of 36 months from the date of manufacture, as indicated by the expiration date printed on the outer carton and syringe label ..."</p> <p>The NuvaRing manufacturer's package insert was presented at 10:29 a.m. on 07/26/2016 by Staff #2 after the surveyor's third request. The manufacturer's package insert directions</p>	T 315		
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T 315	Continued From page 24 presented to the surveyors was for how the patient should store their NuvaRing and not provider storage. An online review of the manufacturer's directions to providers for the storage of NuvaRing read in part: "16.1 Storage: Prior to dispensing to the user, store refrigerated 2 to 8 [degrees] C (36 to 46 [degrees] F) ... " Review of the facility's policy (Review of the facility's policy titled "Administration, Storage, and Dispensing of Drugs") contained the verbiage of the regulations: "Drugs maintained in the abortion 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."	T 315		
T 355	12VAC5-412-300 Health Information Records An accurate and complete clinical record or chart shall be maintained on each patient. The record or chart shall contain sufficient information to satisfy the diagnosis or need for the medical or surgical service. It shall include, but not be limited to the following: 1. Patient identification; 2. Admitting information, including patient history and physical examination; 3. Signed consent; 4. Confirmation of pregnancy; 5. Procedure report to include: a. Physician orders; b. Laboratory tests, pathologist's report of tissue, and radiologist's report of x-rays;	T 355		

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T 355	<p>Continued From page 25</p> <p>c. Anesthesia record; d. Operative record; e. Surgical medication and medical treatments; f. Recovery room notes; g. Physician and nurses' progress notes, h. Condition at time of discharge, i. Patient instructions, preoperative and postoperative; and j. Names of referral physicians or agencies.</p> <p>6. Any other information required by law to be maintained in the health information record.</p> <p>This RULE: is not met as evidenced by: Based on interviews, document reviews and in the course of a complaint investigation, it was determined the facility staff:</p> <p>1. Administered medications including narcotics without a physician's order for five (5) of twenty-seven (27) patients included in the inspection sample that received MAC (Monitored Anesthesia Care) or Intravenous (IV) sedation (Patients #9, #11, #14, #21, and #26);</p> <p>2. Failed to ensure the physician documented the post-procedure re-assessment related to the concerns of one (1) of twenty-seven (27) patients included in the inspection sample (Patient #18);</p> <p>3. Failed to implement the facility's policy to inform the physician of abnormal laboratory results for one (1) of twenty-seven (27) patients included in the inspection sample (Patient #19); and</p> <p>4. Failed to implement the facility's policy for correcting medical record documentation errors for one (1) of twenty-seven (27) patients included</p>	T 355		

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T 355	<p>Continued From page 26</p> <p>in the inspection sample (Patient #10).</p> <p>The findings included:</p> <p>1. Review of Patient #9's medical record documented the patient was admitted on 02/19/2016 and had a surgical procedure to terminate her pregnancy on 02/20/2016. Patient #9's medical record indicated the patient's surgical procedure was performed with monitored anesthesia care (MAC). The physician's operative note for medications and assessment documented "See MAC notes." The "Anesthesia Record" documented Patient #9 received the following intravenous (IV) medications between 12:00 and 12:30 p.m. on 02/20/2016: "Versed 2 mg (milligrams) between "1200 [p.m.] and 1215 [p.m.]" and 2 mg between 1215 and 1230"; Fentanyl 6 mcg (microgram) at approximately "1215"; Propofol documented as "<200 [mg] >"; and Toradol 30 mg [unable to determine time administered]." The "Anesthesia Record" was signed by the nurse anesthetist. The "Anesthesia Record" was not co-signed by the physician performing the procedure. Patient #9's medical record did not contain a separate physician's order sheet or other documentation, which provided for the medication administration orders.</p> <p>Review of Patient #11's medical record documented the patient had a surgical termination of her pregnancy on 07/11/2015. Patient #11's medical record indicated the patient's surgical procedure was performed with monitored anesthesia care. The physician's operative note for medications and assessment documented "See MAC notes." The "Anesthesia Record" documented Patient #11 received the following intravenous (IV) medications: Versed 2 mg, Fentanyl 2 mcg, Propofol 100 mg, Zofran 4</p>	T 355		

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T 355	<p>Continued From page 27</p> <p>mg, and Toradol 30 mg. The documented time of administration of the above medications was not legible. Patient #11's "Anesthesia Record" was not co-signed by the physician performing the procedure. The "Anesthesia Record" was signed by the nurse anesthetist. Patient #11's medical record did not contain a separate physician's order sheet or other documentation, which provided for the medication administration orders.</p> <p>Review of Patient #14's medical record documented the patient had a surgical termination of her pregnancy on 01/30/2016. Patient #14's medical record indicated the patient's surgical procedure was performed under monitored anesthesia care. The physician's operative note for medications and assessment documented "See MAC notes." The "Anesthesia Record" documented Patient #14 had the following intravenous (IV) medications administered between 4:15 p.m. and 4:30 p.m. on 01/30/2016: Versed 2 mg, Fentanyl 10 mcg, Propofol 50 mg, Zofran 4 mg, and Toradol 30 mg. The "Anesthesia Record" was signed by the nurse anesthetist. Patient #14's "Anesthesia Record" was not co-signed by the physician performing the procedure and did not have evidence the medications had been ordered by a physician.</p> <p>Review of Patient #21's medical record documented the patient had a surgical termination of her pregnancy on 02/13/2016. Patient #21's medical record indicated the patient's surgical procedure was performed with monitored anesthesia care. The physician's operative note for medications and assessment documented "See MAC notes." The "Anesthesia Record" documented Patient #21 was administered the following intravenous (IV)</p>	T 355		

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T 355	<p>Continued From page 28</p> <p>medications during her/his procedure between 2:05 p.m. and 2:20 p.m. on 02/13/2016: Versed 2 mg, Fentanyl 100 mcg [Sic], Brevital total of 100 mg, and Toradol 30 mg. The "Anesthesia Record" was signed by the nurse anesthetist. Patient #21's "Anesthesia Record" was not co-signed by the physician performing the procedure and did not have evidence that a physician ordered the medications.</p> <p>Review of Patient #26's medical record documented the patient had a surgical termination of her pregnancy on 06/04/2016. Patient #26's medical record indicated the patient's surgical procedure was performed under IV sedation. Patient #26's medical record documented the patient experienced "heavy bleeding" post-procedure while in Recovery. The nurse administered "Pitocin 1 ml L (left) deltoid" at 4:23 p.m. on 06/04/2016. Nursing documented that Patient #26 continued to experience "heavy bleeding" and at 6:50 p.m. on 06/04/2016 the nurse administered "Methylergonovine [Sic]" [dosage not legible]. Patient #26's medical record did not contain written or verbal order notations for the administration of Pitocin or Methylergonovine /Methergine.</p> <p>Review of the facility's policy titled "Administration, Storage, and Dispensing of Drugs" read in part: "Purpose - to provide scope of responsibility for medication administration to patients ... Procedure: ... 2. Physician Orders and patient allergies will be verified prior to medicating patients ..."</p> <p>Review of the facility's policy titled "Administration, Storage, and Dispensing of Drugs - Controlled Substances Procedure" read in part: "Purpose - to determine guidelines for</p>	T 355		

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T 355	<p>Continued From page 29</p> <p>handling and control of narcotics in the facility ...</p> <p>4. All medications can be administered only on a written order of a physician. Telephone orders to a licensed nurse will be verified and read back by the nurse and are to be signed by the doctor within 30 days [Sic] ..."</p> <p>An interview was conducted on 07/26/2016 from 10:11 a.m. through 10:18 a.m., with Staff #4. Staff #4 reviewed the medical records for Patients #9, #11, #14, #21, and #26. Staff #4 stated, "[Patient #26's name] the Pitocin and Methergine would be verbal orders directly to the nurse from [Staff #6's name]." Staff #4 stated, "Yes, the nurse wrote the medications were given, but did not write out the verbal orders." Staff #4 reviewed the operative notes for Patients #9, #11, #14, and #21. Staff #4 verified the physician had crossed through options to write out medications for MAC procedures and documented "See MAC note." Staff #4 stated, "Each patient needs different amounts of medication. [Staff #6's name] leaves it up to the CRNAs (Certified Registered Nurse Anesthetists) to determine the amount required to care for each patient." The surveyor asked if the certified nurse anesthetists employed by the facility to assist in monitored anesthesia care had their own DEA (Drug Enforcement Administration) number for prescribing medications. Staff #4 stated, "No, they work under the physician's DEA." Staff #4 reviewed the "Anesthesia Record" for Patients #9, #11, #14, and #21. Staff #4 verified the forms did not have a physician's signature as a co-sign for medications and narcotics administered by the CRNA. Staff #4 reported the facility had standing orders. Staff #4 presented the standing orders for review. Review of the standing orders included orders for pre-operative and post-operative medications and tests. Staff #4</p>	T 355		
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T 355	<p>Continued From page 30</p> <p>verified the facility did not have standing orders for medications and narcotics administered during monitored anesthesia care (MAC).</p> <p>[According to www.drugs.com and medical-dictionary.com: "Versed is a Schedule IV narcotic medication used for anesthesia, procedural sedation. Fentanyl citrate is a narcotic analgesic. In low doses it is used to provide analgesia during short surgical procedures and as a premedicant. Propofol is a short-acting medication that results in a decreased level of consciousness and lack of memory for events. Its uses include the starting and maintenance of general anesthesia ... and procedural sedation. Toradol a nonsteroidal anti-inflammatory drug (NSAID), is indicated for the short-term (up to 5 days in adults) management of moderately severe acute pain that requires analgesia at the opioid level. Zofran is used to prevent nausea and vomiting that may be caused by surgery or by medicine to treat cancer. Brevital Sodium is used for inducing anesthesia (lack of sensation or feeling) prior to surgical procedures ... Brevital Sodium may be used alone or in combination with other medicines. Brevital Sodium is a barbiturate anesthetic. It works by depressing the activity of the brain to inhibit painful sensations and inducing sleep. Pitocin is a uterine stimulant. It works by causing uterine contractions by changing calcium concentrations in the uterine muscle cells. Methylergonovine/Methergine is in a group of drugs called ergot alkaloids. It affects the smooth muscle of a woman's uterus, improving the muscle tone as well as the strength and timing of uterine contractions."]</p> <p>2. Review of Patient #18's medical record</p>	T 355		

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T 355	<p>Continued From page 31</p> <p>documented the patient had been seen at the emergency department of a local hospital on 03/26/2016 related to an "incomplete miscarriage." The medical record documented Patient #18 was seen first in Staff #6's medical office on 03/28/2016 an ultrasound indicated "sac in uterus but no smooth edge." Patient #18's medical record documented the patient was admitted to the facility on 03/29/2016 for evacuation of the remaining products of conception under IV sedation. Patient #18's medical record documented a follow-up visit on 04/13/2016 the patient complained of continued "light bleeding" and the ultrasound was interpreted as "intrauterine debris no continued pregnancy."</p> <p>Nursing documentation on 04/21/2016 noted Patient #18 called to facility and reported continued "vaginal bleeding and passing clot the size of a tennis ball - US [ultrasound] shows - debris Informed patient that [Name of Staff #6] to look at US when [she/he] gets here [Sic] ..."</p> <p>Nursing documented Patient #18 called again on 05/31/2016 requesting an additional ultrasound and a transvaginal ultrasound was performed. Review of Patient #18's medical record did not have documentation that Staff #6 was informed of Patient #18's concerns on 04/21/2016. Patient #18's medical record did not have documentation that Staff #6 reviewed Patient #18's ultrasound or made a determination related to the ultrasound findings of 04/21/2016.</p> <p>An interview was conducted on 07/26/2016 at 11:52 a.m. with Staff #4. Staff #4 reviewed Patient #18's medical record. Staff #4 verified Patient #18's medical record did not have documentation that Staff #6 reviewed the ultrasound or gave staff instructions regarding the patient's concerns.</p> <p>3. Review of the medical record for Patient #19</p>	T 355		
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T 355	<p>Continued From page 32</p> <p>on 07/20/16 at 3:06 p.m., revealed documentation showing a local procedure being performed on 11/28/15. Documentation revealed an ultrasound was performed on 11/24/15 confirming the pregnancy and gestational age. Documentation revealed labs were performed on 11/28/15 for Patient #19 to confirm the status of the patient's hemoglobin (Hgb) level and Rhesus (Rh) factor before performing Patient #19's abortion procedure on 11/28/15. The laboratory results revealed a Hgb of 7.4 gram/deciliter (g/dl). The medical record did not provide any progress notes by the Laboratory Technician or Registered Nurse (RN) documenting a low Hgb pre or post abortion on 11/28/15.</p> <p>An interview was conducted on 07/25/16 at approximately 11:30 a.m., with Staff #4. Staff #4 reviewed Patient #19's medical record regarding the findings listed above. Staff #4 acknowledged the physician usually gives iron supplements to patients with low Hgb, but he/she is not able to determine due to no documentation provided in the record. Staff #4 stated, "According to the H&P (History and Physical) this patient has a history of being anemic and having a low Hgb, but I don't know what was done for her because it is not documented."</p> <p>Staff #4 presented the surveyor with a document titled "Panic Value Chart" on 07/26/16 at 10:20 a.m. Staff #4 acknowledged the document presented to the surveyor is the staff's process regarding the result values of a patient's Hgb. The "Panic Value Chart" revealed in part: "The test for Hemoglobin critical below value 11 g/dl and critical above value 16.0 g/dl should notify the Recovery Room Nurse. A result of less than 7 g/dl notify the physician."</p> <p>A review of Patient #19's medical record failed to</p>	T 355		

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T 355	<p>Continued From page 33</p> <p>include progress notes from the "Recovery Room Nurse" notifying the physician of abnormal lab values.</p> <p>Progress notes were discussed at multiple times on 07/25/16 and during the exit conference on 07/26/16 at 6:30 p.m. with Staff #4 and Staff #6.</p> <p>4. Review of the medical record for Patient #10 on 07/19/16 at 10:35 a.m., revealed documentation showing evidence on the "24-hour Informed Consent" form that Patient #10's last name was scratched out with two (2) lines placed over the incorrect name and a corrected last name written. Patient #10 signed the document on 06/02/16 and revealed the patient's correct last name and witnessed by a staff member on 06/02/16. In the "Office Use Only Box" it stated: "At least 24 hours before her appointment (Patient's first and last name listed) listened to the information recorded by a registered nurse and recorded her name at the end of the recording." Patient #10's last name observed in the space provided was not Patient #10's correct last name. Documentation failed to be corrected by the staff. The form titled "Test Requisition - Report Form" revealed again the wrong last name for Patient #10 and it failed to be corrected by the staff.</p> <p>An interview was conducted on 07/19/16 at approximately 11:10 a.m. with Staff #4. Staff #4 reviewed Patient #10's medical record regarding the findings listed above. The surveyor inquired about the staff ensuring the patient information is accurate. Staff #4 acknowledged the "24-hour Informed Consent" form is filled out by the staff when the patient calls to verbally make an appointment. Upon arrival of the patient for the first appointment, the patient completes the face sheet which includes the admitting information,</p>	T 355		

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T 355	<p>Continued From page 34</p> <p>including patient history and physical information. Staff #4 confirmed the staff complete the other forms from the information completed on the "24-hour Informed Consent" form. However, if the information is inaccurate on the "24-hour Informed Consent" form then the other forms for the patient's identification may be inaccurate. However, upon the patient completing the face sheet and making any necessary changes, the staff should draw a line through the inaccurate information and initial it showing an error was made.</p> <p>A review of the policy and procedure on 07/19/16 titled "Health Information Records" revealed in part the following: "Accurate medical records are vital to appropriate patient care. An accurate and complete clinical record or chart shall be maintained on each patient. Errors in a patients file will be noted with a strike through, and the word error over it. No efforts will be made to scratch out or white out errors. No erasures or deletions will be made. Documentation should always be precise, objective, accurate and complete."</p> <p>Correcting medical record documentation errors were discussed at multiple times on 07/19/16 and during the exit conference on 07/26/16 at 6:30 p.m. with Staff #4 and Staff #6.</p>	T 355		
T 390	<p>12VAC5-412-320 F Required Reporting</p> <p>Abortion facilities shall ensure that employees mandated to report suspected child abuse or neglect under § 63.2-1509 of the Code of Virginia comply with the reporting requirements of § 63.2-1509 of the Code of Virginia.</p>	T 390		

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T 390	<p>Continued From page 35</p> <p>This RULE: is not met as evidenced by: Based on interview and document review it was determined the facility staff failed to ensure that mandated employees were aware of the requirement and how to report suspected child abuse or neglect for seven (7) of seven (7) employees included in the survey sample.</p> <p>The findings included:</p> <p>During the record review for seven (7) personnel files on 07/25/16 from approximately 11:30 a.m. to 1:00 p.m., the surveyor failed to locate any evidence staff had received training regarding suspected child abuse or neglect.</p> <p>Staff #4 (Administrator) was interviewed at 4:02 p.m., he/she acknowledged the findings and stated "I know we trained everyone because I trained them. We don't have those documents to show the training because it was done verbally."</p> <p>The policy titled "Required Reporting - Suspected Child Abuse or Neglect" was reviewed on 07/20/16 and read in part: "Scope: All facility personnel. Procedure: If any staff member observes a suspected situation of child abuse or neglect they will report this immediately to the administrator or her designee who will initiate the required reporting through the Department's toll-free child abuse and neglect hot-line." The policy failed to include training to ensure employees are trained of mandatory reporting for suspected child abuse or neglect to comply with the reporting requirements.</p> <p>An exit interview was conducted on 07/26/16 at approximately 6:30 p.m., with Staff #4 and Staff #6. The findings were reviewed. Staff #4</p>	T 390		

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T 390	Continued From page 36 reported the facility needed to address the issues found by the survey team.	T 390		