State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-0019	A. BUILDING _____ B. WING _____	12/06/2012

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

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T 000	12 VAC 5- 412 Initial comments An unannounced Licensure re-visit to the initial licensure survey conducted August 1, 2012 through August 2, 2012, was conducted December 5, 2012 through December 6, 2012 by two Medical Facilities Inspectors from the Office of Licensure and Certification, Virginia Department of Health. At the time of the Revisit survey complaint #2012-AC-019 was investigated and the allegations were unsubstantiated. The following citations were not corrected by the facility, and therefore were re-cited: 12 VAC 5-412-170H- Personnel 12 VAC 5-412-220B- Infection Prevention 12 VAC 5-412-270 - Equipment and Supplies. The agency was not in compliance with 12 VAC-412 Regulations for the Licensure of Abortion Clinics (effective 12/29/2011). Deficiencies cited follow in this report.	T 000		
T 095	12 VAC 5-412-170 H Personnel H. Personnel policies and procedures shall include, but not be limited to: 1. Written job descriptions that specify authority, responsibility, and qualifications for each job classification; 2. Process for verifying current professional licensing or certification and training of employees or independent contractors; 3. 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	T 095	RECEIVED FEB 20 2013 VDH/OLC T 095 **PERSONNEL – SIGNED JOB DESCRIPTION** **12 VAC 5-412-170 H Personnel** PLAN OF CORRECTION: *BACKGROUND:* *The OLC revisit was during our Annual Staff review process. The job descriptions had not yet been returned to employee files.* Correction: The Job descriptions have been signed and returned to employee files for all completed staff reviews. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. The implementation of Governing Body and the QAC check list will prevent recurrence. Measures to maintain compliance: Staff trained to new process/procedure. Governing Body will review annually and address any emergent issues and take corrective actions. No patients were affected by this deficiency	02/15/13

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

Rosemary W Cadden — Director of Patient Services — 2-14-2013

PRINTED: 01/30/2013
FORM APPROVED

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T 095	Continued From Page 1 licensing or certification standards to the appropriate board within the Department of Health Professions. This RULE: is not met as evidenced by: Based on staff interview and employee record review, the facility staff failed to ensure job descriptions for 4 (four) of four (4) employees were signed and included in the employee personnel files. The findings included: On 12/5/12 at approximately 2:00 p.m., employee files were reviewed. Four (4) of four (4) employee files reviewed revealed no signed job description in the personnel file. Employee # 1 stated, "I have the job descriptions completed, I just have not gotten them signed yet and placed in the employees files."	T 095		
T 170	12 VAC 5-412-220 B Infection prevention B. Written infection prevention policies and procedures shall include, but not be limited to: 1. Procedures for screening incoming patients and visitors for acute infectious illnesses and applying appropriate measures to prevent transmission of community acquired infection within the facility; 2. Training of all personnel in proper infection prevention techniques; 3. Correct hand-washing technique, including indications for use of soap and water and use of alcohol-based hand rubs; 4. Use of standard precautions; 5. Compliance with blood-bourne pathogen requirements of the U.S. Occupational Safety & Health Administration. 6. Use of personal protective equipment;	T 170	T 170 Infection Prevention – Expired Medication. Supplies **12 VAC 5 – 412-220B** Correction: The expired medications , fluids and supplies were removed and discarded Medication cart monthly checked as scheduled. Discussed with consultant how to address medicines that expire between scheduled checks. Consultant amended existing policy to include marking those items with a green sticker as well as indicating on the check list. (see attached). Incident Kits added to consultant monthly checks. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Amended policy given to staff and rereviewed procedures for point of use cross checks for items used in patient care. Measures to maintain compliance: Staff trained to new process/procedure. Governing Body will review annually and address any emergent issues and take corrective actions. No patients were affected by this deficiency	12/5/12 12/07/12 2/12/13

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T 170	Continued From Page 2 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 observations, interview and record review the facility failed to implement its policies related to safe injection practices related to expired medications available for administration. The findings included: Observations conducted on December 5, 2012 at 11:06 a.m., with Staff #1 revealed the emergency cart had the following expired medications: Two injectable Atropine Sulfate 1 mg (milligram), which had expired "1 Dec 2012" and Four vials of Flumazenil 0.5 mg/5 ml (milliliter), which had expired "11/12". Staff #1 reported the facility had a new system in place for all medications to be checked monthly. The documentation revealed the cart had been check for the month of November 2012. Staff #1 reported the cart was due to be checked mid month December 2012. An observation on December 5, 2012 at 11:33 a.m., with Staff #1 in "Procedure Room 1" revealed an incident kit available for use during procedures. A label on the incident kit indicated staff had last documented checking the kit on "3/27/12". Within the incident kit the following items were expired: One 250 ml bag of Dextrose 5% in Lactated	T 170		

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T 170	Continued From Page 3 Ringers, which had expired 6/11; One 250 ml bag of Dextrose 5% in Lactated Ringers, which had expired 9/11; and One 250 ml bag of Normal Saline 0.9 %, which had expired 3/12. Staff #1 reported staff should have pulled the IV fluids, which had expired in 2011 during the documented check of the incident kit on 3/27/2012. Staff #1 verbally acknowledged the expired medications and IV fluids were available for administration to patients.	T 170		
T 290	12 VAC 5-412-270 Equipment and supplies An abortion facility shall maintain medical equipment and supplies appropriate and adequate to care for patients based on the level, scope and intensity of services provided, to include: 1. A bed or recliner suitable for recovery; 2. Oxygen with flow meters and masks or equivalent; 3. Mechanical suction; 4. Resuscitation equipment to include; as a minimum, resuscitation bags and oral airways; 5. Emergency medications, intravenous fluids, and related supplies and equipment; 6. Sterile suturing equipment and supplies; 7. Adjustable examination light; 8. Containers for soiled linen and waste materials with covers; and 9. Refrigerator. This RULE: is not met as evidenced by: Based on observations, interview and record review the facility failed to ensure emergency medications and intravenous fluids available for	T 290	Equipment and Supplies Expired Medication, Supplies **12 VAC 5 – 412-270** Correction: The expired medications , fluids and supplies were removed and discarded Medication cart monthly checked as scheduled. Discussed with consultant how to address medicines that expire between scheduled checks. Consultant amended existing policy to include marking those items with a green sticker as well as indicating on the check list. (see attached). Incident Kits added to consultant monthly checks. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Amended policy given to staff and rereviewed procedures for point of use cross checks for items used in patient care. Measures to maintain compliance: Staff trained to new process/procedure. Governing Body will review annually and address any emergent issues and take corrective actions. No patients were affected by this deficiency	12/5/12 12/07/12 2/12/13

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T 290	Continued From Page 4 administration to patients were not expired. The findings included: Observations conducted on December 5, 2012 at 11:06 a.m., with Staff #1 revealed the emergency cart had the following expired medications: Two injectable Atropine Sulfate 1 mg (milligram), which had expired "1 Dec 2012" and Four vials of Flumazenil 0.5 mg/5 ml (milliliter), which had expired "11/12". Staff #1 reported the facility had a new system in place for all medications to be checked monthly. The documentation revealed the cart had been check for the month of November 2012. Staff #1 reported the cart was due to be checked mid month December 2012. An observation on December 5, 2012 at 11:33 a.m., with Staff #1 in "Procedure Room 1" revealed the incident kit available for use during a procedure. A label on the incident kit documented staff had last checked the kit on "3/27/12". Within the incident kit the following items were expired: One 250 ml bag of Dextrose 5% in Lactated Ringers, which had expired 6/11; One 250 ml bag of Dextrose 5% in Lactated Ringers, which had expired 9/11; and One 250 ml bag of Normal Saline 0.9 %, which had expired 3/12. Staff #1 reported staff should have pulled the IV fluids, which had expired in 2011 during the documented check of the incident kit on 3/27/2012. Staff #1 verbally acknowledged the expired medications and IV fluids were available for administration to patients.	T 290		

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FALLS CHURCH HEALTHCARE CENTER

Admin Policies and Procedures Manual

To ensure compliance with the *Emergency and Temporary Regulations for Licensure of Abortion Facilities* (12 VAC 5-412) that expire 12/31/2012

Department: Patient Care & Quality Assurance	**Policy Description: Expiration of items to be used for patient care**
Page: 1 of	**Replaces Policy Dated**: 9-30-2002
Effective Date: 8-25-2012	**Reference Number:** VAC 5-412
Approved:	Revised 12/15/12

Scope:	All staff with patient care responsibilities, Consultants and Medical Director
Purpose:	To provide safe and appropriate patient care consistent with Infection Control and Quality Assurance policies all staff and healthcare workers will help to ensure suitability of medications, solutions, reagents, supplies and equipment used in patient care
Policy:	Staff will provide best practices to monitor medications, solutions, reagents, supplies and equipment used in patient care and ensure sequence of cross checks for rotation of stock and dated items in addition to following aseptic technique and infection prevention when handling or preparing medications, administering injections and procurement and sampling of blood. Before patient use or administration all medications, IV solutions, equipment and supplies will be rechecked at point of use for expirations and condition in accordance with expiration and maintenance procedures.
Procedure:	1. Annual Preventive Maintenance (PM) will be conducted on all equipment for patient care by contract. The Log of PM will be kept in the CLIA book and overseen by Surgical Coordinator and Assistant Administrator. 2. Monthly review of expiration of medications, IV solutions and medical carts will be conducted by contract or by in-house medical staff. The log of monthly reviews will be kept on the medical cart with items expiring within the month marked with green labels, noted on the log and/or cart. Assistant Administrator will be notified in a timely manner of all shortages and/or expired medications to be replaced. 3. All Laboratory specimen testing reagents will be verified daily before use with patient specimen as detailed in the CLIA procedure manual. Daily controls will be recorded on the Quality Control Log and maintained in the Laboratory. All controls, cassettes etc. will be monitored for expiration dates and as needed labeled date opened. Medical Director and Lab Director oversee implementation. 4. All medical devices and instruments will be cleaned and/or sterilized, dated and initialed by instrument tech who prepared the items. The sterilized items will be stored, covered, at point of use, care taken to avoid contamination and in a way to preserve the packaging of the instruments. Rotate stock with older items being used first. Event related shelf-life guidelines will be used. Event-related shelf life for sterilized items recognizes that autoclaved medical instruments would remain sterile indefinitely, unless an event causes them to become contaminated, e.g., torn or wet packaging. Packages must be examined before use to ensure integrity and dryness. Sterile wrap will be inspected prior to patient use, if damaged, torn, open or water stained the items are not to be used but returned for reprocessing. Upon opening any instrument the sterilization indicator is to be checked for color change, if not sterile the items are not to be used but returned for reprocessing. The Guideline Manual for Autoclaving are to be followed and spore testing done by contract. Log of these verifications are kept and overseen by Gynecology Coordinator. 5. All medical supplies such as gloves, syringes, IV solutions, needles, cannulas, will follow event related shelf-life guidelines recognizing they would remain sterile indefinitely, unless an event causes them to become contaminated, e.g., torn or wet packaging or if the manufacturer specifies otherwise. 6. All items used in patient care will be cross check at point of use before patient care. Before patient use or administration all medications, IV solutions, equipment and supplies will be rechecked at point of use for expirations and condition in accordance with expiration and maintenance procedures.
Reference:	CDC guidelines shelf-life of packaged sterile items, Manufacturers guidelines for shelf life of their products

Falls Church Healthcare Center
Policy and Procedure Manual

Department: Infection Prevention	**Policy Description:** Injection Safety
Page: 1 of 1	**Replaces Policy Dated**: 4/01/2003
Effective Date: 4/1/12	**Reference Number:**
Approved:	

Scope:	Clinical Staff
Purpose:	Injection safety includes practices intended to prevent transmission of infectious diseases between one patient and another, or between a patient and healthcare provider during preparation and administration of parenteral medications and to assure medications, solutions and equipment are suitable for patient use.. Aseptic technique- the manner of handling medications and injection equipment to prevent microbial contamination – will be used.
Policy:	All healthcare workers will adhere to the safe injection practices by following aseptic technique and infection prevention when handling or preparing medications, administering injections and procurement and sampling of blood. Before patient administration all medications, IV solutions, equipment and supplies will be rechecked at point of use for expirations and condition in accordance with expiration policies.
Procedure:	Dispose of used needles at the point of use in a sharps container that is closable, puncture-resistant, and leak-proof per Medical waste and OSHA guidelines. Before use on patient medications, solutions and dated supplies are to be checked at point of use in accordance with FCHC policy. **ASEPTIC TECHNIQUE** All injectables should be accessed in an aseptic manner. Proper hand hygiene should be performed before handling medications, and if a medication vial has already been opened, the rubber septum should be disinfected with alcohol prior to piercing it. The use of a new sterile syringe and needle should be used to draw up medications while preventing contact between the injection materials and the non-sterile environment. Syringes and needles should be used for a single patient only and for a single procedure. The storage and preparation of medications and supplies should be performed in a designated area that is not where contaminated items are placed. Never store needles and syringes unwrapped as sterility cannot be assured. A single use medication should be administered to one patient only. If a multi-dose medication vial must be used for more than one patient, the vial should only be accessed with a new unused sterile syringe and needle even if the vial is dedicated to a single patient. **IV SOLUTIONS** Single-use IV solutions should be administered to one patient only, during one treatment. **FLUSHING** Use single dose containers for flush solutions whenever possible. Never use in use intravenous solution containers to obtain flush solutions.
Reference:	**12VAC5-412-220-B7** (http://www.cdc.gov/injectionsafety/)