Annandale
Women and Family Center
2839 Duke Street, Bldg III, Alexandria, VA 22314 • (703) 751-4702 • Fax : (703) 751-2983 • www.awfc.net

Karen Remley, M.D, M.B.A., F.A.A.P.
Office of Licensure and Certification
9960 Mayland Drive suite 401
Henrico, VA 23233

September 21, 2012

Dear Dr. Remley,

We have enclosed the Plan of Correction for Annandale Women & Family Center. Our plan answers each listed deficiency. We have also included amended Policy and Procedure for each listed deficiency and have designated the corresponding deficiency on the bottom right corner of the document.

Each plan of correction lists the number of the deficiency, an assessment, the plan of correction, who will monitor the correction, and the date of completion.

We have kept a copy of this document in our offices.
The Plan of Correction has been reviewed and approved by the Board of Directors, the Operation Director and the Practice Administrator.

We await any further requirements and/or instructions from your office.

Sincerely,

Penny Smith
Administrator

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-0015	A. BUILDING _____ B. WING _____	08/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE WOMEN & FAMILY CENTER	2839 DUKE STREET ALEXANDRIA, VA 22314

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T 000	12 VAC 5- 412 Initial comments An announced Initial Licensure Abortion Facility inspection was conducted at the above referenced facility August 14 and 15, 2012 by two (2) Medical Facility Inspectors from the Virginia Department of Health's, Office of Licensure and Certification. The facility was found to not be in compliance with the State Board of Health 12 VAC 5-412, Regulations for Abortion Facility's effective December 29, 2011. Deficiencies were identified and cited, and will follow in this report.	T 000	All Policy and Procedure amendments were written by the Operation Director with approval of the Board of Directors. Policies and Procedures are implemented by the Administrator. Abbreviations: OP Operation Director QA Quality Assurance Supervisor BOD Board of Directors NP nurse practitioner PA Practice Administrator IP Infection Preventionist	
T 030	12 VAC 5-412-140 E Organization and management E. The bylaws shall include at a minimum the following: 1. A statement of purpose; 2. Description of the functions and duties of the governing body, or other legal authority; 3. A statement of authority and responsibility delegated to the administrator and to the clinical staff; 4. Provision for selection and appointment of clinical staff and granting of clinical privileges; and 5. Provision of guidelines for relationships among the governing body, the administrator and the clinical staff. This RULE: is not met as evidenced by: Based on document review and staff interview the facility's governing body failed to ensure the bylaws had a provision for the selection and appointment of clinical staff and granting of clinical privileges. The findings include:	T 030	0030 monitored by OP Metro Medical Centers, Inc by laws have been amended by the Board of Directors to include a provision for selection and appointment of clinical staff and the granting of privileges as of 8/23/2012 Metro Medical Medical Centers, Inc By Laws have been amended by the BOD to provide guidelines for relationships among the governing body, the Administrator and the clinical staff as of 8/23/2012	T030 8/23/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amy Smith RN, BSN — TITLE: Administrator — (X6) DATE: 9-21-12

State of Virginia

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T 030	Continued From Page 1 On 8/14/12 the facility policy and procedure manuals were review. The owner was asked to provide the governing body minutes. The governing body minutes did not contain guidelines on how clinical staff were selected or granted privileges.	T 030		
T 035	12 VAC 5-412-150 Policy and procedure manual. Each abortion facility shall develop, implement and maintain an appropriate policy and procedures manual. The manual shall be reviewed annually and updated as necessary by the licensee. The manual shall include provisions covering at a minimum, the following topics: 1. Personnel; 2. Types of elective and emergency procedures that may be performed in the facility; 3. Types of anesthesia that may be used; 4. Admissions and discharges, including criteria for evaluating the patient before admission and before discharge; 5. Obtaining written informed consent of the patient prior to the initiation of any procedures; 6. When to use ultrasound to determine gestational age and when indicated to assess patient risk; 7. Infection prevention; 8. Risk and quality management; 9. Management and effective response to medical and/or surgical emergency; 10. Management and effective response to fire; 11. Ensuring compliance with all applicable federal, state and local laws; 12. Facility security; 13. Disaster preparedness; 14. Patient rights; 15. Functional safety and facility maintenance; and	T 035		

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T 035	Continued From Page 2 16. Identification of the person to whom responsibility for operation and maintenance of the facility is delegated and methods established by the licensee for holding such individual responsible and accountable. These policies and procedures shall be based on recognized standards and guidelines. This RULE: is not met as evidenced by: Based on observation, record review and interview the governing body failed to ensure policies and procedures for patient's rights were developed, implemented and annually reviewed. The findings included: Observations conducted on August 14, 2012 from 9:44 a.m. to 12:44 p.m. during the initial tour revealed the facility had failed to include information regarding how to file a complaint. Staff #8 and Staff #10 conducted the tour of the	T 035	0035 monitored by QA Patients Rights have been amended to include the name of the center with address and phone number instructions on how to file a complaint and the address and phone number of the OLC in Virginia as of 8/23/2012. This has been posted in two places the patient waiting room and the patient lounge. All patients are given a copy of this on admission. The Policy and Procedure Manual has been amended to include P&P on the dissemination of this information and documentation of the patients receipt of the information. 9/21/12.	8/23/12 9/21/12

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T 035	Continued From Page 3 facility. Staff #10 discussed the facility's process for reviewing rights with each patient. Staff #10 verified the information did not include the facility's name, address and telephone number or the address for the state licensing agency. On August 14, 2012, the facility's policy and procedure manual was reviewed with Staff #8 and Staff #10. Staff #8 verified the facility did not have a written process for distributing patient's rights information to each patient. Staff #8 agreed the facility did not have a method of documentation, which indicated each patient would receive a copy of their patient rights in a language the patient understood. Staff #8 the facility failed to develop patient rights policies and procedures.	T 035	T045	
T 045	12 VAC 5-412-160 A Administrator A. The governing body shall select an administrator whose qualifications, authority and duties shall be defined in a written statement adopted by the governing body. This RULE: is not met as evidenced by: Based on document review and staff interview the facility failed to ensure the governing body appointed the administrator. The findings include: On 8/14/19 the facility owner and administrator were interviewed regarding the administrator's appointment and approval by the governing body as the administrator. The owner stated, "We do not have that in writing."	T 045	monitored by OP The BOD of Metro Medical Centers, Inc has documented the selection of the current administrator in accordance with the qualifications, authority and duty defined and documented. The BOD has further acknowledged that she has been Administrator of said center since its inception. 8/23/12	8/23/12
T 050	12 VAC 5-412-160 B Administrator B. Any change in the position of the	T 050		

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T 050	Continued From Page 4 administrator shall be reported immediately by the licensee to the department in writing. This RULE: is not met as evidenced by: Based on document review and staff interview the facility failed to ensure there was a policy to report changes in the position of the administrator to the Virginia Department of Health's Office of Licensure. The findings include: On 8/14/19 the facility owner and administrator were interviewed regarding notifying Virginia Department of Health's Office of Licensure should there be a change in who the administrator was. The owner stated, "No we do not have a policy that says we will report a change."	T 050	T50 monitored by OP The BOD of Metro Medical Centers, Inc has amended By Laws to stipulate that any change in the position of Administrator will be reported to the OLC in writing as of 8/23/12	T50 8/23/12
T 055	12 VAC 5-412-160 C Administrator C. A qualified individual shall be appointed in writing to act in the absence of the administrator. This RULE: is not met as evidenced by: Based on document review and staff interview the facility failed to ensure an individual was appointed in writing to act in the absence of the administrator. The findings include: On 8/14/19 the facility owner and administrator were interviewed regarding who could act in the administrator's absence. The owner stated, "That would be me but we do not have that in writing."	T 055	T055 monitored by OP The BOD of Metro Medical Centers, Inc has named a qualified person to be appointed to act in absence of the Administrator as of 8/23/12	T055 8/23/12
T 070	12 VAC 5-412-170 C Personnel C. Each abortion facility shall obtain a criminal	T 070		

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T 070	Continued From Page 5 history record check pursuant to 32.1-126.02 of the Code of Virginia on any compensated employee not licensed by the Board of Pharmacy, whose job duties provide access to controlled substances within the abortion facility. This RULE: is not met as evidenced by: Based on document review and staff interview the facility failed to ensure the criminal records checks pursuant to § 32.1 - 126.02 of the Code of Virginia were performed on employees not licensed by the Board of Pharmacy, whose's job duties proved access to controlled substances within the facility. The findings include: On 8/14/12 the facility administrator provided the personnel files of all employees, CRNA's (Certified Registered Nurse Anesthetist) and physicians who have access to controlled substances. None of the personnel files reviewed had a criminal record check performed. The administrator stated, "I will get those done."	T 070	T070 monitored by PA A criminal history record will be obtained on the four individuals having access to the Center maintained controlled substances. This report was generated from the State Police of Virginia and obtained and maintained by the Administrator. 9/21/12	T070 9/21/12
T 075	12 VAC 5-412-170 D Personnel D. When abortions are being performed, a staff member currently certified to perform cardio-pulmonary resuscitation shall be available on site for emergency care. This RULE: is not met as evidenced by: Based on document review and staff interview the facility failed to ensure a staff member trained in cardio-pulmonary resuscitation (CPR) was available in the facility when abortions were being performed in the event of an emergency. The findings include: On 8/14/12 the facility administrator provided the personnel files of all employees, CRNA's (Certified Registered Nurse Anesthetist) and physicians who are present when abortions are being	T 075	T075 monitored by QA monitored by PA A staff member with CPR certification will be available on site for emergency care while abortion procedures are being performed. The Policy & Procedure Manual has been amended to ensure at least one person has current CPR certification and that the documentation is maintained in the employee file. 9/21/12	T075 9/21/12

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T 075	Continued From Page 6 performed. None of the personnel reviewed had a current CPR certification in their file. The owner stated, "(Name of Person, CRNA) is current in CPR. I will get a copy of her card." On 8/15/12 the owner was asked if the CPR card of the CRNA had been located and she stated, "Not yet."	T 075		
T 080	12 VAC 5-412-170 E Personnel E. The facility shall develop, implement and maintain policies and procedures to document that its staff participates in initial and ongoing training and education that is directly related to staff duties, and appropriate to the level, intensity and scope of services provided. This shall include documentation of annual participation in fire safety and infection prevention in-service training. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure policies and procedures were implemented and maintain regarding initial and ongoing training and education related to their duties. The findings include: The policy and procedure manuals were reviewed on 8/14 and 15/12 with the administrator and or owner present. There were no policies related to staff training and education at hire or on an ongoing basis. The administrator stated, "We have some training but we don't have policies and procedures related to their initial and ongoing training".	T 080	T080 monitored by PA Quality Assurance and Staff In service Training to ensure compliance of Center Policies and Procedures will be documented in log books. The P&P has been amended to include documentation of orientation and continuing training. The QA training will be documented by the QA supervisor and other staff in service will be documented by the Administrator. 9/21/12	T080 9/21/12

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T 085	Continued From Page 7	T 085		
T 085	12 VAC 5-412-170 F Personnel F. Job descriptions. 1. Written job descriptions that adequately describe the duties of every position shall be maintained. 2. Each job description shall include: position title, authority, specific responsibilities and minimum qualifications. 3. Job descriptions shall be reviewed at least annually, kept current and given to each employee and volunteer when assigned to the position and when revised. This RULE: Is not met as evidenced by: Based on document review and interviews the facility failed to have job descriptions that describe the duties of the Quality Assurance person and the person responsible for Infection Control. The facility also failed to review the job descriptions of these two individuals at least annually. The findings include: On 8/14/12 the administrator was asked to identify who was in charge of Quality Assurance. The person identified did not have anything related to their responsibilities of directing the Quality Assurance program in their job description in their personnel file. The Administrator was also asked to identify who was in charge of Infection Control. The owner was identified as the person responsible for Infection Control. The owner's personnel file did not contain a job description related to being in charge of infection control.	T 085	T085 monitored by PA Job descriptions for the QA supervisor and the Infection Prevention person have been written to describe duties, title, authority, specific responsibilities and qualifications. Completed 8/22/12 Policy and Procedure has been amended to include that annual review based on employee job description is kept current in employee file and that each employee is given a copy of this review. Completed 8/22/12	T085 8/22/12
T 095	12 VAC 5-412-170 H Personnel H. Personnel policies and procedures shall	T 095		

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T 095	Continued From Page 8 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. Process for annually evaluating employee performance and competency; 4. Process for verifying that contractors and their employees meet the personnel qualifications of the facility; and 5. Process for reporting licensed and certified health care practitioners for violations of their licensing or certification standards to the appropriate board within the Department of Health Professions. This RULE: is not met as evidenced by: Based on document review and interviews the facility failed to ensure they had policies and procedures related to the process for verifying current professional licensing or certifications and training of employees and independent contractors, a process for evaluating employees performance and competency at least annually, a process for verifying that contractors and their employees meet the personnel qualifications of the facility and a process for reporting licensed and certified health care practitioners for violations of their licensing or certifications standards to the appropriate board within the Department of Health Professions. The findings include: On 8/14/12 a review of the owner's, who is a Nurse Practitioner, the administrator's, who is a registered nurse, the CRNA (Certified Registered Nurse Anesthetist) and the physicians' credentials revealed no verification of their respective	T 095	T095 monitored by PA Process for verifying current professional licensing and certification and training of employees and independent contractors has been added to the Policy and Procedure Manual. Completed 8/23/12 Process for evaluating employee performance on annual basis using job descriptions has been added to the Policy and Procedure Manual. 8/23/12 Process for verification of qualifications of employees and contractors has been added to the Policy and Procedure Manual. Completed 8/23/12 Process for reporting licensed and certified health care practitioners for violations of their licensing or certification standards to the appropriate board of the Dept of Health Professions has been written by the QA supervisor and Administrator and added to the Policy and Procedure Manual. 8/27/12	T095 8/27/12

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T 095	Continued From Page 9 licenses. The administrator stated, "I have a copy of their licenses but I guess I need more." Also on 8/14 and 15/12 a review of the facility policies and procedures with the administrator and or owner present was performed. Policies and or procedures related to the process for verifying current professional licensing or certifications and training of employees and independent contractors, a process for evaluating employees performance and competency at least annually, a process for verifying that contractors and their employees meet the personnel qualifications of the facility and a process for reporting licensed and certified health care practitioners for violations of their licensing or certifications standards to the appropriate board within the Department of Health Professions could not be located. The owner stated, "That is not a problem I can fix that. I will write the policies"	T 095	T100 monitored by QA	T100 8/27/12
T 100	12 VAC 5-412-170 I Personnel I. A personnel file shall be maintained for each staff member. Personnel record information shall be safeguarded against loss and unauthorized use. Employee health-related information shall be maintained separately within the employee's personnel file. This RULE: is not met as evidenced by: Based on document review and interviews the facility staff failed to ensure employee health related information was maintained separately within the employee's personnel file for 8 of 8 personnel files. The findings include:	T 100	Personnel Files are maintained for each staff member. Health related information is maintained separately within the employees personnel file. Policy and Procedure Manual has been amended requiring documentation of vaccinations and tb testing be maintained on separate forms in the employee files. All personnel files have been updated. 8/27/12	

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T 100	Continued From Page 10 On 8/14/12 the personnel files were reviewed for all employees with the administrator. The administrator stated, "The employees are required by policy to have hepatitis, tetanus and flu vaccines along with their PPD or chest x-rays." Three of the employees had their proof of hepatitis vaccines mixed in with their applications, salary info and tax deduction information. No other facility required vaccines or test could be located in their personnel files and could not be located by the administrator.	T 100		
T 105	12 VAC 5-412-180 A Clinical staff A. Physicians and non-physician health care practitioners shall constitute the clinical staff. Clinical privileges of physicians and non-physician health care practitioners shall be clearly defined. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility staff failed to ensure the privileges of the clinical staff were clearly defined for 4 for 4 clinical staff in their credential files. The findings include: The credential files of 2 Nurse Practitioners, 1 CRNA (Certified Registered Nurse Anesthetist) and 1 physician were reviewed on 8/14/12 with the owner and or administrator. The 4 clinical staff did not have documentation of their privileges in their credential files. The owner stated, "We will get that documented."	T 105	T105 monitored by PA Clinical Privileges have been defined and approved by the BOD for physician and non-physician health care practitioners. Copies of the privileges of four clinical staff members have been given to the individual staff and placed in their employee file. 8/27/12	T105 8/27/12
T 110	12 VAC 5-412-180 B Clinical staff B. Abortions shall be performed by physicians	T 110		

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T 110	Continued From Page 11 who are licensed to practice medicine in Virginia and who are qualified by training and experience to perform abortions. The facility shall develop, implement and maintain policies and procedures to ensure and document that abortions that occur in the facility are only performed by physicians who are qualified by training and experience. This RULE: is not met as evidenced by: Based on document review and interviews the facility staff failed to develop, implement and maintain policies and procedures to ensure the abortions that occurred at the facility were performed by a licensed physician who is privileged to practice in Virginia. The findings include: On 8/14/12 the facility's policies and procedures were reviewed with the facility owner. The owner stated, "We do not have policies related to verifying the credentials of the physician. I thought a copy of his license was enough." The credential file for the facility physician was reviewed with the owner of the practice. The credential file did not contain verification of the physician's license with the Department of Health Professions.	T 110	T/10 monitored by PA Policy and Procedure Manual has been amended to include provision that all abortions are performed only by Virginia licensed physicians qualified by training and practice. Verification of license is maintained in the employee file. 8/22/12	T/10 8/22/12
T 135	12 VAC 5-412-210 A Patients' rights A. 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	T 135		

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T 135	Continued From Page 12 admission. This RULE: is not met as evidenced by: Based on observation, record review and interview the facility failed to developed and implemented policies and procedures that included the patient would receive a copy of their rights and responsibilities in a language the patient understood. The facility also failed to ensure the rights information included how to file a complaint with the facility and the state licensing agency. The facility failed to implement the required policies and procedures for one of one patient in the sample (Patient #1) The findings included: Observations conducted on August 14, 2012 from 9:44 a.m. to 12:44 p.m. revealed the posted Patient's Rights and Responsibilities did not include information regarding how to file a complaint with the facility or the state licensing agency. The observations and interviews with Staff #8 and Staff #10 revealed the facility staff verbally informed the patients of their rights and responsibilities. Staff #8 reported the patient received information, a form with Staff #8's name, for contacting related to concerns. The information did not have the facility's name, address, telephone number or information related to filing a complaint. Staff #8 verified the information did not include the state licensing agency's name, address and telephone number. On August 14, 2012, the facility's policy and procedure manual was reviewed with Staff #8 and Staff #10. Staff #8 verified the facility did not have a written process for distributing patient's rights information to each patient. Staff #8 agreed the facility did not have a method of documentation, which indicated each patient would receive a copy their patient rights in a language the patient understood. Review of Patient #1's medical record on August	T 135	T135 monitored by QA Policy and Procedure Manual has been amended to include protocol for informing patients of their rights and responsibilities and how to file a complaint with both the facility and the state agency. All patients are given a copy of this document at admission. The documentation includes the facility name, address and phone number as well as the state licensing name, address and phone number. Documentation of patient receipt and understanding of this information is maintained in the patient file. Completed 8/22/12	T135 8/22/12

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T 135	Continued From Page 13 15, 2012 did not reveal documentation the patient had received their rights and responsibilities. Patient #1's medical record did not have documented evidence the patient understood his/her rights and responsibilities or how to file a complaint with the facility or the state licensing agency.	T 135		
T 140	12 VAC 5-412-210 B Patients' rights B. The facility shall establish and maintain complaint handling procedures which specify the: 1. System for logging receipt, investigation and resolution of complaints; and 2. Format of the written record of the findings of each complaint investigated. This RULE: Is not met as evidenced by: Based on record review and interview the facility failed to develop a system for logging receipt of patient complaints. The findings included: During the entrance conference conducted on August 14, 2012 at 9:45 a.m., with Staff #8 and Staff #10 the facility's complaint log was requested for review. An interview conducted on August 14, 2012 at 10:33 a.m., with Staff #12 revealed the facility did not have a formal method of data collection related to patient satisfaction and complaints. Review of the facility's complaint policies and procedures conducted August 15, 2012 at 9:10 a.m., with Staff #10 did not reveal the facility had a policy/procedure for logging the receipt of complaints. A second request was made to review the facility's complaint log. Staff #10	T 140	T140 monitored by QA The Policy and Procedure Manual has been amended to include provision of a log book of patient complaints. This log includes the complaint, the date of receipt, investigation and resolution of complaints. There is a specific format of the record of findings of each complaint which is investigated.. 9/21/2012.	9/21/12

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T 140	Continued From Page 14 deferred the request to Staff #8. Staff #8 reported the facility did not have a complaint log.	T 140		
T 150	12 VAC 5-412-210 D Patients' rights D. The patient shall be given a copy of the complaint procedures, in a language or manner she understands, at the time of admission to service. This RULE: Is not met as evidenced by: Based on observations, record review and interview the facility failed to implement policies and procedures related to patient complaint information for one of one patient in the survey sample. The findings included: Observations conducted on August 14, 2012 from 9:44 a.m. to 12:44 p.m. revealed the posted Patient's Rights and Responsibilities did not include information regarding how to file a complaint with the facility or the state licensing agency. The observations and interviews with Staff #8 and Staff #10 revealed the facility staff verbally informed the patients of their rights and responsibilities. Staff #8 reported the patient received information, a form with Staff #8's name, for contacting related to concerns. The information did not have the facility's name, address, telephone number or information related to filing a complaint. Staff #8 verified the information did not include the state licensing agency's name, address and telephone number. A review conducted on August 15, 2012 at 12:35 p.m., with Staff #10 revealed a complaint policy, which stated the facility would provide to each patient information related to filing a complaint. Staff #10 verified the information posted and the	T 150	T 150 monitored by QA Patients are given a copy of the complaint procedures at the time of admission. The P&P Manual has been amended to include this process. The Patient Rights and Responsibilities have been amended to include the facility name, address and phone number as well as the state agency name, address and phone number. Information on the process of filing a complaint is given to each patient. The information on filing complaints is posted in the waiting area and the patient recovery lounge. Completed 8/22/12	T150 8/12/12

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T 150	Continued From Page 15 information given to the patient did not provide details for the patient to file a complaint. Review of Patient #1's medical record on August 15, 2012 did not reveal documentation the patient had received information related to the procedure for filing a complaint. Patient #1's medical record did not have documented evidence the patient understood his/her rights and responsibilities or how to file a complaint with the facility or the state licensing agency.	T 150		
T 155	12 VAC 5-412-210 E Patients' rights E. The facility shall provide each patient or her designee with the name, mailing address, and telephone number of the: 1. Facility contact person; and 2. The OLC Complaint Unit, including the toll-free complaint hotline number. Patients may submit complaints anonymously to the OLC. The facility shall display a copy of this information in a conspicuous place. This RULE: Is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure patients received information on how to file a complaint with the facility and anonymously with the state licensing agency. The findings included: Observations conducted on August 14, 2012 from 9:44 a.m. to 12:44 p.m. revealed the posted Patient's Rights and Responsibilities did not include information regarding how to file a complaint with the facility or the state licensing agency. The observations and interviews with	T 155	T155 monitored by QA Patients are given a copy of the Center address, phone number and person of contact and the name of the OLC its address and toll-free complaint hotline phone number. The copy of this information is displayed in two places: waiting room and patient lounge. Policy and Procedure Manual has been amended to include the posting in two places and submission to each patient on admission. Documentation of patient understanding and receipt of this information is maintained in the patient file.8/23/12	T155 8/23/12

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T 165	Continued From Page 17 1. The process for development, implementation and maintenance of infection prevention policies and procedures and the regulations or guidance documents on which they are based shall be documented. 2. All infection prevention policies and procedures shall be reviewed at least annually by the administrator and appropriate members of the clinical staff. The annual review process and recommendations for changes/updates shall be documented in writing. 3. A designated person in the facility shall have received training in basic infection prevention, and shall also be involved in the annual review. This RULE: is not met as evidenced by: Based on record review and interview the facility's infection prevention plan failed to: Include a process for documenting the annual review, recommendation for changes and infection prevention updates in writing; and Ensure the person designated as the infection preventionist had documented training and the facility had documented evidence the infection preventionist was involved in the annual review of the infection prevention plan, policies and procedures. The findings included: 1. A review of the infection prevention plan, on August 15, 2012 at 9:40 a.m., with Staff #10 did not reveal a process for documenting the annual review, recommendation for changes and infection prevention updates in writing. Staff #10 verified the facility had not included a process for annual review of the facility's infection prevention plan. Staff #10 was not able to locate a policy or procedure, which detailed how assessment, recommendations, changes and updates would be incorporated into the facility infection prevention	T 165	T 165 monitored by PA The Policy and Procedure Manual has been amended to include a process for documenting the annual review and recommended changes and infection prevention updates in writing. The P&P further is amended to show training of the Infection Prevention Supervisor and documentation of annual review by the supervisor. The Infection Prevention Supervisor is required to secure training in infection prevention. Documentation of such training is maintained in the staff file. The Infection Prevention Supervisor provides documentation of annual review of the prevention plan, policies and procedures including assessment, recommendations, changes and updates. Completed 9/21/12	T165 9/21/12

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T 155	Continued From Page 16 Staff #8 and Staff #10 revealed the facility staff verbally informed the patients of their rights and responsibilities. Staff #8 reported the patient received information, a form with Staff #8's name, for contacting related to concerns. The information did not have the facility's name, address, telephone number or information related to filing a complaint. Staff #8 verified the information did not include the state licensing agency's name, address and telephone number. A review conducted on August 15, 2012 at 12:35 p.m., with Staff #10 revealed a complaint policy, which stated the facility would provide to each patient information related to filing a complaint. Staff #10 verified the information posted and the information given to the patient did not provide details for the patient to file a complaint. Review of Patient #1's medical record on August 15, 2012 did not reveal documentation the patient had received information related to the procedure for filing a complaint. Patient #1's medical record did not have documented evidence the patient received details on how to file a complaint with the facility or the state licensing agency.	T 155		
T 165	12 VAC 5-412-220 A Infection prevention A. The abortion facility shall have an infection prevention plan that encompasses the entire facility and all services provided, and which is consistent with the provisions of the current edition of "Guide to Infection Prevention in Outpatient Settings: Minimum Expectations for Safe Care", published by the U.S. Centers for Disease Control and Prevention. An individual with training and expertise in infection prevention shall participate in the development of infection prevention policies and procedures and shall review them to assure they comply with applicable regulations and standards.	T 165		

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T 170	Continued From Page 19 procedures shall include, but not be limited to: 1. Procedures for screening incoming patients and visitors for acute infectious illnesses and applying appropriate measures to prevent transmission of community acquired infection within the facility; 2. Training of all personnel in proper infection prevention techniques; 3. Correct hand-washing technique, including indications for use of soap and water and use of alcohol-based hand rubs; 4. Use of standard precautions; 5. Compliance with blood-bourne pathogen requirements of the U.S. Occupational Safety & Health Administration. 6. Use of personal protective equipment; 7. Use of safe injection practices; 8. Plans for annual retraining of all personnel in infection prevention methods; 9. Procedures for monitoring staff adherence to recommended infection prevention practices; and 10. Procedures for documenting annual retraining of all staff in recommended infection prevention practices. This RULE: is not met as evidenced by: Based on record review and interview the facility failed to develop a policy and procedure or process to document infection prevention training and annual re-training of staff for four of eight employee records reviewed. The findings included: Review of eight current and or contracted employee records revealed four staff did not have documented evidence of infection prevention training or annual re-training: Staff #2 -hired July 11, 2011; Staff #4 -contracted July 3, 1992;	T 170	T170 monitored by PA Policy and Procedure Manual has been amended to include process for documentation of infection prevention training and annual training of all staff members. Further documentation is maintained in each staff file. Files have been updated regarding staff #2, staff#4, staff#10 and staff#12. 9/21/12	T170 9/21/12

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T 165	Continued From Page 18 plan in writing. 2. During the entrance conference, conducted on August 14, 2012 at 9:45 a.m., with Staff #8 and Staff #10. Staff #10 reported he/she was the infection preventionist. Review of Staff #10's employee file did not provide evidence of infection prevention training. An interview was conducted on August 14, 2012 at 4:44 p.m. with Staff #10 and Staff #10. Staff #10 reported he/she had training as an advanced health care practitioner. Staff #10 confirmed he/she had not included evidence of training in his/her employee file. A request was made for any additional evidence of training. Review of the facility's infection prevention plan, policies, and procedures did not documented evidence the infection preventionist was involved in the annual review of the infection prevention plan, policies and procedures. An interview was conducted on August 15, 2012 at 9:44 a.m., with Staff #10. Staff #10 did not locate policies, procedures or information within the facility's infection prevention plan, which specified the infection preventionist involvement in the annual review. Staff #10 was not able to provide documentation of his/her annual review of the infection prevention plan, policies and procedures. The facility did not provide additional information prior to exit.	T 165		
T 170	12 VAC 5-412-220 B Infection prevention B. Written infection prevention policies and	T 170		

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T 170	Continued From Page 20 Staff #10 -year of hire 1973; and Staff #12 -year of hire 1982. Review of the facility's infection prevention policies and procedures on August 15, 2012 at 9:44 a.m. with Staff #10 did not reveal policies/procedures for documenting training and annual retaining of employees' infection prevention practices. Staff #10 was not able to locate documented evidence for the four employees' infection prevention training. The facility did not provide additional information prior to exit.	T 170		
T 175	12 VAC 5-412-220 C Infection prevention C. Written policies and procedures for the management of the facility, equipment and supplies shall address the following: 1. Access to hand-washing equipment and adequate supplies (e.g., soap, alcohol-based hand rubs, disposable towels or hot air dryers); 2. Availability of utility sinks, cleaning supplies and other materials for cleaning, disposal, 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:	T 175	T175 (over)	

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T 175	Continued From Page 21 (i) the level of cleaning/disinfection/sterilization to be used for each type of equipment, (ii) the process (e.g., cleaning, chemical disinfection, heat sterilization); and (iii) the method for verifying that the recommended level of disinfection/sterilization has been achieved. The procedure shall reference the manufacturer's recommendations and any applicable state or national infection control guidelines; 8. Procedures for appropriate disposal of non-reusable equipment; 9. Policies and procedures for maintenance/repair of equipment in accordance with manufacturer recommendations; 10. Procedures for cleaning of environmental surfaces with appropriate cleaning products; 11. An effective pest control program, managed in accordance with local health and environmental regulations; and 12. Other infection prevention procedures necessary to prevent/control transmission of an infectious agent in the facility as recommended or required by the department. This RULE: is not met as evidenced by: Based on observations, record review and interviews the facility failed to develop and implement infection prevention policies to prevent the spread of infections as evidenced by: The sink in the laboratory area had hands-only twist knobs to access the water. The "Recovery I" area did not have a sink for staff providing direct patient care to wash their hands. The "Recovery I" area did not have hand sanitizer for staff to sanitizer their hands between patients. The closest sink for staff to wash their hands was located in the laboratory area, which had hands-only twist knobs to access the water.	T 175	T175 monitored by QA monitored by IP The faucet handles of the laboratory area have been changed to 'wrist operated' handles. Recovery Rm 1 has sanitizer available for staff to clean hands between patients. Staff also has access to the laboratory sink. 9/21/12 Policy and Procedure Manual has been amended to include a process of cleaning stethescopes, blood pressure cuffs and thermometers between patient use. The procedure table was replaced and an invoice shown to the inspectors. The new table was installed 8/20/12. The two recovery room stretchers were cleaned of all tape rendering the surfaces intact as of 8/24/12. The 'dark smudges' were removed. Staff has been informed to use only single dose medications with all patients. Medications are placed into a small disposable cup using a spoon before giving to patient. 8/17/12 Sponges used for instrument cleaning are soaked in 10% bleach water between usage. All instruments cleaned are then steam autoclaved. 8/17/12 Sterile supplies have been moved to an area designated as 'clean and sterile' supplies. This supply room has evidence of ventilation, humidity and temperature control. 8/17/12 The hot water heater has been adjusted from 140 F to 160 F. 8/18/12 Laundry sorting and processing has a distinct area removed from the soiled utility. 8/27/12 All under counter sinks are free of any storage items. 8/15/12 Policy and Procedure Manual has been amended to include process for: maintaining proper medical furniture, using only single dose medication, storage of sterile supplies, proper temperature of on site linen washing, sorting of linen and storage of supplies under sink cabinets. 9/21/12	T175 9/21/12

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T 175	Continued From Page 22 Staff failed to clean direct care equipment (Stethoscopes, blood pressure cuffs and thermometers) between patients. One of one procedure table did not have an intact surface and could not be disinfected between patients. There was evidence of dried blood in the procedure table's decorative stitching. Two of two stretchers did not have intact surfaces and could not be disinfected between patients. Staff retrieved and administered medications from a multi-dose container in the room with the patient. The staff re-used sponges as part of the cleaning process for the instruments. The facility did not have a policy/procedure for disinfecting the sponges. Observation revealed staff did not disinfect the sponges. The facility did not have designated "Clean" supply storage area. Sterile supplies were stored on open shelf in the autoclave room. The areas utilized for storage did not have evidence of ventilation, humidity, and temperature control. The plumping used to perform the on-site laundry did not meet the required temperature (106 degrees Fahrenheit) The on-site laundry did not have a distinct and separate processing area. The combination washer/dryer was housed in the soiled utility room, where instruments utilized during procedures were cleaned and processed. The facility staff had stored chemicals and paper products under the sink in three work areas (The blood draw Lab, procedure room and the soiled	T 175	T175 Further review of Center found several other pieces of equipment which had tape and or rust. Tape was removed and rusted equipment painted. Antimicrobial wipes used to clean treatment room and counter tops were replaced with "medical grade' wipes. Staff training has been provided to review all changes.	T175 9/3/12

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T 175	Continued From Page 23 utility room). The findings included: 1. An observation conducted on August 14, 2012 at 10:08 a.m., with Staff #8 and Staff #10 revealed the sink in the laboratory area had hands-only twist knobs to access the water. Staff #8 and Staff #10 verified the observation. An interview was conducted on August 14, 2012 at 12:22 p.m. with Staff #10. Staff #10 acknowledged the sink did not have valves, which allowed the use of wrist or elbow to access water. Staff #10 affirmed the risk of cross-contamination of hands post hand washing and the spread of infections associated with hands-only twist type knobs. 2. An observation on August 14, 2012 at 11:16 a.m., with Staff #8 and Staff #10 in "Recovery I" area did not reveal a sink for staff to wash their hands while or after providing direct patient care. The pump hand sanitizer bottle available for staff use had expired. Observations conducted on August 15, 2012 "Recovery I" area did not have hand sanitizer for staff to sanitize their hands between patients. An interview was conducted on August 14, 2012 at 12:29 p.m., with Staff #10. Staff #10 verified the "Recovery I" area was used to stabilize patients after conscious sedation procedures. Staff #10 acknowledged the "Recovery I" area did not have a sink for staff to wash their hands before, during or after direct patient care. Staff #10 reported the closest sink to "Recovery I" area for staff to wash their hands was located in the laboratory area, which had hands-only twist knobs to access the water.	T 175		

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T 175	Continued From Page 24 3. An observation conducted on August 15, 2012 at 12:40 p.m., Staff #8 failed to clean direct care equipment (Stethoscopes, blood pressure cuffs and thermometers) between patients. An interview was conducted on August 15, 2012 at 2:44 p.m., with Staff #8 and Staff #10. Staff #8 and Staff #10 was informed of the findings. Staff #8 acknowledged he/she failed to follow the procedures for cleaning equipment employed in direct patient care. Staff #10 reported that equipment should be cleaned between patients. 4. An observation and interview conducted on August 14, 2012 from 10:10 a.m. to 11:11 a.m., with Staff #8 and Staff #10 revealed the procedure table's surface was not intact. The procedure table had tears covered with tape. Staff #8 and Staff #10 acknowledged the procedure table could not be disinfected between patients. Staff #8 and Staff #10 verified the finding of dried blood in the procedure table's decorative stitching. 5. Observations and interview conducted on August 14, 2102 at 11:12 a.m. with Staff #8 and Staff #10 revealed two of two stretchers did not have intact surfaces and could not be disinfected between patients. The observation revealed the two designated clean stretchers located in "Recovery I" area had multiple areas of dark smudges. Staff #8 acknowledged the findings. 6. An observation conducted on August 15, 2012 from 11:30 a.m. to 12:40 p.m. revealed staff's administration of pre-procedure medication. Staff #8 retrieved a multi-dose container of Ibuprofen 800 mg (milligram). Staff #8 brought the multi-dose container into the pre-procedure area, opened the container, using his/her finger to limit	T 175		

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T 175	Continued From Page 25 the flow of pills from the container, shook two tablets into the lid of the container. Staff #8 using the lid of the multi-dose container placed the pills in the patient's hand. Staff #8, without cleaning the lid replaced it on the multi-dose container. An interview was conducted on August 15, 2012 at approximately 3:15 p.m. with Staff #8 and Staff #10. The surveyor informed Staff #8 and Staff #10 of the findings. Staff #8 acknowledged the risk of cross-contamination by touching the pills within the container and bringing the multi-dose container to the patient. 7. An observation conducted on August 14, 2012 at 11:20 a.m., with Staff #8 and Staff #10 revealed three kitchen-scouring sponges stacked on the sink within the "Soiled utility" room. [A "Dirty" scrub/utility room is a room designated to receive, clean and disinfect used instruments and or equipment following a procedure. After instruments are cleaned and disinfected in the "Dirty" scrub/utility room/designated area, they are taken to the "Clean" scrub/utility room/designated area where instruments are packaged and sterilized as appropriate for use again.] Observations were conducted on August 15, 2012 from 1:11 p.m. to 2:08 p.m., with Staff #3 in the "Soiled utility" room. Staff #3 received a tray of instruments post a procedure. After soaking the instruments, Staff #3 used one of the three scouring sponges to remove blood and tissues from the instruments. After cleaning the instruments, Staff #3 emptied the soaking solution, which contained clotted blood and tissues from the sink, sprayed the sink with a 10 % bleach solution, used the sponge to wipe down the sink, rinsed the sink and placed the sponge on top of the two stacked sponges. Staff #3 reported the sponges were re-used.	T 175		

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T 175	Continued From Page 28 Staff #3 verbalized not being aware of a procedure specific for cleaning the sponges. The observation did not reveal the sponges were disinfected between usages. Review of the facility's policy and procedure manual did not reveal a policy or procedure for disinfecting the sponges. An interview was conducted on August 15, 2012 at approximately 3:15 p.m. with Staff #8 and Staff #10. Staff #8 and Staff #10 were informed of the observation and findings. Staff #10 reported the facility probably did not have a specific policy or procedure for disinfecting the sponges. Staff #10 acknowledged blood and tissues could reside within the crevices of the sponge and cross-contaminate other contact items. According to the USDA Agriculture Research Service (ARS) newsletter dated February 2008 "...Sponges were soaked in 10% bleach solution for 3 minutes, lemon juice for 1 minute, or pure water for 1 minute, placed in a microwave oven for 1 minute at full power, or placed in a dishwasher for a full wash-dry cycle, or left untreated (control). Microwaving and dishwashing treatments significantly lowered bacterial counts compared to any of the immersion chemical treatments or the control. Counts of yeasts and molds recovered from sponges receiving microwave or dishwashing treatments were significantly lower than those recovered from sponges immersed in chemical treatments." According to ARS website Best Ways to Clean Kitchen Sponges - April 23, 2007 - News from the USDA Agricultural Research Service.mht read: "...treated each sponge in one of five ways: soaked for three minutes in a 10 percent chlorine bleach solution, soaked in lemon juice or	T 175		

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T 175	Continued From Page 27 deionized water for one minute, heated in a microwave for one minute, placed in a dishwasher operating with a drying cycle-or left untreated...They found that between 37 and 87 percent of bacteria were killed on sponges soaked in the 10 percent bleach solution, lemon juice or deionized water-and those left untreated. That still left enough bacteria to potentially cause disease. Microwaving sponges killed 99.99999 percent of bacteria present on them, while dishwashing killed 99.9998 percent of bacteria..." 8. Observations conducted on August 14, 2012 from 10:02 a.m. to 12:45 p.m., with Staff #8 and Staff #10 did not reveal the facility had a designated "Clean" supply storage area. The observation revealed sterile supplies were stored on open shelf in the autoclave room. The area did not have evidence of ventilation, humidity, and temperature control. Staff #8 verified the room that housed the autoclave and the sterile supplies was not monitored for ventilation, humidity, and temperature. 9. Observations on August 14, 2012 from 10:10 to 11:20 a.m., with Staff #8 and Staff #10 revealed five blanket and fifteen (15) sheets in a cabinet. Staff #8 reported the linens and staff scrubs were washed on-site. Observations were conducted on August 14, 2012 at 11:25 p.m., with Staff #8 and Staff #10 of the on-site washer and dryer. Staff #8 reported the washer was connected to the general hot water system. Staff #10 verified the hot water, which flowed to the sinks and the washer was from the same source. Staff #10 verified the plumping used to perform the on-site laundry did not meet the required temperature (106 degrees Fahrenheit)	T 175		

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T 175	Continued From Page 28 10. Observations and interview conducted on August 14, 2012 at approximately 11:40 a.m., with Staff #10 revealed the on-site laundry was located in the "Soiled utility" room. The on-site laundry did not have a distinct and separate processing area. The observation revealed the washer door was open. The washer door was adjacent to a red-biohazard box, used to dispose of contaminated non-reusable items post procedures. [A "Dirty" scrub/utility room is a room designated to receive, clean and disinfect used instruments and or equipment following a procedure. After instruments are cleaned and disinfected in the "Dirty" scrub/utility room/designated area, they are taken to the "Clean" scrub/utility room/designated area where instruments are packaged and sterilized as appropriate for use again.] Staff #10 acknowledged the risk of cross-contamination of the linens and the basket used to retrieve the linens from the dryer. Staff #10 verified the clean linens would have to cross over areas designated as "soiled" prior to leaving the "Soiled utility" room. 11. Observations conducted during the initial tour on August 14, 2012 from 10:02 a.m. to 12:25 p.m., Staff #8 and Staff #10 revealed chemicals and paper products were stored under the sink in three work areas (The blood draw Lab, procedure room and the soiled utility room). Staff #8 verified the findings.	T 175		
T 180	12 VAC 5-412-220 D Infection prevention D. The facility shall have an employee health program that includes: 1. Access to recommended vaccines; 2. Procedures for assuring that employees with communicable diseases are identified and prevented from work activities that could result in	T 180		

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T 180	Continued From Page 29 transmission to other personnel or patients; 3. An exposure control plan for blood-bourne pathogens; 4. Documentation of screening and immunizations offered/received by employees in accordance with statute, regulation or recommendations of public health authorities, including documentation of screening for tuberculosis and access to hepatitis B vaccine; 5. Compliance with requirements of the U.S. Occupational Safety & Health Administration for reporting of workplace-associated injuries or exposure to infection. This RULE: is not met as evidenced by: Based on document review and interviews the facility staff failed to ensure documentation of the employee's immunizations required by the facility were documented on 8 of 8 employees for tetanus and flu and that 5 of 8 had documentation of hepatitis and that 8 of 8 had documentation of annual TB test or chest x-ray. The findings include: On 8/14/12 the personnel files were reviewed for all employees with the administrator. The administrator stated, "The employees are required by policy to have hepatitis, tetanus and flu vaccines along with their PPD or chest x-rays." Three of the employees had their proof of hepatitis vaccines mixed in with their applications, salary info and tax deduction information. No other facility required vaccines or test could be located in their personnel files and could not be located by the administrator.	T 180	T180 monitored by PA Policy and Procedure Manual has been amended to include documentation of screening for tb and required vaccinations to be recorded in employee file. Files have been updated in each employee record. Completed 8/27/12	T180 8/27/12
T 185	12 VAC 5-412-220 E Infection prevention E. The facility shall develop, implement and	T 185		

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T 185	Continued From Page 30 maintain policies and procedures for the following patient education, follow-up, and reporting activities: 1. Discharge instructions for patients, to include instructions to call or return if signs of infection develop; 2. A procedure for surveillance, documentation and tracking of reported infections; and 3. Policies and procedures for reporting conditions to the local health department in accordance with the Regulations for Disease Reporting and Control (12 VAC 5-90), including outbreaks of disease. This RULE: is not met as evidenced by: Based on record review and interview the facility failed to develop and maintain infection surveillance, documentation and tracking. The findings included: An interview conducted on August 14, 2012 at 10:33 a.m., with Staff #12 revealed the facility did not have a formal method of data collection related to patient infections. Review of the facility's infection prevention policies and procedures on August 15, 2012 at 9:44 a.m. with Staff #10 did not reveal policies/procedures for infection surveillance, infection documentation and infection tracking. Staff #10 acknowledged the facility did not have collected data related to infections. Staff #10 did not offer additional information prior to exit.	T 185	T185 monitored by IP The Policy and Procedure Manual has been amended to include a method of documenting patient infections. A log of book of complications including any infections is maintained for each providing physician and a copy of any complications given to the physician . The protocol for reporting specific required diseases to the local health department is included in this amendment. 9/21/12	T185 9/21/12
T 265	12 VAC 5-412-260 A Administration, storage and dispensing of dru A. Controlled substances, as defined in 54.1-3401 of the Drug Control Act of the Code of	T 265		

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T 265	Continued From Page 31 Virginia, shall be stored, administered and dispensed in accordance with federal and state laws. The dispensing of drugs, excluding manufacturers' samples, shall be in accordance with Chapter 33 of Title 54.1 of the Code of Virginia, Regulations Governing the Practice of Pharmacy (18 VAC 110-30). This RULE: is not met as evidenced by: Based on observations, interviews and document reviews the facility staff failed to store, administer and dispense controlled substances as defined in 54.1-3401 of the Drug Control Act of the Code of Virginia. The facility administered Propofol (unscheduled), Fentanyl (Schedule II), Versed (Schedule III) and Brevital (Schedule IV) for conscious sedation and failed to document the medications' arrival, dispensing and wasting. The findings include: On 8/14/12 the narcotic log book was observed. The administrator stated only the CRNA (Certified Registered Nurse Anesthetist) documents in the narcotic log book. The log book had no separate documentation noting when drugs were received. All drugs were documented on one page. On one page dated 8/10/12, in the margin of the page, was written, "4 Brevital received, 3 remain." Each of the 3 Brevital (500 mg (milligrams) each) were locked in the narcotic box. If the Brevital was reconstituted as directed with 50 ml (milliliters) of sterile water each vial would contain 500 mg. At the top of the page in columns was typed Propofol 10 cc (cubic centimeters), 20 cc and 50 cc. Also across the top was Versed 10 cc and Fentanyl 20 cc. There were 4 patient names listed on the page dated 8/10/12. Beside of each patient's name was a dosage of	T 265	T 265 monitored by QA Policy and Procedure Manual has been amended to include protocol for the arrival, dispensing and wasting of all controlled medications. Record keeping must be legible with no white outs. There is a separate inventory record. 9/21/12 A review of the narcotic log and patient records in question was performed by the QA supervisor A review, assessment and recommendations of correction was documented by the QA. The Operations Director, Administrator and CRNA held a meeting and discussed the errors and the needed corrections. A report was filed with the office of licensing and credentialing. QA supervisor and Administrator will monitor the narcotic log information records and patient records over the next 90 days.	9/21/12

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T 265	Continued From Page 32 Brevital in the following order: 90 mg, 90 mg, 70 mg and a fourth documentation that could be 70 or 90 mg, it is not clearly written. The owner looked at the page and stated, "I am not sure if is 70 or 90 mg." Several other pages from the narcotic sign out log book were observed and contained scribbled out amounts, dates and names and on one page the entire line was covered with liquid paper (white out). The owner stated, "This is not good. She knows better than to document like this. I guess I will have to report her to the Nursing Board." The DEA (Drug Enforcement Agency) states controlled substances are divided into 5 schedules by the Control Substance Act. The schedule is based on the abuse potential and likelihood of causing dependence. Schedule I have no medical purpose. Schedule II have a high potential for abuse which may lead to severe psychological or physical dependence. Schedule III have a potential for abuse less than substances in schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence. Schedule IV have a low potential for abuse. The facility administered Propofol (unscheduled), Fentanyl (Schedule II), Versed (Schedule III) and Brevital (Schedule IV) for conscious sedation and failed to document the medications' arrival, dispensing and wasting	T 265		
T 275	12 VAC 5-412-260 C Administration, storage and dispensing of dru C. Drugs maintained in the facility for daily administration shall not be expired and shall be properly stored in enclosures of sufficient size with restricted access to authorized personnel only. Drugs shall be maintained at appropriate	T 275		

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T 275	Continued From Page 33 temperatures in accordance with definitions in 18 VAC 110-20-10 This RULE: is not met as evidenced by: Based on observations, document review and interviews the facility staff failed to ensure medications in the facility and available for use were not expired, were dated when opened and accessed. The findings include: On 8/14/12 during the initial tour of the facility with the owner and administrator the medication refrigerator in the lab area contained a Levemir Flexpen of insulin available for use with an expiration date of 7/12. The administrator removed the Flexpen and disposed of it while stating, "We received that from a drug rep." Also in the refrigerator was a vial of opened, accessed and available for use of Purified Tuberculin that was not dated as to when it was accessed. The storage room contained opened, accessed and available for use bottles for multi patient dispensing of ibuprofen (2 bottles total, one with 11 - 200 mg (milligrams) tablets that expired 2/11 and another with 11 - 200 mg tablets that expired 1/12) and a bottle 30 tablets of 500 mg acetaminophen that expired 5/11. The administrator stated, "I will get rid of those." The emergency box in the procedure/ultrasound room was inspected with the owner and administrator present on 8/14/12. The emergency box contained intravenous fluids as follows: 3 bags of 500 milliliters of lactated ringers all out of the protective bag covering and 1 bag of expired (6/12 expiration date) of sodium chloride out of the protective bag covering. The administrator stated, "Should I have disposed of these bags after they	T 275	monitored by IP T 275 monitored by QA Policy and Procedure Manual has been amended to include provision for checking expiration dates of all medications. The P&P also stipulates that date of opening multi vial doses be documented on the vial and expiration of vial also documented. IV solutions removed from outer wrapping are dated when opened with a two week expiration date also documented. Completed 8/23/12	T275 8/23/12

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T 275	Continued From Page 34 were opened?" The surveyor asked when the bags were removed from the protective bag covering and the administrator stated, "I don't know." Pharmacy One Source by Wolters Kluwer dated 6/19/11 stated "Once they (intravenous fluids) are removed from the overwrap/moisture barrier the manufacturer's expiration date is no longer applicable because storage conditions have been altered. So the question has always been "what kind of BUD (Beyond Use Date) do I assign to these products once they are removed from the overwrap"? Most have wording on the label similar to "Use immediately once overwrap is removed". But what do they mean by "immediately"? A few years ago I sent letters to several pharmaceutical manufacturers asking them to define "immediately" in relation to applying a meaningful Beyond Use Date. Most of the responses I received were 14 days".	T 275		
T 285	12 VAC 5-412-260 E Administration, storage and dispensing of dru E. Records of all drugs in Schedules I-V received, sold, administered, dispensed or otherwise disposed of shall be maintained in accordance with federal and state laws, to include the inventory and reporting requirements of a theft or loss of drugs found in 54.1-3404 of the Drug Control Act of the Code of Virginia. This RULE: Is not met as evidenced by: Based on observations, interviews and document reviews the facility staff failed to ensure all Schedule II-V drugs received, administered and disposed of was done so in accordance with the Drug Control Act found in the Code of Virginia 54.1-3404. Narcotic log book contained	T 285	T285 monitored by PA Policy and Procedure Manual has been amended to include protocol for the recording of all Schedule 1-V medications including arrival, administered, dispensed or disposal in accordance with federal and state laws. New charting forms have been designed with the required regulation as template. Changes have been implemented to include proper documentation, legible writing, separate logging of arrival and inventory control, and procedure for disposing or wasting of unused controlled substances. Compliance with written standards will be checked on a random basis by the QA supervisor. Completed 9/21/12	T285 9/28/12

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T 285	Continued From Page 35 documentation of medications given that were not documented in the medical record as given, had information covered by liquid paper (white out) and had scribbling over dates, patient names and amounts of medications administered. The narcotics log also did not contain witnessed wastage of narcotic. The facility administered Propofol (unscheduled), Fentanyl (Schedule II), Versed (Schedule III) and Brevital (Schedule IV) for conscious sedation and failed to document the medications' arrival, dispensing and wasting. The findings include: On 8/14/12 the narcotic log book was observed. The administrator stated only the CRNA (Certified Registered Nurse Anesthetist) documents in the narcotic log book. The log book had no separate documentation noting when drugs were received. All drugs were documental on one page. On one page dated 8/10/12 in the margin of the page was written, "4 Brevital received, 3 remain." Each of the 3 Brevital (500 mg (milligrams) each) were locked in the narcotic box. If the Brevital was reconstituted as directed with 50 ml (milliliters) of sterile water each vial would contain 500 mg. At the top of the page in columns was typed Propofol 10 cc (cubic centimeters), 20 cc and 50 cc. Also across the top was Versed 10 cc and Fentanyl 20 cc. There were 4 patient names listed on the page dated 8/10/12. Randomly the medical record of the 3rd patient listed (Patient #2) on 8/10/12 on the narcotic log page was reviewed on 8/14/12 with the owner. The medical record of Patient #2 did not contain documentation of Brevital being given. The owner then reviewed the remaining 3 records for documentation of Brevital being given. The owner stated, "The other 3 have documentation of the	T 285		

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T 285	Continued From Page 36 Brevital being given and showed the surveyor the medical records of the 3 other patients. The surveyor pointed out the documentation indicated Propofol was given. The owner stated, "You are correct, there is no documentation of Brevital." Beside of each patient's name was a dosage of Brevital in the following order: 90 mg, 90 mg, 70 mg and a forth documentation that could be 70 or 90 mg, it is not clearly written. The owner looked at the page and stated, "I am not sure if is 70 or 90 mg." Several other pages from the narcotic sign out log book were observed and contained scribbled out amounts, dates and names and on one page the entire line was covered with liquid paper (white out). The owner stated, "This is not good. She knows better than to document like this. I guess I will have to report her to the Nursing Board." Pharmacy Purchasing and Products, Tools to Effectively Manage Controlled Substances January 2011 Vol. 8 No. 1 page 8 by Ira Kurland, RPh and Tim L'Hommedieu,PharmD, MS stated the following: "The process for wasting controlled medications, such as narcotics, requires a witness and includes the following: Two authorized users are required. One user will be designated as witness to the wasting process. ...., whose job description or licensing allows the handling of controlled substances, may serve as a witness in the absence of a second nurse. The witness must view the vial, syringe, tablet, etc, that is used to prepare the medication dose. The witness is required to visualize the solution vial, syringe, tablet, etc, to verify the medication being wasted. The witness must watch the solution ejected from the syringe (preferably in a solid waste/trash	T 285		

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	FTAF-0018	A. BUILDING _____ B. WING _____	08/15/2012

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T 285	Continued From Page 37 receptacle) or watch the destruction of the unused portion (e.g., the tablet). Unplanned wasting (e.g., patient refusal of medication) must be witnessed when the medication is actually wasted using the procedure described above.	T 285		
T 295	12 VAC 5-412-280 Emergency equipment and supplies An abortion facility shall maintain medical equipment, supplies and drugs appropriate and adequate to manage potential emergencies based on the level, scope and intensity of services provided. Such medical equipment, supplies and drugs shall be determined by the physician and shall be consistent with the current edition of American Heart Association's Guidelines for Advanced Cardiovascular Life Support. Drugs shall include, at a minimum, those to treat the following conditions: 1. Cardiopulmonary arrest; 2. Seizure; 3. Respiratory distress; 4. Allergic reactions; 5. Narcotic toxicity; 6. Hypovolemic shock; and 7. Vasovagal shock. This RULE: is not met as evidenced by: Based on observations, document review and interviews the facility staff failed to ensure the medical supplies and personnel trained in medical emergencies were available while patients were present. The facility administered Fentanyl (sublimaze) for conscious sedation but failed to have a reversal agent available and failed to have staff trained in CPR (cardio-pulmonary resuscitation) in the facility when procedures were performed.	T 295	T 295 monitored by PA Policy and Procedure Manual has been amended to include staff proof of evidence of certification of CPR in employee files and presence of such person while patients are in present.. Further provision has been added to include drugs to counter narcotic toxicity. The drug Narcan has been ordered to counter the effects of Brevitol. This facility does not administer Fentanyl. Completed 8/23/12	T295 8/23/12

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T 296	Continued From Page 38 The findings include: During the initial tour of the facility with the owner and administrator the narcotic log book and the narcotic box were viewed. The narcotic log book showed the administration of Fentanyl and Versed for conscious sedation. The narcotic box had Fentanyl inside. The box did not contain Narcan (naloxone) the recommended reversal agent for Fentanyl. The administrator stated, "I can't believe we don't have that here, it will be ordered."	T 295		
T 340	12 VAC 5-412-310 Medical 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 limited to the following: 1. Patient identification; 2. Admitting information, including a patient history and physical examination; 3. Signed consent; 4. Confirmation of pregnancy; and 5. Procedure report to include: a. Physician orders; b. Laboratory tests, pathologist's report of tissue, and radiologist's report of x-rays; 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.	T340 monitored by QA T 340	Policy and Procedure Manual has been amended to include a complete listing of contents of the abortion chart: patient identification, history and physical exam., signed consent, confirmation of pregnancy, physician orders, lab testing, tissue exam, ultrasound report, anesthesia record, operative record, surgical and medical treatments, recovery room notes, physician and nurse progress notes, condition at discharge, patient instructions, (pre and post operative) referral physician or agencies. Further amendments include requirement of physician or nurse practitioner signature for pre-operative testing medications. Completed 8/23/12	T340 8/23/12

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T 340	Continued From Page 39 This RULE: is not met as evidenced by: Based on observations, document review and interviews the facility staff failed to ensure the medical record was complete and accurate by including physician orders or the patients condition at discharge. The findings include: On 8/14/12 the administrator provided the surveyor with a blank medical record. The medical record did not include a place for physician orders for labs or medications. On 8/15/12 the medical record of Patient #1 was reviewed during and following a procedure. The medical record did not contain physician orders for labs performed or medications given prior to the procedure. The medical record of Patient #1 did not document her condition at discharge. The administrator stated, "We have standing orders signed by the physician." There were no standing orders in Patient #1's medical record. The administrator stated, "Do we need to put a copy of the standing orders in each patient's medical record? We can fix the form to include all of those things."	T 340		
T 345	12 VAC 5-412-320 Record storage Provisions shall be made for the safe storage of medical records or accurate and eligible reproductions thereof according to applicable federal and state law, including the Health Insurance Portability and Accountability Act (42 USC 1320d et seq.). In the event of closure of the facility, the facility shall notify OLC concerning the location where patient medical	T 345		

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T 345	Continued From Page 40 records are stored. This RULE: is not met as evidenced by: Based on record review and interview the facility failed to have a policy, procedure or process for notifying the state licensing agency related to the location of patient record storage in case the facility closed. The findings included: Review of the facility's policies and procedures did not include provisions for notifying the state licensing agency regarding the storage location of patient records, in the case of facility closure. An interview was conducted on August 14, 2012 at 4:15 p.m., with Staff #10. Staff #10 reported he/she was unable to locate the policy, if one had been developed. An interview was conducted on August 15, 2012 at 9:00 a.m., with Staff #10. Staff #10 reported the facility had failed to develop a policy, procedure or process for informing the state licensure agency where patient record would be stored, if the facility closed.	T 345	T345 monitored by OP Policy and Procedure Manual has been amended to include provision of medical record storage. All records are maintained in a safe and secure place for a minimum of 5 yrs. This policy has been adopted by the BOD and includes a provision for notification to the OLC in the event of closure and the location of records at closure. Completed 8/23/12	T345 8/23/12
T 355	12 VAC 5-412-330 B Reports B. Abortion facilities shall report all patient, staff or visitor deaths to the OLC within 24 hours of occurrence. This RULE: is not met as evidenced by: Based on record review and interview the facility failed to have a policy, procedure or process for notifying the state licensing agency if a patient, staff or visitor died within twenty-four (24) hours of occurrence.	T 355		

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T 355	Continued From Page 41 The findings included: Review of the facility's policies and procedures did not include provisions for notifying the state licensing agency regarding the death of a staff, patient or visitor within twenty-four hours of the occurrence. An interview was conducted on August 14, 2012 at 4:15 p.m., with Staff #10. Staff #10 reported he/she did not develop a policy. Staff #10 reported the regulation did not provide a timeframe related to when the patient, visitor, or staff had been at the facility, that relationship to their death and reporting the occurrence to the state licensing agency.	T 355	T355 monitored by PA Policy and Procedure Manual has been amended to include provision of notification to the OLC of any staff, visitor or patient death with a 24 hr time period. Completed 8/23/12	T355 8/23/12
T 360	12 VAC 5-412-340 Policies and procedures 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 users of the facility. This RULE: is not met as evidenced by: Based on observations, interviews and document reviews the facility failed to develop, implement and maintain policies and procedures pertaining to the safe storage of gases, liquids, drugs and	T 360	T360 monitored by PA Policy and Procedure Manual has been amended to include for the safe and secure storage of oxygen. Holding racks have been ordered. The medications are now kept under double lock.	T360 8/23/12

State of Virginia

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T 360	Continued From Page 42 supplies within the facility, 5 of 6 oxygen canisters were not secured and narcotics were not double locked. The findings include: On 8/13/12 during the initial tour of the facility with the owner and the administrator 5 oxygen canisters were observed in the storage room unsecured. One canister was observed in the procedure/ultrasound room in a rolling holder. The owner stated, "We just got full ones. We will get a rack from the supplier." Also during the initial tour the locked box of medications were observed in the procedure/ultrasound room. The door to the procedure/ultrasound room did not lock.	T 360	T375 monitored by PA monitored by QA	T375 8/23/12
T 375	12 VAC 5-412-360 A Maintenance A. The facility's structure, its component parts, and all equipment such as elevators, heating, cooling, ventilation and emergency lighting, shall be all be kept in good repair and operating condition. Areas used by patients shall be maintained in good repair and kept free of hazards. All wooden surfaces shall be sealed with non-lead-based paint, lacquer, varnish, or shellac that will allow sanitization. This RULE: is not met as evidenced by: Based on observations and interview the facility failed to maintain the heating ventilation and cooling (HVAC) system in good operating condition. The findings included: Observations conducted on August 14, 2012 at 11:26 a.m., with Staff #8 and Staff #10 revealed	T 375	Policy and Procedure Manual has been amended to include maintenance of the facility structure and mechanical equipment. Provisions include that said equipment is kept in good repair and operating condition. Areas used by patients are maintained in good repair and kept free from hazards. Ventilation filters are labeled at date of expiration according to mfg recommendations. Completed 8/23/12	

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T 375	Continued From Page 43 the HVAC system had a filter designated as "30 Days" the filter was not dated as to when it had been placed in service or a date for removal. Staff #8 reported he/she had failed to date the filter. Staff #8 could not offer the date of when the filter had been installed. The observation on August 14, 2012 revealed the filter was protruding approximately three inches out of the filter housing area. Staff #8 attempted to reposition the filter without success. Staff #8 reported the filter was not in its proper place and needed to be replaced. Staff #8 reported awareness that the role of the filter involved removing particulate matter from the air.	T 375		
T 380	12 VAC 5-412-360 B Maintenance B. When patient monitoring equipment is utilized, a written preventative maintenance program shall be developed and implemented. This equipment shall be checked and/or tested in accordance with manufacturer's specifications at periodic intervals, no less than annually, to ensure proper operation and a state of good repair. After repairs and/or alterations are made to any equipment, the equipment shall be thoroughly tested for proper operation before it is returned to service. Records shall be maintained on each piece of equipment to indicate its history of testing and maintenance. This RULE: is not met as evidenced by: Based on observations, interviews and document review the facility staff failed to ensure the preventive maintenance (PM) program was developed, implemented and maintained for the facility equipment. The findings include:	T 380	T380 monitored by QA Policy and Procedure Manual has been amended to include for protocol of preventative maintenance on an annual basis. A separate log of all equipment with date of PM is maintained. Medical equipment is inspected and tested according to the manufacturing specifications. Completed 9/21/12	T380 9/21/12

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T 380	Continued From Page 44 On 8/14/12 during the tour of the facility with the owner and administrator the PM could not be located on the suction machine, defibrillator, light source, blood pressure equipment and ultrasound machines. The administrator stated, "We just had those done." The documentation provided contained equipment used in the family practice not for abortions. The administrator stated, "We will make sure all the equipment is serviced."	T 380		
T 390	12 VAC 5-412-370 B Fire-fighting equipment and systems B. All fire protection and alarm systems and other fire fighting equipment shall be inspected and tested in accordance with current edition of the Virginia Statewide Fire Prevention Code (27-94 et seq. of the Code of Virginia) to maintain them in serviceable condition. This RULE: is not met as evidenced by: Based on observations and interview the facility failed to have fire and smoke detectors. The findings included: Observations conducted on August 14, 2012 at 11:26 a.m. to 12:16 p.m., with Staff #8 and Staff #10 revealed the facility did not have an integrated fire system and did not have smoke detectors. An interview was conducted on August 15, 2012 at 10:11 a.m., with Staff #10. Staff #10 reported the facility had an integrated fire system in the past, but canceled the service related to frequent false alarms. Staff # 10 reported the facility did not have smoke alarms. Staff #10 reported if a fire started in the back of the building, the staff	T 390	T390 monitored by PA Policy and Procedure Manual has been amended to include a fire protection system in accordance with current Virginia Fire Prevention Code. Smoke detectors have been ordered and placed in the back hallways A monitoring system of fire and safety laws and regulations has been established. The person responsible for monitoring the program is the Administrator. The City of Alexandria Fire Department will make an inspection of the facility. The facility systems will be maintained up to code of the Virginia Statewide Fire Prevention Code. Completed 9/26/12	T390 9/26/12

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T 390	Continued From Page 45 and patients would not be aware of the situation until the smell of smoke had reached the front of the building.	T 390		
T 400	12 VAC 5-412-380 Local and state codes and standards Abortion facilities shall comply with state and local codes, zoning and building ordinances, and the Uniform Statewide Building Code. In addition, abortion facilities shall comply with Part 1 and sections 3.1-1 through 3.1-8 and section 3.7 of Part 3 of the 2010 Guidelines for Design and Construction of Health Care Facilities of the Facilities Guidelines Institute, which shall take precedence over Uniform Statewide Building Code pursuant to Virginia Code 32.1-127.001. Entities operating as of the effective date of these regulations as identified by the department through submission of Reports of Induced Termination of Pregnancy pursuant to 12 VAC 5-550-120 or other means and that are now subject to licensure may be licensed in their current buildings if such entities submit a plan with the application for licensure that will bring them into full compliance with this provision within two years from the date of licensure. Refer to Abortion Regulation Facility Requirements Survey workbook for detailed facility requirements. This RULE: is not met as evidenced by: Based on observations and interviews the facility failed to provide evidence of compliance with state and local codes, zoning and building ordinances, and the Uniform Statewide Building Code. In addition, abortion facilities shall comply with Part 10 and sections 3.10-10 through 3.10-8 and section 3.7 of Part 3 of the 2010 Guidelines for Design and Construction of Health Care Facilities	T 400		

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T 400	Continued From Page 46 of the Facilities Guidelines Institute, which shall take precedence over Uniform Statewide Building Code pursuant to Virginia Code 32.10-1027.0010. The findings included: An interview conducted with Staff #10 on August 14, 2012 at 9:46 a.m., revealed the facility had not obtained an attestation from an architect related to the building's compliance with FGI guidelines. Observations were conducted on August 14, 20102 from 9:55 a.m. to 10:20 a.m., with Staff #10. The observations revealed the following: There was no documentation that the treatment rooms had the minimum of two outside air exchanges. The facility did not have designated "Clean" supply storage area. Sterile supplies were stored on open shelf in the autoclave room. The areas utilized for storage did not have evidence of ventilation, humidity, and temperature control. The facility did not have a separate and distinct janitor's closet. The staff utilized the heating, ventilation and cooling (HVAC) area as a janitor's closet. Staff had stored three window screens, a light fixture, a large commercial moping bucket and six floor care devices (dusters, mops, and for hard floor cleaner) on top of the HVAC ductwork. Within the HVAC closet, two towels were located on the floor under the ductwork. The sink in the laboratory area had hands-only twist knobs to access the water. The "Recovery I" area did not have a sink for staff providing direct patient care to wash their hands. The "Recovery I" area did not have hand sanitizer for staff to sanitizer their hands between patients. The closest sink for staff to wash their hands was located in the laboratory area, which had hands-only twist knobs to access the water. The public corridor used to gain access to the "Recovery II" area was less that the required five	T 400	monitored by PA T400 monitored by OP The facility is waiting to see final regulations regarding the design and construction code. An architect inspection has been performed and a report received. Requirements to have two outside air exchanges per hour in the treatment room will be met within the specified time frame. All sterile supplies are stored in a closed ventilation, humidity, temperature monitored space. We have purchased a separate janitor closet and removed all items from the HVAC closets. The sink in laboratory has had the handles replaced with 'wrist operated' turning capacity. Recovery Room 1 has hand sanitizer available. A preliminary architectural report has shown corridors to be in compliance once the hallway floor cabinets are removed. The hot water heater has been adjusted from 140F to 160F. The on-site laundry has been re-designed to have a separate sorting and processing area away from the soiled space. The on-site laundry has a distinct and separate processing area. The air filters are documented to be at least 39% efficiency rating with MERV 7. All supplies from the described under counter sinks have been removed. A paper towel dispenser has been installed in the public bathroom. The fire alarm system and smoke alarms are in place.	T400 2014 Sept

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T 400	Continued From Page 47 feet. The corridor had a counter/cabinet unit used for storage and charting, which reduced the accessibility of the hallway. The plumping used to perform the on-site laundry did not meet the required temperature (106 degrees Fahrenheit) The on-site laundry did not have a distinct and separate processing area. The combination washer/dryer was housed in the soiled utility room used to clean and process instruments post procedures. The facility could not provide evidence of the airflow requirements of two air changes (AC) per hour outside air in the examination, treatment and procedure rooms. The facility could not provide evidence the building air handlers were equipped with filters of at least 30 percent efficiency rating and equipped with at least MERV 7 filters. The facility staff had stored chemicals and paper products under the sink in three work areas (The blood draw Lab, procedure room and the soiled utility room). The public bathroom located near the blood draw area did not have a paper towel dispenser. The paper towels had been placed in a wicker basket. When the paper towels were removed from the basket, water from the person's hands dripped on the remaining towels located in the basket. The facility did not have an integrated fire alarm system or smoke alarms. Staff #10 verified the above findings during the observations on August 14, 2012 and during an interview conducted from 9:55 a.m. to 11:00 a.m., on August 15, 20102.	T 400		

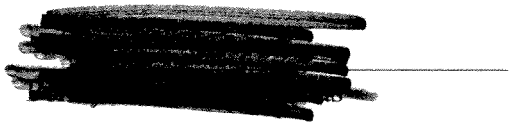
METRO MEDICAL CENTERS, INC BY LAWS

The By-Laws are hereby amended to include written criteria and privileges for physicians and nurse practitioners as noted in the Policy and Procedure Manuals.

The By-Laws are hereby amended to provide the guidelines of the relationships of this Board of Directors and the Administrator and clinical staff. The chart of organization is maintained in the Policy and Procedure Manual.

The Board of Directors appoints the Operational Director as its liaison in all clinical matters including but not limited to: selection of an administrator and alternate, approval of a policy and procedure manual, and criteria for privileges of providers. The Operational Director and the Administrator must initial the Policy and Procedure Manual at the beginning of each calendar year.

The Operational Director must be a person with a health care background and at least three years experience in the provision of abortion services.



T030

I have received a copy of the Patient's Rights and Responsibility document from Annandale Women & Family Center. I understand the contents. I have also been given information on how and with whom to file a complaint. Have been given the address and phone number to contact of Annandale Women & Family Center. I understand I may also file a complaint with the Health Dept of Virginia and have been given the name and address and phone number of this agency. I understand how to file a complaint with both agencies. I understand that I can receive a copy of the state agency complaint form from any staff member.

_____ _____

Patient Signature Date

_____ _____

Witness Date

Annandale Women &
Family Ctr
2839 Duke St
Alexandria, VA 22314

F035

METRO MEDICAL CENTERS BY LAWS
STAFF APPOINTMENTS

Metro Medical Centers, Inc. Hereby acknowledges the service of Gail Frances as Operational Director and Penny Smith as Administrator of the Annandale Women & Family Center since inception.

The Corporation further approves the continued service of Gail Frances and Penny Smith in these roles for the duration of the company or until resignation or termination is instituted.

The Operational Director is charged with naming an alternate Administrator in the absence of the acting Administrator

Any changes to the position of Administrator or Operations Director will be reported to the OLC.

[redacted] Date

[redacted] Date

Annandale Women &
Family Ctr
2839 Duke St
Alexandria, VA 22314

T045 T055
T050

PATIENTS RIGHTS AND RESPONSIBILITIES

Patients have the right to know how their personal information may be shared with other agencies.
Patients have the right to restrict information sharing to other family members or friends or employers or those designated.
Patients have the right to informed consent of all procedures
Patients have the right to appropriate referrals for services not provided by our Center.
Patients have the right to a complete copy of their records.
Patients have the right to file a complaint if they feel their rights were violated.
Patients have the right to participate in the treatment plans of their care.

Patients have the responsibility to give accurate information regarding demographics of name, address, contact phone, contact person and insurance coverage.
Patients have the responsibility to disclose any and all medical conditions including allergies and medications taken on a regular basis.
Patients have the responsibility to disclose any past medical conditions or surgical procedures.
Patients have the responsibility to inform medical personnel if they do not understand a proscribed treatment or medication.
Patients have the responsibility to maintain regular scheduled preventative health care appointments and to have the proscribed lab tests done.
Patients have the responsibility to follow proscribed treatments and medications unless they specifically decline this treatment verbally and in writing.
Patients have the responsibility to either show for a scheduled appointment or call and cancel 24 hr before hand.
Patients have the responsibility to be pro-active in their health care and to view the Center as their partner.

If you have a complaint or problem, please let us know. You may speak with the Practice Administrator in person or by telephone. If you prefer to write: send remarks to
Annandale Women & Family Center
2839 Duke St
Alexandria, VA 22314 Phone 703-751-4702 email: info@awfc.net
You may also address complaints to the Dept of Health by writing or calling
Office of Licensure and Credentialing
Virginia Dept of Health
9960 Mayland Drive
Richmond, VA 23233 Phone 800-955-1819
You may also receive a copy of the consumer complaint report from the receptionist or any staff member.

T035

MEDICAL EMERGENCIES

POLICY The Practice maintains equipment, supplies and medications to manage potential emergencies in accordance to guidelines of the American Heart Association

CRNA or Physician maintains a current CPR certification
A person certified in CPR is to be present during abortion procedures

PROCEDURE; Medications for treating cardiopulmonary arrest, respiratory distress allergic reaction, narcotic toxicity, hypovolemic chock and vasovagal shock are maintained in the crash cart.

Monthly inventory is done and expiration dated checked. Expired drugs brought to Administrator attention who replaces them.

Equipment necessary for resuscitation and monitoring are maintained
- Oxygen with appropriate delivery apparatus
- EKG monitor
- Cervical suture supplies

Periodic drills of medical emergency are conducted by the QA committee

CPR certification is documented in personnel files

T075

AMBULATORY HEALTH CARE QUALITY ASSURANCE PROGRAM

Policy
Ambulatory Health Care Quality Assurance (AHCQA) has established lines of authority and responsibility.

The purpose of AHCQA is to define and maintain areas of quality assurance activities.

The Corporation (Metro Medical Centers, Inc) assumes all legal authority and responsibility for quality assurance activities.

The practice administrator assumes overall responsibility and authority for the review and evaluation of each provider and their service.

Administrator maintains a standing AHCQA committee to coordinate QA activities

ACHQA committee manager assumes responsibility for coordinating QA activities

Operation Director provides info regarding QA activities to BOD

Administrator provides information regarding QA activities to the AHCQA committee and the Operation Director

PROCEDURE
AHCQA committee supports staff with inservice meetings. Documentation of orientation and on going staff training are kept in a log. Staff orientation is kept in individual staff file

Responsibility and authority for QA tasks are documented on the QA Task Chart and the QA Organization Chart

Job description of the QA supervisor is filed in the current QA personnel file.

AHCQA COMMITTEE

Representatives on this committee from each department:
- Nursing
- Internal Medicine
- Gynecology
- Aesthetics
- Laboratory

AHCQA committee coordinator is the Administrator

Meetings are held quarterly

T080
T085
T180

Scope of AHCQA Committee is to establish and review:

- services of practice
- patient visits
- medical supervision
- plan of care
- emergency care
- clinical records
- personnel qualifications
- practice evaluation

Minutes of AHCQA committee;

- provided to the Administrator and the Operation Director
- filed in AHCQA file

JOB DESCRIPTION: INFECTION CONTROL SUPERVISOR

POLICY

The Infection Control Supervisor is a provider with experience in the practice setting for 2 yrs
The Infection Control Supervisor is a nurse practitioner, physician or registered nurse
The Infection Control Supervisor is appointed by the Practice Administrator

PROCEDURE
JOB DESCRIPTION OF INFECTION CONTROL SUPERVISOR

Supervisor: Practice Administrator

GENERAL RESPONSIBILITIES;

Implement and evaluate policies and procedures of infection control
Cite guidance documents
Provide annual review of all policies and procedures and provide the Administrator with updates or recommendations.
Provide training for all personnel on a quarterly basis

SPECIFIC RESPONSIBILITIES

Implement procedures of infection control:
- Hand Hygiene
- Protective Equipment
- Staff Education
- OSHA compliance
- Environment
- Equipment medical and business
- Respiratory Hygiene
- Sterilization of equipment and storage
- Linen

T085
T165

JOB DESCRIPTION
QUALITY ASSURANCE SUPERVISOR

POLICY
The QA supervisor is a provider with experience in the practice setting for two years.
The QA supervisor is either a nurse practitioner or a physician or registered nurse

PROCEDURE
JOB DESCRIPTION: QUALITY ASSURANCE SUPERVISOR

Supervisor: Practice Administrator

GENERAL RESPONSIBILITIES;

Implements and evaluates all QA policies set by the Administrator
Assign staff members to serve on the QA committee
Hold quarterly meetings
Provide the Administrator with all deficiencies found with a list of recommended corrections
Maintains a Log of all deficiencies and actions recommended with follow-up of compliance

SPECIFIC:

Establish and review:
- Services of practice
- Patient visits
- Medical supervision
- Plan of car
- Emergency care
- Clinical records
- Personnel qualifications and files
- Practice Evaluation

T085
T265
T180

PHYSICIAN PRIVILEGES

ABORTION PROVIDER

POLICY

Abortions both surgical and medical are performed by a licensed physician with at least one year experience in providing general gyn services and surgery.

PROCEDURE

The following privileges are granted to the physician providing abortion/gyn services:

Abortion up to 12 weeks gestation for surgical abortion
Abortion up to 7 weeks gestation for medical abortion
Insertion of IUD
Colposcopy
Endometrial Biopsy
STD testing and treatment
Diagnostic D&C
Provision of all standard of care contraceptive methods
Uterine ablation
Cervical biopsy
Ultrasound abdominal and vaginal for gestational dating and gyn diagnostic
Pap smears
Testing and treatment of all vaginitis etiologies
Complete gyn examinations

T105
T110

NURSE PRACTITIONER PRIVILEGES

POLICY:

Nurse Practitioners and Certified Nurse Anesthetists are licensed to order, prescribe, dispense and dispose of medications. They are further licensed to diagnose and proscribe treatments of care within their specialty.

PROCEDURE;

The following privileges are granted to gyn and adult NP
in the provision of abortion services:

order pre testing labs and ultrasounds for abortion patients.
Order pre-medications for pain for abortion patients
Order post abortion medication and contraceptive methods
Sign for the arrival and disposal of Class II-V medications
Perform pelvic examinations and ultrasound imaging
Order STD testing and treatment

The following privileges are granted to the CRNA
in the provision of abortion services

order pre-testing labs and ultrasounds for abortion patients
order pain medications for pre abortion patients
obtain written consent for sedation from patients
sign for the arrival and disposal of Class II-V medications
dispense conscious sedation medications
monitor patients during conscious sedation
dispense emergency drugs and treatments during medical emergencies
monitor patients until discharge criteria for Recovery Rm I are met
maintain inventory control of Class II-V drugs and crash cart drugs

T105

PATIENT COMPLAINT POLICY

Procedures for receiving patient complaints are developed and implemented by the Practice Administrator.

Patients have the right to make complaints regarding their treatment either to staff or to an outside agency.

The Practice Administrator is responsible to develop and implement a plan to give each patient a copy of their Rights And Responsibilities. This plan should contain provisions of accepting patient complaints, review of complaints by the QA committee, resolution verification, and staff training to address the complaint.

Documentation of patient complaints and actions taken are kept for three years.

PROCEDURE:

Patient right and responsibilities and methods of filing complaints are given to each patient. This document includes the name of the facility, address, phone number and the state agency, address and phone number for filing complaints. This is posted in two prominent places in the facility.

Abortion patients sign a form stating they have received the document, they understand it and they know how to file a complaint both with the facility and with the state agency. This form is maintained in the patient record

The QA supervisor monitors that patients are given the form and that the procedure is posted.
A copy of the form is included in the P&P Manual
A log book of complaints filed containing date of receipt, investigation, and resolution of complaint is maintained for five years.

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T 140
T 150
T 155

PATIENT COMPLAINT PROCEDURE:

Patients have the right to make complaints regarding their treatment either to the staff or to an outside agency.
Complaints made in writing will be kept in a file for three years.
Complaints will be discussed at the regularly scheduled staff meetings. The discussion will be used to determine how the incident could have been averted or handled in another more positive way.
The Administrator will investigate each complaint, review the findings and issue a resolution. Staff members and patient involved in the complaints will be notified of the resolution within a thirty day period.

All new patients will be given the HIPPA consent form and offered to view the complete "Privacy Practice Notice" which will be kept at the front intake desk.

Patients will be given a copy of their rights and responsibilities on admission.
If the patient is unable to understand this, she/he will be given opportunity to discuss this with a staff member. Patients seeking abortion services will be offered the Virginia pamphlet describing abortion and alternatives. All new primary care and gyn patients will be given a 'new patient package' including information on living wills, gun safety, and bicycle and helmet safety.

PATIENTS RIGHTS AND RESPONSIBILITIES

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Patients have the right to restrict information sharing to other family members or friends or employers or those designated.
Patients have the right to informed consent of all procedures
Patients have the right to appropriate referrals for services not provided by our Center.
Patients have the right to a complete copy of their records.
Patients have the right to file a complaint if they feel their rights were violated.
Patients have the right to participate in the treatment plans of their care.

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Patients have the responsibility to disclose any past medical conditions or surgical procedures.
Patients have the responsibility to inform medical personnel if they do not understand a proscribed treatment or medication.
Patients have the responsibility to maintain regular scheduled preventative health care appointments and to have the proscribed lab tests done.
Patients have the responsibility to follow proscribed treatments and medications unless they specifically decline this treatment verbally and in writing.
Patients have the responsibility to either show for a scheduled appointment or call and cancel 24 hr before hand.
Patients have the responsibility to be pro-active in their health care and to view the Center as their partner.

If you have a complaint or problem, please let us know. You may speak with the Practice Administrator in person or by telephone. If you prefer to write: send remarks to
Annandale Women & Family Center
2839 Duke St
Alexandria, VA 22314 Phone 703-751-4702 email: info@awfc.net
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You may also receive a copy of the consumer complaint report from the receptionist or any staff member.

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2839 Duke St
Alexandria, VA 22314

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IF YOU HAVE A PROBLEM OR COMPLAINT

Please let us know if you have a problem or complaint. Usually we are able to resolve this immediately. Our practice administrator is available to meet with you in person or speak with you on the phone. If you prefer to send your complaint in writing send to our center at:

Annandale Women & Family Center
2839 Duke St
Alexandria, VA 22314
Phone 703-751-4702

You may also leave comments on-line at our email: info@awfc.net

We appreciate your feedback and do everything possible to improve our quality of care.

There are consumer complaint forms which are available. Just ask the receptionist for a copy.

You may also file complaints with the Virginia Dept of Health

Office of Licensure and Certification
Virginia Dept of Health
9960 Maryland Drive
Richmond, VA 23233
phone: 800-955-1819

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Personnel records

Potential personnel must complete a written application including references.
All licensed personnel must submit current license, malpractice insurance certification, DEA

All staff are required to complete the orientation pkg with signatures before the probation period has expired. Copies of orientation completion is kept in individual employee files.
OSHA and Infectious Disease Prevention forms are provided, signed and filed in employee file

Administrator is responsible to update all licensed medical personnel files on annual basis

Personnel are given copy of Personnel Policies and appropriate orientation forms at hiring.

All personnel are given an annual evaluation based on their job description with their direct supervisor - this is done and documented in their individual file.

All staff must attend staff training regarding OSHA Bloodborn pathogens, and safety precautions. Annual training of Infection Control are provided

Records of scheduled Infection Control and Employee Safety Training are maintained by the Practice Administrator. Evidence of attendance is maintained in staff files.

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T165

INFECTION PREVENTION

Policy and Procedures

The practice will follow all recommendations established by the CDC for ambulatory health care facilities This includes adherence to all local, state and federal requirements regarding reportable disease and outbreak reporting.

The Infection Preventionist has a job description which is maintained in her file and given to her. The Infection Preventionist performs annual review of policies and makes recommendation for change and updates in writing. This documentation is given to the PA.
Documentation of the IP training in infection control is maintained in the staff file

The practice will comply with all recommendations established by the CDC for the screening of sexually transmitted diseases including appropriate responses to positive testing.

Sinks used for hand washing in the abortion treatment room, the soil room and laboratory have wrist or elbow operated handles. There is sanitizer available in both recovery rooms.
All medical furniture must have intact exteriors which are able to be sanitized.
Stethescopes, blood pressure monitors and thermometers are cleaned with spray disinfectant after each use.
Medical grade disinfectant cloths are used to clean equipment and countertops.
Sponges are used to clean instruments before sterilization and are soaked for three minutes in 10% bleach water between cleaning. Sinks are cleaned and sprayed with 10% beach water in between instrument cleaning.
All sterile supplies are kept in closed cabinets at wall level. Sterile supply rooms are monitored for ventilation, humidity and temperature.

Procedures are evaluated by the AHCQA Committee

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INFECTION CONTROL POLICY AND PROCEDURES

Hand Hygiene
Before touching any patient even if gloves are used
Before exiting patient area after touching patient or patient environment
After contact with blood, body fluids or wounds even if gloved
Prior to performing any aseptic task eg, starting IV; taking blood
Moving from contaminated body site to clean body site
After removing gloves
Preferred method of hand hygiene is soap and water

Protective Equipment
PPE personal protective equipment is wearable equipment intended to protect staff from exposure to or contact with infectious agents. Eg gloves, face shields, goggles, gowns
Use of gloves in situations of possible contact with blood or body fluids or non intact skin; use of gown to protect skin and clothing where contact of blood or body parts anticipated; use of mouth eye and nose protection when there is anticipated likelihood of splash or spray of blood or body fluid. Hand hygiene is always final step after removing and disposing of PPE

Education
All personnel must be educated on proper selection and use of PPE; removal and disposal of PPE

Implementation of OSHA bloodborne standards is expected by all personnel

Cleaning and disinfection of environmental surfaces:
Policies and procedures of cleaning must be followed including:
Surfaces in proximity to patient
Use of EAP disinfectants with claims for use in health care
Mfg recommendations for cleaners and disinfectants - amount, dilution, contact time and disposal

Medical Equipment
All reusable equipment must be cleaned and maintained according to mfg instructions

Critical items - surgical instruments must be sterilized before each use.
Semi-critical items- colposcopy and ear irrigation must be cleaned with high level disinfection prior to reuse
Noncritical items - blood pressure cuffs should undergo low or intermediate level disinfection
Environmental surfaces - in contact with patients (exam tables) intermediate level disinfection unless there is contamination with body fluid then high level
Environmental surfaces- that are not in contact with patient (floors, walls) low level disinfectant

Respiratory Hygiene

Policy to contain respiratory secretions in patients and individuals having signs and symptoms of URI especially accompanied with fever

Signs in waiting area with instructions for patients to cover mouth and noses when sneezing or coughing.
Use and disposal of tissue
Hand hygiene after contact with respiratory secretions

Masks kept at reception desk for patients and others with symptoms upon entry to office

Masks in each exam room for patients and staff use

LINEN

Any linen contaminated with body fluids must be soaked in 10% bleach solution for 1 hr. in a container in the dirty utility room. After soaking, this linen is rinsed and dried in a drying machine before being placed in the soiled lined receptacle.

A biohazard collection bin is kept in the recovery room #1 for all contaminated linen. Contaminated linen is kept separate from other soiled linen.

Linen is cleaned in-house. Water temperature of the hot water heater is set at 160 F and linen is cleaned on 'hot' temperature. The sorting and processing of the linen is done in the clean area and away from all trash and bio-hazard containers. Linen is stored in closed wall cabinets.

Personnel Policies and Procedures

Each employee is to receive a copy of the Personnel Policies at hiring.
Potential employees are to be screened for previous work experience, references, license revocation and substance abuse violations.

All employees are placed on 90 day probation. During this time they must complete the general and job specific forms. They are to work under close supervision until deemed fit to work in an independent nature by the Administrator.

All immunization records are to kept in the employee file. Employees not immunized against Hep B will be offered this at the Center.
All employees must undergo an annual TB testing which is maintained in the employee file.
Health records of employees are documented on a separate form kept in the employee file

All licensed personnel must submit current proof of licensure.
All personnel must submit proof of citizenship or work permits.
All licensed personnel must have license verification performed by the Administration.
The verification of license and the license are maintained in the employee file.

All licensed physicians and nurse practitioners are required to carry their own malpractice. Annual proof must be provided to the Center Administrator. Physician and Nurse Practitioner credentialing certification must be provided as dated expiration. All certification and insurance documentation is maintained in the employee file

Personnel with access to Class II-V medications must have a state agency conducted criminal investigation report. This report is maintained by the PA. Any infractions of policy and procedures of Class II-V medications must be reported to the OLC. Documentation of the infraction is maintained in the staff file. The QA and PA monitor the personnel for a minimum of one year.

Clinical Privileges of licensed physicians and advanced nurse practitioners are adopted by the BOD. Copies of said privileges are kept in staff files and given to the provider.

All personnel must participate in scheduled disaster drills, CPR training and 70% of staff meetings.

All personnel must complete the OSHA and HIPPA training as set forth in the PROCEDURE MANUAL

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QUALITY ASSURANCE
STAFF
POLICY AND PROCEDURE

All professional staff are required to maintain current credentialing and licensure. Copies of current licensure and credentialing are kept in the employee file. Verification of licensure is obtained and documented in each staff file.
Employees with access to the Class II-V medications kept in the office are subject to criminal investigation. CI reports are maintained by the Practice Administrator

New employees are required to complete specific job training orientation with specific attention to OSHA bloodborn pathogens, CLIA regulations, and practice Infection Control policies. Proof of orientation training is maintained in staff file. Annual QA training and Infection Prevention training are held and documentation of attendance maintained in each staff file. Practice Administrator provides Personnel Policies to each new employee and as they are updated.

An employee contact in case of emergency is maintained by the Practice Administrator.

Staff evaluations are performed on an annual basis and are correlated with the specific job description. Documentation of evaluation is maintained in the staff file..

Complication statistics are compiled for each physician providing abortion services. A log of complications including infections is kept in the providers staff file and in the log. Infectious diseases designated reportable are reported to the health department.

Licensed staff are required to wear name tags with license designation when in contact with patients.

POLICY & PROCEDURE:
CONTROLLED SUBSTANCE RECORDS

Practitioners must maintain inventory of each class I-V substance as classified by the DEA Class I-II records must be maintained separately from other substances.

Records of inventory and administration and disposal are maintained for a two year period. All recording logs must be legible and 'whiting out' is strictly forbidden.
Registered practitioners are those practitioners with the corresponding DEA classification qualification to prescribe the controlled substance.

A DEA registered practitioner is required to keep records of controlled substances which are dispensed to patients, other than by prescribing or administering. Controlled substances which are administered and for which the patient is charged a fee must be recorded.
Registered practitioners are not required to keep records of controlled substances that are prescribed in the lawful course of professional practice, unless the substances are prescribed in the course of maintenance or detoxification treatment. Medications of Class I-V used in conscious sedation anesthesia are subject to inventory record keeping and administration and disposal.

INVENTORY

Each registrant who maintains an inventory of controlled substances must maintain a complete and accurate record of the substance on hand and the date the inventory was conducted.

ADMINISTRATION

Controlled substances administered on site must be recorded on a separate log from the patient chart. The administration of controlled substances log must include date of administration, drug and dose, patient name, and signature of registered practitioner.
The administration log must also contain starting and ending inventory if contained in multi-dose vials. This log requires two signatures of registered practitioners.

DISPOSAL

Disposal of expired, damaged or otherwise unusable controlled substances must be transferred to a registered practitioner who is authorized to receive such materials. This person is called a "Reverse Distributor' A list of Reverse Distributors is maintained by the Administrator. The substance is transferred with a DEA Form 222 for substances of Class I-II. Schedule III-V may be transferred via invoice.

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ANESTHESIA AND MEDICINES

POLICY: Written procedures for accepting, storing, dispensing and disposing of all medication are maintained in the manual. All dispensed medication must have a written order by a qualified provider.(licensed physician, NP, or CRNA)

PROCEDURES:

Monitoring of procedures is done by the Practice Adm. and the QA supervisor

Anesthesia is administered to abortion patients by or under the supervision of a licensed physician. This practice uses only local or conscious sedation anesthesia.

The Practice Administrator maintain procedures addressing criteria for discharge and monitoring the patient.
Persons administrating anesthesia must be current in CPR certification.
Practice Administrator implements procedures to treat anesthesia complications. Crash cart medications are maintained in the procedure room.
Oxygen tanks are stored in a secure rack.

All DEA Class II-V medications are maintained according to the federal and state regulations, to include inventory and reporting theft or according to the Drug Control Act of the Code of Virginia. All drugs shall be stored, administered and dispensed in accordance with federal and state regulations. Class II-V medications are stored in the crash cart under double lock. Logs of inventory are kept separate from patient records and contain the name of the drug, date and amount at arrival, amount dispensed and amount discarded. Logs of Class II-V drugs require two signatures. All logs must be written in legible writing with no 'white outs' allowed. Errors are to be noted by drawing ONE straight line through the entry and the word 'error' written above it.

Medicine intended to induce termination of a pregnancy shall only be prescribed, dispensed or administered by a licensed physician.

Procedures for anesthesia equipment preventative maintenance and calibration are implemented by the Practice Administrator. Procedures of storing and maintaining medicines are implemented by the Practice Administrator and monitored by the QA supervisor..

Oral medications are dispensed in a single dose container to the patient. Medications are not to be touched by bare hands of nursing staff.
Multi-dose vials are labeled on date of opening and discarded after 28 days. All medications are checked for expiration dates at the weekly and monthly cleaning. The exception is Class II-V and crash cart medications which are checked by the CRNA on each procedure day. IV solutions are checked weekly for expiration. IV solutions taken out of the outer wrapping are labeled to date of unwrapping and labeled 14 days thereafter as to expiration.

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INVENTORY - CONTROLLED SUBSTANCE

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DATE	DRUG	AMOUNT ON HAND	SIGNATURE & DEA #
			T 285

DISPOSAL CONTROLLED SUBSTANCE

DATE	DRUG	AMOUNT	REASON		SIGNATURE # 1	SIGNATURE # 2
			EXPIRED	CONTAMINATED		
						T285

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DATE	DRUG	USED	PATIENT	BEGINNING INVENTORY	END INVENTORY	SIGNATURE # 1	SIGNATURE #

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MEDICAL RECORDS

POLICY Documentation of any patient visit is of extreme importance.
Abortion medical records include several forms to be completed by patient
Records are maintained according to HIPPA regulations
All medical records are maintained in safe storage for five years from the time of admission
QA reviews documentation and reports any discrepencies to the Administrator along with suggested actions of remedy.
OLC is to be notified of the sale or closure of facility

PROCEDURE

A complete listing of what is included in the abortion chart is as follows:
Ultrasound report and consent
Abortion chart 4 part
Consents - procedure (medical/surgical) 24 hr consent, minor consent of parent, any outside lab reports Conscious sedation record also includes npo check list, anesthesia record. Patient acknowledge of receipt of rights and responsibilities and method of filing a complaint and HIPPA regulations and post ab instructions..
Emancipated minor court order
Copies of records to a 3rd party must have written approval of patient.
Charting must be legible and in black ink
Pre-op and discharge orders must be signed by physician or NP or CRNA
Medicine allergies are noted on the top of each page
All consents must be witnessed by a staff member at least 21 yrs of age
Charting on progress notes is done in the SOAP manner
Subjective, Objective, Assessment, Plan
Discharge assessment must be charted on abortion patients.
Medications are noted as to name, dose, time, route and person administering-if injection also noted lot number and expiration date
All outside labs and imaging are to be signed by attending physician or NP with instructions for follow up
Abortion discharge instructions are signed by patient and copy kept in record
QA reviews include completion of chart, proper use of forms, evidence of witness and compliance of Practice policies and procedures

In the event of closure of practice, the storage and status of records will be reported to the OLC

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MEDICAL PROCEDURES

POLICY:
All medical procedures including blood drawing, ultrasound, EKG, ear irrigation, medication dispensing which may be performed by a technician or nurse require an order written or verbal from a qualified practitioner such as a physician or nurse practitioner

PROCEDURE

Written orders should be noted on the documentation of the specific procedure or on progress notes.

Abortion pre-operative medication must be signed by the physician or nurse practitioner in attendance.

7340

DEATH

POLICY The practice reports deaths of a patient, visitor or staff member to the OLC

PROCEDURE As the practice Administrator is made aware of a death of a patient, staff member or visitor she will report said death to the OLC within 24 hr of this knowledge

T355

FACILITY MAINTENANCE

POLICY The practice will keep in good repair all heating and air conditioning and hot water heating equipment.
Areas used by patients will be kept in good repair and free from hazards

PROCEDURE Emergency lighting will be maintained in operable condition
Filters on HAVAC units will be replaced according to mfg criteria
Paint will be lead free
Corridors will remain free of obstacles
Hazardous liquids and chemicals will be maintained out of patient accessibility
No supplies are stored under sink cabinets
Brooms and mops are stored in a separate broom closet

QA on facility maintenance will be done and reported to Administrator on an annual basis

PREVENTATIVE MAINTENANCE

POLICY

Preventative maintenance is provided according to mfg recommendations
Maintenance is performed and recorded by staff
Annual certification of PM is performed and recorded according to mfg recommendations

PROCEDURE

General: Lab equipment, refrigerators, sedation equipment, suction equipment, EKG exam lights, colposcope, opthalmascope, otoscope, ear irrigation, spirometry and elos equipment

Specific: Centrifuge: Weekly Unplug the equipment: Clean each tube holder using a large currette swab with alcohol. Wipe the external and internal lid surfaces.
Every six months or if there is a tube breakage: Follow mfg instructions for rotor removal and cleaning. This is done with isopropyl alchol. DO NOT SUBMERGE THE CENTRIFUGE IN LIQUID

Refrigerators: temperature must be recorded and maintained within criteria
Oxygen tanks must be maintained in proper stands to avoid tipping
Suction equipment is cleaned after each use and tubing replaced. Suction must meet appropriate level
EKG must be cleaned after each use with alcohol. Calibration is required annually
Exam lights are cleaned after each use. Monthly inspections are done to insure proper working order and integrity of the cord
Colposcope is cleaned after each use. Calibration is done annually
opthalmascope and otoschope are cleaned at the day end cleaning and stored in the battery charger
Ear irrigation is cleaned after each use. Disposable tips are discarded. Tubing is dried before storage
Spirometry is cleaned after each use. Disposable tips are discarded
Elos equipment is cleaned after each use. Monthly maintenance is performed and recorded
Fire extinguisher inspected annual and recorded exp. date and contents

A log of annual inspection of medical equipment is maintained by the Practice Administrator
Any deficiencies are documented and strategy of correction included.

T380

FIRE AND ALARM SYSTEMS

POLICY The Practice maintains facility which is in compliance with state and local fire safety regulations.

PROCEDURE

Smoke detectors in hallways away from usual staffing pattern are required
Fire extinquisher is maintained in operable condition in a space accessible to both ends of the facility
Fire inspections are scheduled with the local Fire Marshall

Fire drills are conducted on a regular and unscheduled basis by the Practice Administrator

T390