State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	12 VAC 5-412 Initial comments An announced Initial Licensure First Trimester Abortion Facility inspection was conducted at the above referenced facility on May 15, 2012 through May 16, 2012 by three (3) Medical Facilities Inspectors from the Virginia Department of Health's, Office of Licensure and Certification. The facility was out of compliance with the State Board of Health 12 VAC 5-412, Regulations for First Trimester Abortion Facility's effective December 29, 2011. Deficiencies were identified, cited, and will follow in this report.	T 000	RECEIVED AUG 0 8 2012 VDH/OLC	
T 070	12 VAC 5-412-170 C Personnel C. Each abortion facility shall obtain a criminal 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 employee record review, center document review, and staff interview, the center staff failed to ensure a criminal record check was obtained for 8 of 10 employees who provided access to controlled substances. Employee #'s 3, 7, 8, 11, 15, 16, 20, and 21. On 5/15/12 at 1:00 p.m., employee records were reviewed. Ten records were included for employees who provided access to controlled substances within the center. For 8 (eight) of the 10 (ten) records, no criminal background check was found. The center policy and procedure "Personnel Policies" was reviewed and evidenced the following, in part: "Criminal history checks will be conducted for staff with access to controlled	T 070	T070 Criminal background checks will be obtained for all employees whose job duties provide access to controlled substances. An item will be added to the orientation checklist for every employee whose job duties provide access to controlled substances that a criminal background has to be obtained. Personnel policy revised to include need for criminal background checks. Job descriptions for those staff will also include need for a criminal background check. Personnel files will be reviewed for completeness on an annual basis. The administrator is responsible for ensuring that the criminal background check is obtained as well as being responsible for reviewing job descriptions and files. Completion date June 28, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	7-9-12

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 070	Continued From Page 1 substances." On 5/16/12 at 9:30 a.m., Staff #2 was interviewed regarding the criminal record checks being completed for the 8 employees. Staff #2 stated the criminal background checks had not been done. No further information was provided by the end of the survey.	T 070		
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 employee record review and staff interview, the center staff failed to ensure cardiopulmonary resuscitation certification (CPR) training was received and documented for 7 of 10 licensed/certified employees. Employee #'s 3, 5, 7, 8, 15, 16, and #20. No evidence of CPR training/recertification was present in the employee records. The findings included: On 5/15/12 at 1:00 p.m., employee records were reviewed. Of the 10 (ten) licensed/certified employee records, 7 (seven) did not have evidence of CPR training/recertification. Employees # 5, 7, 8 and 16 were Certified Registered Nurse Anesthetists, #3 was a Nurse Practitioner, and # 15 and 20 were Registered Nurses. In an interview with Staff #2 on 5/16/12 at 12:00 p.m., he/she stated he/she knew each of the employees held current CPR certifications, however acknowledged the evidence of certification was not present in the employee records.	T 075	T 075 CPR documentation obtained for Certified Registered Nurse Anesthetist and Registered Nurses. CPR training will be added to the orientation list. CPR training will be added to the Personnel Policy. Personnel files will be reviewed for completeness annually. Job descriptions will also include need for CPR training. Administrator is responsible for ensuring certification is up to date. Completion date: June 21, 2012	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 080	Continued From Page 2	T 080	T 080	
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 employee record review, center document review, and staff interview, the center failed to ensure 16 of 24 employees participated in annual infection control training. Employee #'s 2, 3, 4, 5, 7, 8, 9, 11, 12, 14, 15, 16, 19, 20, 21, and 23. The findings included: Employee records were reviewed on 5/15/12 at 1:00 p.m. There was no evidence of annual infection control training for 16 employees. On 5/16/12 at 9:30 a.m., Staff #2 stated the employees had not received annual infection control training. "Most all of our employees have been here a long time and I guess we just became complacent ..." No further information was provided by the end of the survey.	T 080	Fire Safety and Infection Prevention In-Service Training will be conducted initially and annually for staff. This has been added to the orientation checklist. This has been added to Personnel Policy. Documentation of In-service training will be included in each staff member's personnel file as well as a manual dedicated to training documents. The Inservice Training manual will be reviewed annually. Personnel files will be reviewed annually for completeness. Administrator will ultimately be responsible but will assign Infection Control Officer (the Nurse Practitioner) the duty of coordinating training and documentation. Completion date June 28, 2012	
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.	T 085	T 085 Job descriptions will be included in every employee's personnel file. She will sign the job description to indicate that she is aware of the responsibilities of her position. Job descriptions will be reviewed at least annually with new copies given to the employee in the event of revisions. The personnel policy will include procedure for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 085	Continued From Page 3 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 employee record review and staff interview, the center staff failed to ensure job descriptions for employees were reviewed at least annually for 19 of 24 employee records reviewed. Employee #'s 1 through 9, 11, 12, 15, 16, 18 through 21, #23 and #24. The findings included: On 5/15/12 at 1:00 p.m., employee records were reviewed. Of the 24 records reviewed, 19 employees did not have evidence the job description was reviewed at least annually in their personnel record. The employees were as follows: Employee #1 - date of hire (DOH) 10/91, #2 - DOH 1/2008, #3 - DOH 9/2010, #4 - DOH 12/2009, #5 - DOH 8/2010, #6 - DOH 8/2006, #7 - DOH 1992 (no month listed), #8 - DOH 9/2008, #9 - DOH 1978 (no month listed), #11 - DOH 12/2010, #12 - DOH 4/2008, #15 - DOH 4/2011, #16 - DOH 5/2006, #18 - DOH 1992 (no month listed), #19 - DOH 12/2000, #20 - DOH 7/2008, #21 - DOH 1993 (no month listed), #23 - DOH 1/2006, and #24 - DOH 1999 (no month listed). On 5/16/12 at 12:00 p.m., Staff #2 was informed of the findings. No further evidence was provided by the end of the survey.	T 085	T085 cont'd reviewing job descriptions at least annually. Personnel files will be reviewed for completeness annually. Job descriptions will be revised to include the date that the employee received the job description. Administrator is responsible for ensuring job descriptions are provided and employee is aware of her responsibilities. Administrator is responsible for ensuring that job description is reviewed annually. Completion date June 28, 2012	
T 090	12 VAC 5-412-170 G Personnel G. A personnel file shall be maintained for each staff member. The records shall be completely and accurately documented, readily available, and systematically organized to facilitate the	T 090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 090	Continued From Page 4 compilation and retrieval of information. The file shall contain a current job description that reflects the individual's responsibilities and work assignments, and documentation of the person's in-service education, and professional licensure, if applicable. This RULE: is not met as evidenced by: Based on employee record review and staff interview, the center staff failed to ensure all employee records contained a current job description for 6 of 24 employee records reviewed. Employee #'s 2, 3, 4, 11, 15, and #20. No job description was present in the employee records when reviewed. The findings included: On 5/15/12 at 1:00 p.m., employee records were reviewed. Of the 24 records reviewed, 6 employees did not have a job description contained in their personnel record: Employee #2 (Housekeeping), #3 (Nurse Practitioner), #4 (Housekeeping), #11 (Registered Nurse), # 15 (registered Nurse), and #20 (Registered Nurse). On 5/16/12 at 12:00 p.m., Staff #2 was informed of the findings. No further evidence was provided by the end of the survey.	T 090	Job descriptions have been added to the personnel files for those staff who did not have them. Orientation checklist includes job descriptions. Personnel policy includes job descriptions must be in the personnel file for each employee. Personnel files will be reviewed annually to ensure completeness. Administrator is responsible for ensuring job descriptions are in each file and that employees are aware of their responsibilities. Administrator is responsible for annual review of files and job descriptions. Completion date June 18, 2012	T090
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	T 170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 170	Continued From Page 5	T 170		

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 observations, interviews and record review the facility failed to ensure:

1. That staff wore the correct personal protective equipment (PPE) related to risk of exposure to blood and body fluids for one (1) of one staff observed in the "soiled" utility room.

2. The development of a procedure/process to monitor staff's adherence to the facility's infection prevention practices. The development of a process for retraining staff annually to infection prevention practices.

3. That staff had documented infection prevention training for sixteen (16) of twenty-four (24) employee records reviewed. (Employee # ' s 2, 3, 4, 5, 7, 8, 9, 11, 12, 14, 15, 16, 19, 20, 21, and 23)

The findings included:

1. Observations and interview were conducted on May 15, 2012 from 12:10 p.m. through 1:30 p.m. with Staff #5 in the "Soiled" utility room after two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 170	Continued From Page 6 (2) procedures. Staff #5 wore a blue cloth jacket over his/her scrub attire. When questioned related to the type of PPE needed to work or be in the "Soiled" utility room; Staff #5 stated, "I just wear this jacket over my clothes and gloves." Staff #5 denied the need for a mask, face shield or eye protection. Staff #5 did not wear a face shield or eye protection when cleaning soiled items in the utility room. The observation revealed Staff #5 retrieved a re-usable glass suction jar from the pass through opening in the wall between the procedure room and the "Soiled" utility room. Staff #5 emptied the liquid contents, blood and other body fluids, from the glass jars into the utility sink. Staff #5 rinsed the jars with tap water and used a bottlebrush to "remove any clotted blood". Staff #5 poured approximately one-forth (1/4) to one-third (1/3) cup of bleach into the glass bottle and swirled the bleach around the inner bottom of the jar. Staff #5 did not have a face shield or eye protection in place to guard against blood, body fluid or bleach splatter. Staff # 5 used a bristled brush to remove blood and body tissues from the instruments utilized during the procedure. At the completion of the first of two-soiled equipment cleaning, Staff #5 had wet splatter areas on the front of his/her blue jacket. A second post procedure cleaning process was observed with Staff #5 in the "Soiled" utility room. Staff #5 followed the same processes. Staff #5 previously confirmed the outside of the glass jar had been rinsed in water only and had not been disinfected prior to placing the jar on the "Clean" utility counter. Staff #5 did not put on gloves prior to placing the stopper into the glass jar and transporting the contaminated glass jar from the "Clean" utility room to the procedure room. An interview was conducted on May 15, 2012 at 3:15 p.m. with Staff #2. The surveyor informed	T 170	T170 Staff member retrained in the proper use of PPE. Documentation of training included in the personnel file. Policy for monitoring infection control compliance written. Infection Control Survey written; to be performed quarterly. Results to be submitted to Quality Assurance Committee. Completion June 23, 2012	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 170	Continued From Page 7 Staff #2 of the findings from the observation of Staff #5's use of PPE and the handling of soiled equipment. Review of the facility's policy titled "Personal Protective Equipment" effective date January 1, 2012 read "... All staff will receive training on the proper selection of and use of PPE ... Wear mouth, nose, and eye protection during procedures that are likely to generate splashes or sprays of blood or other body fluids ..." 2. The center had no procedure for monitoring staff compliance of infection control procedures and had no documentation of annual retraining for infection control. The Center's "Policies and Procedures" were reviewed on 5/15/12 at 10:00 a.m. There was no policy or procedure regarding how staff would be monitored to ensure they were adhering to infection control practices. 3. Employee records were reviewed on 5/15/12 at 1:00 p.m. There was no evidence of annual infection control training for 16 employees. On 5/16/12 at 9:30 a.m., Staff #2 stated the employees had not received annual infection control training. When interviewed regarding how staff was being monitored to ensure they were following proper infection control practices, Staff #2 stated, "Most all of our employees have been here a long time and I guess we just became complacent ..." Staff #2 stated there was no policy/procedure which addressed the process for monitoring staff. No further information was provided by the end of the survey.	T 170	T 170 Policy for monitoring infection control compliance written. Infection Control Survey tool to be used quarterly to monitor adherence to plan. Results to be reported to Quality Assurance Committee. Infection control training to be done initially and at least annually. This has been added to orientation checklist and personnel policy. Personnel files to be reviewed annually for completeness. Completion date June 28, 2012	
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:	T 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 8	T 175		

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:
(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 9	T 175		

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, Interview and record review the facility failed to ensure the implementation of infection prevention practices as evidenced by:

1. Dried blood was observed on the sling between the seat and footrest on two (2) of three (3) Recovery recliners.

2. Three (3) of three (3) Recovery recliners had torn surfaces and could not be disinfected between patients. Two (2) of two (2) Recovery stretcher pads had multiple torn surfaces and could not be disinfected between patients. The metal finish and armrest pad were not intact and could not be disinfected between patients for one (1) of one (1) Procedure table.

3. The facility staff was not able to determine that linens laundered on-site were processed at the correct water temperature of 160 degrees Fahrenheit.

4. Staff failing to perform hand hygiene between glove changes and the lack of hand hygiene supplies.

5. Chemicals were stored on the shelves with "Clean" supplies; expired supplies were readily availability for access and supplies stored in opened packages.

6. The failure to perform preventative maintenance on equipment utilized in direct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 10	T 175		

patient care.
7. Snacks provided for patients were multiple unwrapped items in opened packages, which increased cross-contamination of the food products.
8. The staff's handling of clean and dirty equipment between patients and staff's knowledge of manufacturer's recommendations for cleaning re-usable equipment between patients. Staff re-used sponges for cleaning blood and body fluid spills post procedures.
9. A failure to develop procedures for the processing of each type of reusable medical equipment between uses on different patients, procedures for appropriate disposal of non-reusable equipment, and procedures for cleaning of environmental surfaces with appropriate cleaning products.
The findings included:
1. An observation and interview was conducted with Staff #2 on May 15, 2012 at 10:50 a.m. in the Recovery room. Staff #2 reported the Recovery recliners were cleaned between each patient use. Staff #2 reported the Recovery recliners had not been utilized since the last procedure day (May 5, 2012) and were ready for patients. Staff #2 and the surveyor placed the Recovery recliners in a raised foot position. The observation revealed two (2) of the three (3) Recovery recliners had an area of five (5) inches or greater of dark reddish brown substance on the sling between the seat and the footrest. Staff #2 identified the dark reddish brown substance as dried blood. Staff #2 reported understanding the infection risk related to blood left on the Recovery recliners between patients.
2. An observation and interview was conducted on May 15, 2012 from 10:20 a.m. to 11:18 a.m. with Staff #2. Staff # 2 reported the procedure table was wiped down with a 1:10 bleach/water solution between patients. The observation in the procedure room revealed the procedure table's

T 175

Staff retrained regarding need to disinfect surfaces between each patient use. Job descriptions revised to include disinfecting as a job responsibility.
Infection Control Survey to be conducted quarterly to monitor adherence to infection control practices. Results to be reported to Quality Assurance Committee.
Staff instructed to monitor condition of equipment and advise administrator in the event of a tear or other condition which would hinder disinfection. Job descriptions reflect that responsibility.
Administrator to be advised of any condition that requires repair/ replacement of equipment.
Completion date June 28, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 11	T 175	T 175	

metal finish was not intact. The full length of the bilateral leg supports for the stirrups (used to position the patient during the procedure) had rust. The ledge of the table that surrounded the table's padded surface had multiple areas of rust. The pedestal of the procedure table had multiple areas of rust. The procedure table's armrest had multiple worn and non-intact areas. The non-intact surfaces prevented the disinfection of the procedure table and its armrest between patients. Staff #2 observed the findings and stated, "You're right the surfaces are not intact." Staff #2 verbally acknowledged the non-intact surfaces prevented disinfection of the procedure table between patients.

The observation conducted with Staff #2 in the Recovery room revealed three (3) of three (3) Recovery room recliners did not have intact surfaces. Staff #2 reported the Recovery "recliners are cleaned between each patient use." Two (2) recliners had torn armrest, one (1) recliner had a torn area on the sling between the seat and the footrest, and all three (3) recliners had torn areas on the back of the headrest. Staff #2 verbally acknowledged the non-intact surfaces prevented the disinfection of the Recovery room recliners between patients.

The observation conducted in the Recovery room with Staff #2 revealed that two (2) of two (2) Recovery Room stretcher pads had extensive torn areas with exposure of the inner padding. The observation revealed a zippered area that separated the upper and lower portion of the pads was torn the width of each pad. The torn area left the inner foam padding exposed on both pads. Both stretcher pads had multiple worn areas and non-intact surfaces, which would allow blood or body fluids to be absorbed into the underlying exposed foam. Staff #2 confirmed the pads on the Recovery room stretchers had non-intact surfaces with exposed foam, which prevented

T 175

Procedure table replaced. Staff retrained to monitor equipment routinely and advise administrator of problem areas. Infection control survey to be conducted quarterly. Results to Quality Assurance Committee.
Completion date June 26, 2012

T 175

One recliner replaced. Two recliners repaired. Staff trained to monitor equipment routinely and advise administrator of problem areas. Job descriptions reflect responsibility of staff. Infection control survey to be conducted quarterly. Results to be reported to Quality Assurance Committee.
completion date June 18, 2012

T 175

Stretcher pads replaced. Staff trained to monitor equipment routinely and advise administrator of problem areas. Job descriptions reflect staff responsibility of advising administrator of need for repair/ replacement of equipment. Infection control survey to be conducted quarterly and results reported to Quality Assurance Committee.
completion date June 26, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	116 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 12 disinfection of the stretchers pads between patients. 3. An observation was conducted on May 15, 2012 during the initial tour. The observation revealed a standard washer and dryer used by the facility to launder linens. An interview was conducted on May 16, 2012 at 9:08 a.m. with Staff #2. Staff #2 reported the facility's linens were washed in hot water. Staff #2 was not able to confirm the linens were laundered at the correct water temperature of 160 degrees Fahrenheit. Staff #2 reported the facility had a single hot water heater, which supplied hot water to all areas (utility and hand washing sinks). Staff #2 reported the washer did not have a water temperature booster or separate water heating unit. 4. Observations and Interview was conducted on May 15, 2012 from 12:10 p.m. through 1:30 p.m. with Staff #5. Observations were conducted with Staff #5 in the "Soiled" utility room for two (2) procedures. With two (2) surveyors present, Staff #5 washed his/her hands at the utility sink in the "Soiled" utility room and used his/her hand to turn off the water. Staff #5 did not have paper towel available to turn off the water at the sink or to dry his/her hands. Staff #5 with contaminated wet hands entered the "Clean" utility room and tore off paper towel from that roll. Staff #5 with contaminated hands pulled gloves from a box of gloves in the "Clean" utility room. Staff #5 did not wash his/her hands between three glove changes or when changing task between the "Soiled" and "Clean" utility rooms. Staff #5 stated, "This is the way I usually do things I hope I'm doing it right." The surveyor informed Staff #5 that his/her current practices introduced contaminates from the "Soiled" utility room into the "Clean" utility room. 5. An observation and interview conducted during the initial tour of the "Clean" utility and Procedure rooms on May 15, 2012 from 10:09 a.m. to 10:50	T 175	T 175 Washing machine being replaced. Replacement ordered with expected delivery date June 26, 2012. Preventive maintenance to be conducted annually and results to be forwarded to Quality Assurance Committee. T 175 Paper towel dispenser installed in "soiled" utility room. Retraining on proper hand hygiene and glove changing conducted. Infection Control Survey to be conducted quarterly. Report of results to Quality Assurance Committee. Completion date June 28, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A BUILDING _____ B WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 13 a.m. with Staff #2. Observations in the "Clean" utility room revealed opened gallon container of bleach, opened gallon container of iodine and soap powder were stored on the shelf with "Clean" supplies. Staff #2 reported the chemicals were stored in the "Clean" utility room for easy excess to the "Soiled" utility and procedure rooms. Staff #2 was not aware that chemicals needed to be in a locked area and not stored with "Clean" supplies. The observation revealed two (2) -pathology collection kit stored under the autoclave; displayed evidence that liquids had damaged the boxes. The observation revealed the following expired supplies were available for use in the procedure room: Two (2) curettage instruments wrapped in sterilization packs, which did not have dates related to sterilization. [A curettage is a surgical instrument used to scrape or remove the lining of the uterus.]; One (1) 3/15 dilator wrapped in a sterilization pack, which did not have a date of sterilization. [A dilator is a surgical instrument used to dilate (widen) the opening of the cervix.]; Two (2) tracheal tubes (7.0 and 3.0) had expired (exp.) 12/31/1995; One tracheal tube (5.0) had exp. 06/30/1996; Four (4) ECG (electro cardiogram) monitoring pads had exp. March 2000; Five (5) packages of snap electrodes had exp. 05/2007; One container of Formalin had exp. 11/ 2004 [Formalin is an aqueous solution of the chemical compound formaldehyde used to preserve tissue samples for analysis.]; Six (6) packs of Ethicon 0.5 silk sutures had exp. 01/2009; One of one containers of glucometer test strips had exp. 05/2007; and One of one sets of glucometer test/calibration	T 175	T 175 Chemicals removed from clean utility area. Moved to locked area. Pathology kits discarded because of damage. Nothing to be stored under sinks to reduce risk of contamination. Administrator responsible for ensuring that chemicals remain locked in appropriate areas. Completion date May 18, 2012. T 175 Instruments must have the date of sterilization and initials of staff person written on them. When setting up the procedure room each day, staff is to monitor appropriate dating and initialling of packs. Pack is to be rejected if not marked appropriately and re-sterilized. Utility and procedure staff responsible for monitoring daily stocking. Infection Control Survey to be completed quarterly with results to QA comm. Completion date May 18, 2012 T 175 Expired tracheal tubes discarded. Expired ECG electrodes discarded. Expired Formalin container discarded. Expired ethicon discarded. Expired glucometer test strips discarded. Expiration dates to be checked monthly and logged. Administrator is responsible for ensuring expiration log completed monthly. Completion date May 18, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 14	T 175		

solutions had exp. 07/2007.
Staff #2 reported facility staff had inspected the Procedure room and had missed the expired supplies. Staff #2 acknowledged the expired supplies were available for use, but should have been discarded by the expiration date.
The following items were stored in a cabinet next to the anesthesia cart. The tracheal tube packages were open, with an inserted guide stylus and left uncovered exposed to contaminates:
Two (2) tracheal tubes (7.0),
Two (2) tracheal tubes (7.5), and
One (8.5) tracheal tube.
Staff #2 reported the nurse anesthetists were aware that the tracheal tubes could not be stored in open packages with the guide stylus in place.
6. Observation on May 15, 2012 during the initial tour revealed the following equipment utilized during direct patient care did not have proof of preventative maintenance per the manufacturer's recommendations:
One of one anesthesia Co 2 (carbon dioxide) absorber;
One of one suction pump used during procedures;
One of one ultrasound devices;
One of two autoclaves; and
One of one glucometer.
Staff #2 acknowledged the findings and was not able to provide proof of preventative maintenance on the above direct care equipment. Staff #2 was not able to provide proof the glucometer was for single or multiple patient use. The facility failed to have an infection prevention process in place related to preventing the spread of hepatitis by glucometers, which have not been thoroughly disinfected.
7. An observation and interview was conducted on May 15, 2012 between 10:50 a.m. and 11:18 a.m. with Staff #2. The observation revealed a plastic container with opened packages of various cookies. The cookies were not individually

T 175
Anesthetists to change to a tracheal tube with an inserted guide stylus packaged with it. This will allow the anesthetists to be prepared but with an unopened package. Administrator is responsible for ensuring proper packaging.
Completion date June 23, 2012

T 175
PM has been performed on suction pump, ultrasound machine, autoclave. CO 2 absorber is filtering system, not electrical. Glucometer removed from service until it can be thoroughly researched whether it may be properly used in this setting.
Completion date June 28, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 15	T 175		

wrapped and some cookies were scattered unprotected on the bottom of the container. Staff #2 reported the cookies were used as snacks for patients during their Recovery room wait. Staff #2 acknowledged the cookies were loose inside the plastic container and not protected from contaminates when staff or patients reached into the plastic container.

8. Observations and interview was conducted on May 15, 2012 from 12:10 p.m. through 1:30 p.m. with Staff #5 in the "Soiled" utility room after two (2) procedures. Staff #5 wore a blue cloth jacket over his/her scrub attire. Staff #5 placed three (3) sponges on the ledge of the opening between the procedure room and the "Soiled " utility room. Staff #5 reported the sponges were used to "wipe up after the procedures." Staff #5 reported the same sponges were reused. Staff #5 reported the sponges were rinse in tap water, then dipped in the 1:10 bleach/water solution and placed back on the ledge.

Staff #5 collected the re-usable glass suction jars from the pass through opening in the wall between the procedure room and the "Soiled" utility room. Staff #5 emptied the liquid contents of the glass jars into the utility sink, rinsed the jars with water, used a bottlebrush to "remove any clotted blood", pour approximately one-forth (1/4) to one-third (1/3) cup of bleach into the glass bottle and swirled the bleach around the inner bottom of the jar. Staff #5 used tap water to rinsed the black stopper, utilized with the suction bottle during procedures then placed the stopper in a container with 1:10 bleach/water solution. The stopper was not submersed in the bleach/water solution. Staff #5 did not have a clock in the "Soiled" utility room. When asked regarding the length of time the bleach needed to be in the glass jar or the stopper needed to be in contact with the 1:10 bleach/water solution; Staff #5 stated, "Not long, a couple of minutes." Staff #5 acknowledged the "Soiled"

T 175
Staff is to wear gloves and package several cookies and crackers in individual sized baggies each day prior to seeing patients. Recovery room staff is responsible. Administrator is to monitor that staff is handling snacks appropriately.
Completion date June 14, 2012

T 175
Sponges are not to be used in the facility in patient areas. One time use saniwipes designated for medical facilities will be used. Staff trained on CDC Principles of Cleaning and Disinfecting Environment Surfaces. Documentation of training in personnel file. Infection control survey to be conducted quarterly. Results to be reported to Qual Assurance Committee.
Completion date June 23, 2012

T 175
Stopper and glass bottle to be sprayed with Cavicide and allowed to remain wet for 3 minutes. A clock or timer to be used in soiled utility. Staff trained to procedure. Documentation of training in personnel file. Infection control survey to be conducted quarterly and reported to Qual Assurance Committee. Infection control training to be conducted initially and at least annually. Administrator and Infection Control Officer are responsible for training.
Completion date June 23, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 16	T 175		

utility room did not have a clock. Staff #5 did not utilize a wristwatch to time the contact time of the stopper in the 1:10 bleach/water solution. Staff #5 did not turn the stopper to ensure all surfaces of the stopper had contact with the 1:10 bleach/water solution. Staff #5 removed the stopper from the bleach/water solution placed the stopper in a metal bowl for transport to the "Clean" utility room. Staff #5 emptied the bleach from the glass jar, removed one "Soiled" glove to open the door between the "Soiled" and "Clean" utility rooms. Staff #5 holding the jar with the other "Soiled" gloved hand placed the jar on the counter in the "Clean" utility room. Staff #5 did not remove the blue cloth jacket worn in the "Soiled" utility room during the cleaning process before he/she entered the "Clean" utility room. Staff #5 acknowledged the bleach poured into the glass jar did not contact the total inner surface of the jar. Staff #5 confirmed the outside of the glass jar had been rinsed in water only and had not been disinfected prior to placing the jar on the "Clean" utility counter.
The observation revealed after the first procedure was completed Staff #2 from the procedure side of the opening retrieved the sponges from the ledge. Staff #2 used the sponges in the procedure room and returned them to the ledge. The sponges were contaminated with bloody fluids. Staff #5 removed the sponges from the ledge, rinsed them in tap water, and dipped them in the 1:10 bleach/water solution. Staff #5 squeezed the sponges over the utility sink and placed the same sponges back on the ledge. The observation revealed the sponges were dipped into the 1:10 bleach/water solution for less that one (1) minute. Staff #5 was asked about the multiple re-using of the sponges and the amount of time the sponges needed to be in the bleach/water solution. Staff #5 stated, "I try to keep them (the sponges) as long as I can, but the

T 175
Stopper and jar to be placed in a closed container designated for the transport of equipment from soiled utility to clean utility. In the clean utility room the stopper and jar to be placed on the counter until ready to be used in the procedure room. It is then placed in a lidded container designated for transport from clean utility to procedure.
Staff to be trained in process. Documentation to be placed in personnel file. Infection Control Survey to be conducted quarterly. Results to Quality Assurance Committee.
Completion date June 23, 2012

T 175
Sponges not to be used in patient areas. Bloody fluids to be cleaned according to CDC Principles of Cleaning and Disinfecting Environment Surfaces using disposable wipes.
Training to be documented in personnel file.
Infection Control Survey to be conducted quarterly.
Results to Quality Assurance Committee.
Completion date June 23, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 17	T 175		

bleach makes them (the sponges) disintegrate." Staff #5 was not able to provide the amount of contact time needed to ensure the sponges were disinfected between uses.
A second post procedure process was observed with Staff #5 in the "Soiled" utility room. Staff #5 followed the same processes. The bottlebrush was not disinfected between usages. Staff #5 did not put on gloves prior to placing the stopper into the glass jar and transporting the contaminated glass jar to the procedure room. Staff #5 did not remove the blue jacket he/she wore in the "Soiled" utility room prior to entering the "Clean" utility room or the procedure room.
The observation after the second procedure revealed from the procedure side Staff #2 retrieved the sponges from the ledge. Staff #2 was observed from the opening by the surveyor to wipe down equipment then return the sponges to the ledge contaminated with bloody fluids. Staff #5 removed the sponges from the ledge, rinsed them in tap water, dipped them in the 1:10 bleach/water solution, squeezed the sponges over the utility sink and placed the same sponges back on the ledge. Staff #2 passed soiled suction pump lines through the opening and in the process dripped bloody fluids on the ledge. Staff #5 used one of the sponges to clean the ledge then cleaned the sponge in the above cited manner and replaced the sponge on the ledge for re-used.
An interview was conducted on May 15, 2012 at 3:15 p.m. with Staff #2. Staff #2 reported the purpose of separating the "Clean" and "Soiled" utility rooms was to reduce cross-contamination. The surveyor informed Staff #2 of the findings from the observation of staff handling "Clean" and "Soiled" equipment. The requested documentation was not received prior to exit related to the procedure, the effectiveness or contact time of the 1:10 bleach/water solution as a

T 175
Bottle brush to be sprayed with Cavicide and allowed to remain wet for 3 minutes. Staff will wear gloves prior to placing the disinfected stopper and glass jar in the designated container.
Staff trained to remove PPE prior to leaving soiled utility room. Infection Control Survey to be conducted quarterly and results reported to QA Committee
Completion date June 23, 2012
T 175
Sponges are not to be used. Disposable wipes to be used to disinfect surfaces contaminated with blood and other body fluids. Infection Control Survey to be conducted quarterly with results reported to QA Committee.
Completion date June 23, 2012
T 175
Training on infection control to be conducted initially and at least annually. Infection control policies to be reviewed at least annually. A designated staff member to receive certification in infection control and be available to review procedures and facilitate further staff training. Infection Control Survey to be conducted quarterly with results reported to Quality Assurance Committee.
Completion date June 23, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 18	T 175		

disinfectant for the stopper and glass jar.
Review of the facility's policy titled "Personal Protective Equipment" effective date January 1, 2012 read "...Perform hand hygiene immediately after removing gloves ..."
Review of the facility's policy titled Hand Hygiene" effective date January 1, 2012 read "... Key situations where hand hygiene should be performed include but are not limited to...after glove removal ... Soap and working sinks with hot and cold running water and disposable paper towels will be available near any area involving body fluids ..."
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 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

T 175
Sponges not to be used in patient areas.
Infection Control Survey to be conducted quarterly with results reported to Quality Assurance Committee.
Completion date June 21, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 19 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..." 9. The center staff failed to ensure development of procedures for the processing of each type of reusable medical equipment between uses on different patients, procedures for appropriate disposal of non-reusable equipment, and procedures for cleaning of environmental surfaces with appropriate cleaning products. On 5/15/12 at 10:00 a.m., the center "policy and procedures" were reviewed. The surveyor was unable to locate any procedural processes regarding reusable medical equipment, non-reusable medical equipment, and cleaning procedures. The "Infection Control Plan" identified the following: E. Laundry Procedures - Facility policies and procedures will outline the handling, processing and storage of clean and dirty linen, as well as the use of disposable supplies ..." No corresponding "procedure/outline " was found. On 5/16/12 at 10:15 a.m., Staff #2 was interviewed. He/she stated there were no procedures for the reusable equipment, non-reusable equipment and for the cleaning of environmental surfaces. No further information was provided by the end of the survey.	T 175	T 175 Policy and procedure for processing reusable equipment has been written. Policy manual to be reviewed annually by administrator. Completion date June 22, 2012 T 175 Policy and procedure for handling soiled linen has been written. Policy manual to be reviewed annually by administrator. Completion date June 22, 2012	
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 transmission to other personnel or patients;	T 180		

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 180	Continued From Page 20 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 employee record review and staff interview, the center staff failed to ensure documentation of screening for tuberculosis (TB/PPD) for 19 of 24 employee records reviewed. Employee # 1, 2, 3, 4, 7, 8, 9, 11, 12, and 14 through 23. The findings included: Employee records were reviewed on 5/15/12 at 1:00 p.m. For 19 of the 24 employee records reviewed, there was no evidence that employees had received TB/PPD screening. On 5/16/12 at 12:00 p.m., Staff #2 was apprised of the findings and no further information was provided by the end of the survey.	T 180	T 180 TB/PPD Screening to be completed for all employees who have not been screened elsewhere in the past year. Personnel files are to be reviewed by administrator for completeness. Completion date June 28, 2012	
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 temperatures in accordance with definitions in 18 VAC 110-20-10	T 275		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 275	Continued From Page 21	T 275		

This RULE: is not met as evidenced by:
Based on observations and staff interviews the facility failed to discard expired medications and medications that had not been dated when opened.

The findings included:

An observation and interview was conducted on May 15, 2012 from 10:20 a.m. to 11:18 a.m. with Staff #2 during the initial tour of the procedure room. The observation revealed the following medications were expired and available for administration:
Diazepam 10 mg (milligram)/ 2 ml (milliliter) syringe had expired (exp.) "2/2012";
Labetalol 20 mg/ 4 ml vial had exp. "4/2012";
Succinylcholine 100 mg/ 5 ml vial had exp. "1 May 12";
One tank of nitrous oxide had exp. "29 Mar (March) 2000."

The following medications were not dated when opened:

Pitocin 10 u (units)/ ml vial; and
One tube of KY jelly.

An interview was conducted with Staff #2 on May 15, 2012 from 10:20 a.m. to 11:18 a.m. during the observations. Staff #2 confirmed each finding and reported the expired medication should have been discarded. Staff #2 stated, "It is our practice to date each medication when it's opened. These have to be discarded."

T 275
Expired medications have been discarded. Expiration log to be completed monthly. Nitrous oxide tank has been removed from facility.
All opened medications are to be labeled with the date and the initials of staff who opened them.
Any opened medications found not to be properly labeled must be discarded. When setting up each procedure day, all items will be checked for proper labeling.
Staff trained to procedure.
Documentation of training in personnel files.
Administrator is responsible for monitoring expiration dates.
Completion date June 28, 2012

T 360 12 VAC 5-412-340 Policies and procedures — T 360

The abortion facility shall develop, implement and maintain policies and procedures to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 360	Continued From Page 22	T 360		

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:
12 VAC 5- 412-340 (2)
Based on observation and interview the facility failed to secure six (6) portable oxygen tanks.

The findings included:

An observation conducted in the building that housed the procedure room on May 15, 2102 at 11:22 a.m. with Staff #2 revealed six (6) unsecured portable oxygen tanks. The oxygen tanks were located between a file cabinet and the wall in an office. Staff #2 reported Staff #1 did not want the the additional oxygen tanks stored in the procedure room. Staff #2 was aware the oxygen tanks needed to be secured.

Review of "Title 29 CFR 1926.350(a)(9) requires employers to store all compressed gas cylinders (including empty ones) upright at all times. This paragraph provides: Compressed gas cylinders shall be secured in an upright position at all times except, if necessary, for short periods of time while cylinders are actually being hoisted or carried. 1926.350(a)(11) Inside of buildings, cylinders shall be stored in a well-protected, well-ventilated, dry location, at least 20 feet (6.1 m) from highly combustible materials such as oil or excelsior. Cylinders should be stored in

Oxygen tanks to be secured in current setting. Administrator is responsible for ensuring that all gas cylinders are kept securely.
Completion date June 28, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 360	Continued From Page 23 definitely assigned places away from elevators, stairs, or gangways. Assigned storage places shall be located where cylinders will not be knocked over or damaged by passing or falling objects, or subject to tampering by unauthorized persons. Cylinders shall not be kept in unventilated enclosures such as lockers and cupboards..."	T 360		
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 observation and interview the facility failed to maintain the procedure table, recovery stretcher pads, and recovery recliners in good repair. The findings included: An observation and interview was conducted on May 15, 2012 from 10:20 a.m. to 11:18 a.m. with Staff #2. The observation in the procedure room revealed the procedure table's metal finish was not intact. The full length of the bilateral leg supports for the stirrups (used to position the patient during the procedure) had rust. The ledge of the table that surrounded the table's padded surface had multiple areas of rust. The pedestal of the procedure table had multiple areas of rest. The procedure table's armrest had multiple worn and non-intact areas. Staff #2 verbally	T 375	T 375 Procedure table replaced. Staff trained to routinely monitor equipment for tears and rust and to advise administrator if problems identified. Job descriptions reflect staff responsibility. Administrator ultimately responsible. Completion date June 26, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 375	Continued From Page 24 acknowledged the procedure table was in need of re-finishing. The observation conducted with Staff #2 in the Recovery room revealed three (3) of three (3) Recovery room recliners had tears in their surface material. Two (2) recliners had torn armrest, one (1) recliner had a torn area on the sling between the seat and the footrest, and all three (3) recliners had torn areas on the back of the headrest. Staff #2 verbally acknowledged the Recovery room recliners were not in good repair. The observation conducted in the Recovery room with Staff #2 revealed that two (2) of two (2) Recovery Room stretcher pads had extensive torn areas with exposure of the inner padding. The observation revealed a zippered area that separated the upper and lower portion of the pads was torn the width of each pad. The torn area left the inner foam padding exposed on both pads. Both stretcher pads had multiple worn areas and non-intact surfaces, which would allow blood or body fluids to be absorbed into the underlying exposed foam. Staff #2 reported the pads on the Recovery room stretchers needed to be replaced.	T 375	T 375 One recliner has been replaced and 2 have been repaired. Completion date June 18, 2012 Stretcher pads replaced Completion date June 26, 2012 Staff trained to routinely monitor equipment and advise administrator if problems identified. Job descriptions reflect that responsibility. Administrator is ultimately responsible. Completion date June 28, 2012	
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.	T 380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 380	Continued From Page 25	T 380		

This RULE: is not met as evidenced by:
Based on observation, interview and record review the facility failed to develop a process to ensure equipment used in direct patient care underwent preventative maintenance (PM) and failed to document proof of preventative maintenance on required direct patient care equipment.

The findings included:

1. An observation on May 15, 2012 during the initial tour revealed the following equipment utilized during direct patient care did not have proof of preventative maintenance per the manufacturer's recommendations:
One of one anesthesia Co 2 (carbon dioxide) absorber;
One of one suction pump used during procedures;
One of one ultrasound devices;
One of two autoclaves; and
One of one glucometer.
Staff #2 acknowledged the findings and was not able to provide proof of preventative maintenance on the above direct care equipment. Staff #2 was not able to provide proof the glucometer was for single or multiple patient use.
A review of the facility's PM log revealed it did not include documentation for all direct care equipment that needed preventative maintenance. The PM log was reviewed with Staff #2, who reported the log was not up-to-date.

Suction pump, ultrasound machine, autoclave have had PMs performed. CO 2 absorber is a filter, not electrical equipment.. Glucometer has been removed from service until it can be researched for appropriate use in this facility. Administrator is responsible for preventive maintenance program.
Completion date June 28, 2012

T 400 12 VAC 5-412-380 Local and state codes and standards — T 400

Abortion faculties 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 400	Continued From Page 26	T 400		

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 interview and facility tour it was determined the facility failed to have an architect attestation and failed to meet FGI (AIA) Guidelines for Chapters 3.1 and 3.7.

The findings include:

1. On May 15, 2012 a facility tour was conducted with the Administrator and the Medical Director, between 9:00 a.m. and 11:30 a.m. During the facility tour there was no evidence that the facility met the state and local codes and building ordinances.

The facility failed to have an attestation from a licensed Architecture that the facility met the required FGI (AIA) guidelines. There was no over head shelter for Buildings #1 and #2 to protect patients from inclement weather. The Medication Distribution Station was located in the Procedure

Have been consulting architects and mechanical engineers to survey areas that need to be retrofitted to come into compliance. See attached
Completion date December 2013

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 400	Continued From Page 27	T 400		

Room, without a sink present for hand hygiene Nourishments were located within the Recovery Room; the staff failed to have documentation of a temperature log for the refrigerator. No temperature control or separate ventilation was seen in the Clean Storage Room. Chemicals were not secured and separated from clean supplies stored in the Clean Storage Room. Soiled Holding failed to have a flushing-rim clinical sink. The facility did not have a wheelchair present or a designated area for wheelchair storage. The facility was not able to provide proof of on-site laundry water temperature (which needs to be at 160 degrees Fahrenheit), prior to exit on 5/16/12 at 12:15 p.m. The facility's Public Corridors failed to meet the minimum 5 feet width. The facility's sinks failed to have valves that could be opened with hands (single handle or wrist blades at least 4 inches in length).

The Administrator was unable to provide documentation that insulation provided: conserve energy, protect personnel, prevent vapor condensation and reduce noise. Insulation have a flame-spread rating of 25 or less and a smoke-developed rating of 50 or less in accordance with NFPA 255. The facility was unable to provide any information for HVAC ductwork.
The facility's electrical receptacle (convenience outlets) were not grounded without use of adapters for three pronged equipment. No manual fire system was available as required.

2. On May 16, 2012 at 12:18 p.m., an interview was conducted with the Administrator in the agency's office. The Administrator acknowledged that the facility was unable to provide evidence that the facility met the state and local codes and building ordinances.

Purell dispenser in the procedure room for hand hygiene for medication preparation area. Completion date May 1, 2012
Temperature log started for refrigerator. June 28. 2012
Mechanical engineer to address ventilation in clean storage room.
Completion date July 30, 2012
Chemicals secured and separated from clean supplies.
Completion date May 17, 2012
Wheelchair purchased and stored in designated area.
Completion date June 28, 2012
New washing machine purchased.
Sink to be replaced with sink with knee operation.
Mechanical engineer and electricians being brought in to address ventilation and electrical concerns
Completion date October 2012
See attached for remainder of timeline.

Richmond Medical Center for Women
359- 5066- phone
353- 2718- fax 539- 1599

From: Jill Abbey

TO: Kathaleen Creegan- Tedeschi

fax: 804- 527- 4503-

I spoke with Brenda this morning who requested some changes to my Plan of Correction.

Thank you.

Called 07/10/12 @ 10:06a
Spoke to Yolanda @ Richmond office - left detailed message

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	12 VAC 5-412 Initial comments	T 000		

An announced Initial Licensure First Trimester Abortion Facility inspection was conducted at the above referenced facility on May 15, 2012 through May 16, 2012 by three (3) Medical Facilities Inspectors from the Virginia Department of Health's, Office of Licensure and Certification.

The facility was out of compliance with the State Board of Health 12 VAC 5-412, Regulations for First Trimester Abortion Facility's effective December 29, 2011. Deficiencies were identified, cited, and will follow in this report.

RECEIVED
JUL 09 2012
VDH/OLC

T 070	12 VAC 5-412-170 C Personnel	T 070	T070	

C. Each abortion facility shall obtain a criminal 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 employee record review, center document review, and staff interview, the center staff failed to ensure a criminal record check was obtained for 8 of 10 employees who provided access to controlled substances. Employee #'s 3, 7, 8, 11, 15, 16, 20, and 21.
On 5/15/12 at 1:00 p.m., employee records were reviewed. Ten records were included for employees who provided access to controlled substances within the center. For 8 (eight) of the 10 (ten) records, no criminal background check was found.
The center policy and procedure "Personnel Policies" was reviewed and evidenced the following, in part: "Criminal history checks will be conducted for staff with access to controlled

Criminal background checks will be obtained for all employees whose job duties provide access to controlled substances.
An item will be added to the orientation checklist for every employee whose job duties provide access to controlled substances that a criminal background has to be obtained.
Personnel policy revised to include need for criminal background checks. Job descriptions for those staff will also include need for a criminal background check.
Personnel files will be reviewed for completeness on an annual basis.
The administrator is responsible for ensuring that the criminal background check is obtained as well as being responsible for reviewing job descriptions and files.
Completion date June 28, 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	7-9-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 070	Continued From Page 1 substances " On 5/16/12 at 9:30 a.m., Staff #2 was interviewed regarding the criminal record checks being completed for the 8 employees. Staff #2 stated the criminal background checks had not been done. No further information was provided by the end of the survey.	T 070		
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 employee record review and staff interview, the center staff failed to ensure cardiopulmonary resuscitation certification (CPR) training was received and documented for 7 of 10 licensed/certified employees. Employee #'s 3, 5, 7, 8, 15, 16, and #20. No evidence of CPR training/recertification was present in the employee records. The findings included: On 5/15/12 at 1:00 p.m., employee records were reviewed. Of the 10 (ten) licensed/certified employee records, 7 (seven) did not have evidence of CPR training/recertification. Employees # 5, 7, 8 and 16 were Certified Registered Nurse Anesthetists, #3 was a Nurse Practitioner, and # 15 and 20 were Registered Nurses. In an interview with Staff #2 on 5/16/12 at 12:00 p.m., he/she stated he/she knew each of the employees held current CPR certifications, however acknowledged the evidence of certification was not present in the employee records.	T 075	CPR documentation obtained for Certified Registered Nurse Anesthetist and Registered Nurses. CPR training will be added to the orientation list. CPR training will be added to the Personnel Policy. Personnel files will be reviewed for completeness annually. Job descriptions will also include need for CPR training. Administrator is responsible for ensuring certification is up to date. Completion date: June 21, 2012	T 075

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 080	Continued From Page 2	T 080	T 080	
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 employee record review, center document review, and staff interview, the center failed to ensure 16 of 24 employees participated in annual infection control training. Employee #'s 2, 3, 4, 5, 7, 8, 9, 11, 12, 14, 15, 16, 19, 20, 21, and 23. The findings included: Employee records were reviewed on 5/16/12 at 1:00 p.m. There was no evidence of annual infection control training for 16 employees. On 5/16/12 at 9:30 a.m., Staff #2 stated the employees had not received annual infection control training. "Most all of our employees have been here a long time and I guess we just became complacent ..." No further information was provided by the end of the survey.	T 080	Fire Safety and Infection Prevention In-Service Training will be conducted initially and annually for staff. This has been added to the orientation checklist. This has been added to Personnel Policy. Documentation of in-service training will be included in each staff member's personnel file as well as a manual dedicated to training documents. The Inservice Training manual will be reviewed annually. Personnel files will be reviewed annually for completeness. Administrator will ultimately be responsible but will assign Infection Control Officer (the Nurse Practitioner) the duty of coordinating training and documentation. Completion date June 28, 2012	
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.	T 085	T 085 Job descriptions will be included in every employee's personnel file. She will sign the job description to indicate that she is aware of the responsibilities of her position. Job descriptions will be reviewed at least annually with new copies given to the employee in the event of revisions. The personnel policy will include procedure for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 085	Continued From Page 3 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 employee record review and staff interview, the center staff failed to ensure job descriptions for employees were reviewed at least annually for 19 of 24 employee records reviewed. Employee #'s 1 through 9, 11, 12, 15, 16, 18 through 21, #23 and #24. The findings included: On 5/15/12 at 1:00 p.m., employee records were reviewed. Of the 24 records reviewed, 19 employees did not have evidence the job description was reviewed at least annually in their personnel record. The employees were as follows: Employee #1 - date of hire (DOH) 10/91, #2 - DOH 1/2008, #3 - DOH 9/2010, #4 - DOH 12/2009, #5 - DOH 8/2010, #6 - DOH 8/2006, #7 - DOH 1992 (no month listed), #8 - DOH 9/2008, #9 - DOH 1978 (no month listed), #11 - DOH 12/2010, #12 - DOH 4/2006, #15 - DOH 4/2011, #16 - DOH 5/2006, #18 - DOH 1992 (no month listed), #19 - DOH 12/2000, #20 - DOH 7/2008, #21 - DOH 1993 (no month listed), #23 - DOH 1/2006, and #24 - DOH 1999 (no month listed). On 5/16/12 at 12:00 p.m., Staff #2 was informed of the findings. No further evidence was provided by the end of the survey.	T 085	T085 cont'd reviewing job descriptions at least annually. Personnel files will be reviewed for completeness annually. Job descriptions will be revised to include the date that the employee received the job description. Administrator is responsible for ensuring job descriptions are provided and employee is aware of her responsibilities. Administrator Is responsible for ensuring that job description is reviewed annually. Completion date June 28, 2012	
T 090	12 VAC 5-412-170 G Personnel G. A personnel file shall be maintained for each staff member. The records shall be completely and accurately documented, readily available, and systematically organized to facilitate the	T 090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 090	Continued From Page 4 compilation and retrieval of information. The file shall contain a current job description that reflects the individual's responsibilities and work assignments, and documentation of the person's in-service education, and professional licensure, if applicable. This RULE: Is not met as evidenced by: Based on employee record review and staff interview, the center staff failed to ensure all employee records contained a current job description for 6 of 24 employee records reviewed. Employee #'s 2, 3, 4, 11, 15, and #20. No job description was present in the employee records when reviewed. The findings included: On 5/15/12 at 1:00 p.m., employee records were reviewed. Of the 24 records reviewed, 6 employees did not have a job description contained in their personnel record: Employee #2 (Housekeeping), #3 (Nurse Practitioner), #4 (Housekeeping), #11 (Registered Nurse), # 15 (registered Nurse), and #20 (Registered Nurse). On 5/16/12 at 12:00 p.m., Staff #2 was informed of the findings. No further evidence was provided by the end of the survey.	T 090	Job descriptions have been added to the personnel files for those staff who did not have them. Orientation checklist includes job descriptions. Personnel policy includes job descriptions must be in the personnel file for each employee. Personnel files will be reviewed annually to ensure completeness. Administrator is responsible for ensuring job descriptions are in each file and that employees are aware of their responsibilities. Administrator is responsible for annual review of files and job descriptions. Completion date June 18, 2012	T090
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	T 170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 170	Continued From Page 5	T 170		

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 observations, interviews and record review the facility failed to ensure:

1. That staff wore the correct personal protective equipment (PPE) related to risk of exposure to blood and body fluids for one (1) of one staff observed in the "soiled" utility room.

2. The development of a procedure/process to monitor staff's adherence to the facility's infection prevention practices. The development of a process for retraining staff annually to infection prevention practices.

3. That staff had documented infection prevention training for sixteen (16) of twenty-four (24) employee records reviewed. (Employee # ' s 2, 3, 4, 5, 7, 8, 9, 11, 12, 14, 15, 16, 19, 20, 21, and 23)

The findings included:

1. Observations and interview were conducted on May 15, 2012 from 12:10 p.m. through 1:30 p.m. with Staff #5 in the "Soiled" utility room after two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 170	Continued From Page 6	T 170	T170 Staff member retrained in the proper use of PPE. Documentation of training included in the personnel file. Policy for monitoring infection control compliance written. Infection Control Survey written; to be performed quarterly. Results to be submitted to Quality Assurance Committee. Completion June 23, 2012	

(2) procedures. Staff #5 wore a blue cloth jacket over his/her scrub attire. When questioned related to the type of PPE needed to work or be in the "Soiled" utility room: Staff #5 stated, "I just wear this jacket over my clothes and gloves." Staff #5 denied the need for a mask, face shield or eye protection. Staff #5 did not wear a face shield or eye protection when cleaning soiled items in the utility room.

The observation revealed Staff #5 retrieved a re-usable glass suction jar from the pass through opening in the wall between the procedure room and the "Soiled" utility room. Staff #5 emptied the liquid contents, blood and other body fluids, from the glass jars into the utility sink. Staff #5 rinsed the jars with tap water and used a bottlebrush to "remove any clotted blood"

Staff #5 poured approximately one-forth (1/4) to one-third (1/3) cup of bleach into the glass bottle and swirled the bleach around the inner bottom of the jar. Staff #5 did not have a face shield or eye protection in place to guard against blood, body fluid or bleach splatter.

Staff # 5 used a bristled brush to remove blood and body tissues from the instruments utilized during the procedure. At the completion of the first of two-soiled equipment cleaning, Staff #5 had wet splatter areas on the front of his/her blue jacket.

A second post procedure cleaning process was observed with Staff #5 in the "Soiled" utility room. Staff #5 followed the same processes. Staff #5 previously confirmed the outside of the glass jar had been rinsed in water only and had not been disinfected prior to placing the jar on the "Clean" utility counter. Staff #5 did not put on gloves prior to placing the stopper into the glass jar and transporting the contaminated glass jar from the "Clean" utility room to the procedure room.

An interview was conducted on May 15, 2012 at 3:15 p.m. with Staff #2. The surveyor informed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 170	Continued From Page 7 Staff #2 of the findings from the observation of Staff #5's use of PPE and the handling of soiled equipment. Review of the facility's policy titled "Personal Protective Equipment" effective date January 1, 2012 read "... All staff will receive training on the proper selection of and use of PPE ... Wear mouth, nose, and eye protection during procedures that are likely to generate splashes or sprays of blood or other body fluids ..." 2. The center had no procedure for monitoring staff compliance of infection control procedures and had no documentation of annual retraining for infection control. The Center's "Policies and Procedures" were reviewed on 5/15/12 at 10:00 a.m. There was no policy or procedure regarding how staff would be monitored to ensure they were adhering to infection control practices. 3. Employee records were reviewed on 5/15/12 at 1:00 p.m. There was no evidence of annual infection control training for 16 employees. On 5/16/12 at 9:30 a.m., Staff #2 stated the employees had not received annual infection control training. When interviewed regarding how staff was being monitored to ensure they were following proper infection control practices, Staff #2 stated, "Most all of our employees have been here a long time and I guess we just became complacent ..." Staff #2 stated there was no policy/procedure which addressed the process for monitoring staff. No further information was provided by the end of the survey.	T 170	T 170 Policy for monitoring infection control compliance written. Infection Control Survey tool to be used quarterly to monitor adherence to plan. Results to be reported to Quality Assurance Committee. Infection control training to be done initially and at least annually. This has been added to orientation checklist and personnel policy. Personnel files to be reviewed annually for completeness. Completion date June 28, 2012	
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:	T 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 8	T 175		

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:
(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 9	T 175		

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, interview and record review the facility failed to ensure the implementation of infection prevention practices as evidenced by:

1. Dried blood was observed on the sling between the seat and footrest on two (2) of three (3) Recovery recliners.

2. Three (3) of three (3) Recovery recliners had torn surfaces and could not be disinfected between patients. Two (2) of two (2) Recovery stretcher pads had multiple torn surfaces and could not be disinfected between patients. The metal finish and armrest pad were not intact and could not be disinfected between patients for one (1) of one (1) Procedure table.

3. The facility staff was not able to determine that linens laundered on-site were processed at the correct water temperature of 160 degrees Fahrenheit.

4. Staff failing to perform hand hygiene between glove changes and the lack of hand hygiene supplies.

5. Chemicals were stored on the shelves with "Clean" supplies; expired supplies were readily availability for access and supplies stored in opened packages.

6. The failure to perform preventative maintenance on equipment utilized in direct

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 10	T 175		

patient care.
7. Snacks provided for patients were multiple unwrapped items in opened packages, which increased cross-contamination of the food products.
8. The staff's handling of clean and dirty equipment between patients and staff's knowledge of manufacturer's recommendations for cleaning re-usable equipment between patients. Staff re-used sponges for cleaning blood and body fluid spills post procedures.
9. A failure to develop procedures for the processing of each type of reusable medical equipment between uses on different patients, procedures for appropriate disposal of non-reusable equipment, and procedures for cleaning of environmental surfaces with appropriate cleaning products.
The findings included:
1. An observation and interview was conducted with Staff #2 on May 15, 2012 at 10:50 a.m. in the Recovery room. Staff #2 reported the Recovery recliners were cleaned between each patient use. Staff #2 reported the Recovery recliners had not been utilized since the last procedure day (May 5, 2012) and were ready for patients. Staff #2 and the surveyor placed the Recovery recliners in a raised foot position. The observation revealed two (2) of the three (3) Recovery recliners had an area of five (5) inches or greater of dark reddish brown substance on the sling between the seat and the footrest. Staff #2 identified the dark reddish brown substance as dried blood. Staff #2 reported understanding the infection risk related to blood left on the Recovery recliners between patients.
2. An observation and interview was conducted on May 15, 2012 from 10:20 a.m. to 11:18 a.m. with Staff #2. Staff # 2 reported the procedure table was wiped down with a 1:10 bleach/water solution between patients. The observation in the procedure room revealed the procedure table's

T 175

Staff retrained regarding need to disinfect surfaces between each patient use. Job descriptions revised to include disinfecting as a job responsibility.
Infection Control Survey to be conducted quarterly to monitor adherence to infection control practices. Results to be reported to Quality Assurance Committee.
Staff instructed to monitor condition of equipment and advise administrator in the event of a tear or other condition which would hinder disinfection. Job descriptions reflect that responsibility.
Administrator to be advised of any condition that requires repair/ replacement of equipment.
Completion date June 28, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 11	T 175	T 175	

metal finish was not intact. The full length of the bilateral leg supports for the stirrups (used to position the patient during the procedure) had rust. The ledge of the table that surrounded the table's padded surface had multiple areas of rust. The pedestal of the procedure table had multiple areas of rust. The procedure table's armrest had multiple worn and non-intact areas. The non-intact surfaces prevented the disinfection of the procedure table and its armrest between patients. Staff #2 observed the findings and stated, "You're right the surfaces are not intact." Staff #2 verbally acknowledged the non-intact surfaces prevented disinfection of the procedure table between patients.

The observation conducted with Staff #2 in the Recovery room revealed three (3) of three (3) Recovery room recliners did not have intact surfaces. Staff #2 reported the Recovery "recliners are cleaned between each patient use." Two (2) recliners had torn armrest, one (1) recliner had a torn area on the sling between the seat and the footrest, and all three (3) recliners had torn areas on the back of the headrest. Staff #2 verbally acknowledged the non-intact surfaces prevented the disinfection of the Recovery room recliners between patients.

The observation conducted in the Recovery room with Staff #2 revealed that two (2) of two (2) Recovery Room stretcher pads had extensive torn areas with exposure of the inner padding. The observation revealed a zippered area that separated the upper and lower portion of the pads was torn the width of each pad. The torn area left the inner foam padding exposed on both pads. Both stretcher pads had multiple worn areas and non-intact surfaces, which would allow blood or body fluids to be absorbed into the underlying exposed foam. Staff #2 confirmed the pads on the Recovery room stretchers had non-intact surfaces with exposed foam, which prevented

Procedure table replaced. Staff retrained to monitor equipment routinely and advise administrator of problem areas. Infection control survey to be conducted quarterly. Results to Quality Assurance Committee. Completion date June 26, 2012

T 175

One recliner replaced. Two recliners repaired. Staff trained to monitor equipment routinely and advise administrator of problem areas. Job descriptions reflect responsibility of staff. Infection control survey to be conducted quarterly. Results to be reported to Quality Assurance Committee.
completion date June 18, 2012

T 175

Stretcher pads replaced. Staff trained to monitor equipment routinely and advise administrator of problem areas. Job descriptions reflect staff responsibility of advising administrator of need for repair/ replacement of equipment. Infection control survey to be conducted quarterly and results reported to Quality Assurance Committee.
completion date June 26, 2012

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 12	T 175	T 175	

disinfection of the stretchers pads between patients.
3. An observation was conducted on May 15, 2012 during the initial tour. The observation revealed a standard washer and dryer used by the facility to launder linens.
An interview was conducted on May 16, 2012 at 9:08 a.m. with Staff #2. Staff #2 reported the facility's linens were washed in hot water. Staff #2 was not able to confirm the linens were laundered at the correct water temperature of 160 degrees Fahrenheit. Staff #2 reported the facility had a single hot water heater, which supplied hot water to all areas (utility and hand washing sinks). Staff #2 reported the washer did not have a water temperature booster or separate water heating unit.
4. Observations and interview was conducted on May 15, 2012 from 12:10 p.m. through 1:30 p.m. with Staff #5. Observations were conducted with Staff #5 in the "Soiled" utility room for two (2) procedures. With two (2) surveyors present, Staff #5 washed his/her hands at the utility sink in the "Soiled" utility room and used his/her hand to turn off the water. Staff #5 did not have paper towel available to turn off the water at the sink or to dry his/her hands. Staff #5 with contaminated wet hands entered the "Clean" utility room and tore off paper towel from that roll. Staff #5 with contaminated hands pulled gloves from a box of gloves in the "Clean" utility room. Staff #5 did not wash his/her hands between three glove changes or when changing task between the "Soiled" and "Clean" utility rooms. Staff #5 stated, "This is the way I usually do things I hope I'm doing it right."
The surveyor informed Staff #5 that his/her current practices introduced contaminates from the "Soiled" utility room into the "Clean" utility room.
5. An observation and interview conducted during the initial tour of the "Clean" utility and Procedure rooms on May 15, 2012 from 10:09 a.m. to 10:50

T 175

Washing machine being replaced. Replacement ordered with expected delivery date June 26, 2012.
Preventive maintenance to be conducted annually and results to be forwarded to Quality Assurance Committee.

T 175

Paper towel dispenser installed in "soiled" utility room. Retraining on proper hand hygiene and glove changing conducted. Infection Control Survey to be conducted quarterly. Report of results to Quality Assurance Committee.
Completion date June 28, 2012

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 13 a.m. with Staff #2. Observations in the "Clean" utility room revealed opened gallon container of bleach, opened gallon container of Iodine and soap powder were stored on the shelf with "Clean" supplies. Staff #2 reported the chemicals were stored in the "Clean" utility room for easy excess to the "Soiled" utility and procedure rooms. Staff #2 was not aware that chemicals needed to be in a locked area and not stored with "Clean" supplies. The observation revealed two (2) -pathology collection kit stored under the autoclave; displayed evidence that liquids had damaged the boxes. The observation revealed the following expired supplies were available for use in the procedure room: Two (2) curettage instruments wrapped in sterilization packs, which did not have dates related to sterilization. [A curettage is a surgical instrument used to scrape or remove the lining of the uterus.]; One (1) 3/15 dilator wrapped in a sterilization pack, which did not have a date of sterilization. [A dilator is a surgical instrument used to dilate (widen) the opening of the cervix.]; Two (2) tracheal tubes (7.0 and 3.0) had expired (exp.) 12/31/1995; One tracheal tube (5.0) had exp. 06/30/1996; Four (4) ECG (electro cardiogram) monitoring pads had exp. March 2000; Five (5) packages of snap electrodes had exp. 05/2007; One container of Formalin had exp. 11/ 2004 [Formalin is an aqueous solution of the chemical compound formaldehyde used to preserve tissue samples for analysis.]; Six (6) packs of Ethicon 0.5 silk sutures had exp. 01/2009; One of one containers of glucometer test strips had exp. 05/2007; and One of one sets of glucometer test/calibration	T 175	T 175 Chemicals removed from clean utility area. Moved to locked area. Pathology kits discarded because of damage. Nothing to be stored under sinks to reduce risk of contamination. Administrator responsible for ensuring that chemicals remain locked in appropriate areas. Completion date May 18, 2012. T 175 Instruments must have the date of sterilization and initials of staff person written on them. When setting up the procedure room each day, staff is to monitor appropriate dating and initialling of packs. Pack is to be rejected if not marked appropriately and re-sterilized. Utility and procedure staff responsible for monitoring daily stocking. Infection Control Survey to be completed quarterly with results to QA comm. Completion date May 18, 2012 T 175 Expired tracheal tubes discarded. Expired ECG electrodes discarded. Expired Formalin container discarded. Expired ethicon discarded. Expired glucometer test strips discarded. Expiration dates to be checked monthly and logged. Administrator is responsible for ensuring expiration log completed monthly. Completion date May 18, 2012	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 14	T 175		

solutions had exp. 07/2007.
Staff #2 reported facility staff had inspected the Procedure room and had missed the expired supplies. Staff #2 acknowledged the expired supplies were available for use, but should have been discarded by the expiration date.
The following items were stored in a cabinet next to the anesthesia cart. The tracheal tube packages were open, with an inserted guide stylus and left uncovered exposed to contaminates:
Two (2) tracheal tubes (7.0),
Two (2) tracheal tubes (7.5), and
One (8.5) tracheal tube.
Staff #2 reported the nurse anesthetists were aware that the tracheal tubes could not be stored in open packages with the guide stylus in place.
6. Observation on May 15, 2012 during the initial tour revealed the following equipment utilized during direct patient care did not have proof of preventative maintenance per the manufacturer's recommendations:
One of one anesthesia Co 2 (carbon dioxide) absorber;
One of one suction pump used during procedures;
One of one ultrasound devices;
One of two autoclaves; and
One of one glucometer.
Staff #2 acknowledged the findings and was not able to provide proof of preventative maintenance on the above direct care equipment. Staff #2 was not able to provide proof the glucometer was for single or multiple patient use. The facility failed to have an infection prevention process in place related to preventing the spread of hepatitis by glucometers, which have not been thoroughly disinfected.
7. An observation and interview was conducted on May 15, 2012 between 10:50 a.m. and 11:18 a.m. with Staff #2. The observation revealed a plastic container with opened packages of various cookies. The cookies were not individually

T 175
Anesthetists to change to a tracheal tube with an inserted guide stylus packaged with it. This will allow the anesthetists to be prepared but with an unopened package. Administrator is responsible for ensuring proper packaging.
Completion date June 23, 2012

T 175
PM has been performed on suction pump, ultrasound machine, autoclave. CO 2 absorber is filtering system, not electrical. Glucometer removed from service until it can be thoroughly researched whether it may be properly used in this setting.
Completion date June 28, 2012

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 15	T 175	T 175 Staff is to wear gloves and package several cookies and crackers in individual sized baggies each day prior to seeing patients. Recovery room staff is responsible. Administrator is to monitor that staff is handling snacks appropriately. Completion date June 14, 2012 T 175 Sponges are not to be used in the facility in patient areas. One time use saniwipes designated for medical facilities will be used. Staff trained on CDC Principles of Cleaning and Disinfecting Environment Surfaces. Documentation of training in personnel file. Infection control survey to be conducted quarterly. Results to be reported to Qual Assurance Committee. Completion date June 23, 2012 T 175 Stopper and glass bottle to be sprayed with Cavicide and allowed to remain wet for 3 minutes. A clock or timer to be used in soiled utility. Staff trained to procedure. Documentation of training in personnel file. Infection control survey to be conducted quarterly and reported to Qual Assurance Committee. Infection control training to be conducted initially and at least annually. Administrator and Infection Control Officer are responsible for training. Completion date June 23, 2012	

wrapped and some cookies were scattered unprotected on the bottom of the container. Staff #2 reported the cookies were used as snacks for patients during their Recovery room wait. Staff #2 acknowledged the cookies were loose inside the plastic container and not protected from contaminates when staff or patients reached into the plastic container.

8. Observations and interview was conducted on May 15, 2012 from 12:10 p.m. through 1:30 p.m. with Staff #5 in the "Soiled" utility room after two (2) procedures. Staff #5 wore a blue cloth jacket over his/her scrub attire. Staff #5 placed three (3) sponges on the ledge of the opening between the procedure room and the "Soiled " utility room. Staff #5 reported the sponges were used to "wipe up after the procedures." Staff #5 reported the same sponges were reused. Staff #5 reported the sponges were rinse in tap water, then dipped in the 1:10 bleach/water solution and placed back on the ledge.

Staff #5 collected the re-usable glass suction jars from the pass through opening in the wall between the procedure room and the "Soiled" utility room. Staff #5 emptied the liquid contents of the glass jars into the utility sink, rinsed the jars with water, used a bottlebrush to "remove any clotted blood", pour approximately one-forth (1/4) to one-third (1/3) cup of bleach into the glass bottle and swirled the bleach around the inner bottom of the jar. Staff #5 used tap water to rinsed the black stopper, utilized with the suction bottle during procedures then placed the stopper in a container with 1:10 bleach/water solution. The stopper was not submersed in the bleach/water solution. Staff #5 did not have a clock in the "Soiled" utility room. When asked regarding the length of time the bleach needed to be in the glass jar or the stopper needed to be in contact with the 1:10 bleach/water solution; Staff #5 stated, "Not long, a couple of minutes." Staff #5 acknowledged the "Soiled"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 16	T 175		

utility room did not have a clock. Staff #5 did not utilize a wristwatch to time the contact time of the stopper in the 1:10 bleach/water solution. Staff #5 did not turn the stopper to ensure all surfaces of the stopper had contact with the 1:10 bleach/water solution. Staff #5 removed the stopper from the bleach/water solution placed the stopper in a metal bowl for transport to the "Clean" utility room. Staff #5 emptied the bleach from the glass jar, removed one "Soiled" glove to open the door between the "Soiled" and "Clean" utility rooms. Staff #5 holding the jar with the other "Soiled" gloved hand placed the jar on the counter in the "Clean" utility room. Staff #5 did not remove the blue cloth jacket worn in the "Soiled" utility room during the cleaning process before he/she entered the "Clean" utility room. Staff #5 acknowledged the bleach poured into the glass jar did not contact the total inner surface of the jar. Staff #5 confirmed the outside of the glass jar had been rinsed in water only and had not been disinfected prior to placing the jar on the "Clean" utility counter.
The observation revealed after the first procedure was completed Staff #2 from the procedure side of the opening retrieved the sponges from the ledge. Staff #2 used the sponges in the procedure room and returned them to the ledge. The sponges were contaminated with bloody fluids. Staff #5 removed the sponges from the ledge, rinsed them in tap water, and dipped them in the 1:10 bleach/water solution. Staff #5 squeezed the sponges over the utility sink and placed the same sponges back on the ledge. The observation revealed the sponges were dipped into the 1:10 bleach/water solution for less that one (1) minute. Staff #5 was asked about the multiple re-using of the sponges and the amount of time the sponges needed to be in the bleach/water solution. Staff #5 stated, "I try to keep them (the sponges) as long as I can, but the

T 175
Stopper and jar to be placed in a closed container designated for the transport of equipment from soiled utility to clean utility. In the clean utility room the stopper and jar to be placed on the counter until ready to be used in the procedure room. It is then placed in a lidded container designated for transport from clean utility to procedure.
Staff to be trained in process. Documentation to be placed in personnel file. Infection Control Survey to be conducted quarterly. Results to Quality Assurance Committee.
Completion date June 23, 2012

T 175
Sponges not to be used in patient areas. Bloody fluids to be cleaned according to CDC Principles of Cleaning and Disinfecting Environment Surfaces using disposable wipes.
Training to be documented in personnel file.
Infection Control Survey to be conducted quarterly.
Results to Quality Assurance Committee.
Completion date June 23, 2012

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 17	T 175		

bleach makes them (the sponges) disintegrate." Staff #5 was not able to provide the amount of contact time needed to ensure the sponges were disinfected between uses.
A second post procedure process was observed with Staff #5 in the "Soiled" utility room. Staff #5 followed the same processes. The bottlebrush was not disinfected between usages. Staff #5 did not put on gloves prior to placing the stopper into the glass jar and transporting the contaminated glass jar to the procedure room. Staff #5 did not remove the blue jacket he/she wore in the "Soiled" utility room prior to entering the "Clean" utility room or the procedure room.
The observation after the second procedure revealed from the procedure side Staff #2 retrieved the sponges from the ledge. Staff #2 was observed from the opening by the surveyor to wipe down equipment then return the sponges to the ledge contaminated with bloody fluids. Staff #5 removed the sponges from the ledge, rinsed them in tap water, dipped them in the 1:10 bleach/water solution, squeezed the sponges over the utility sink and placed the same sponges back on the ledge. Staff #2 passed soiled suction pump lines through the opening and in the process dripped bloody fluids on the ledge. Staff #5 used one of the sponges to clean the ledge then cleaned the sponge in the above cited manner and replaced the sponge on the ledge for re-used.
An interview was conducted on May 15, 2012 at 3:15 p.m. with Staff #2. Staff #2 reported the purpose of separating the "Clean" and "Soiled" utility rooms was to reduce cross-contamination. The surveyor informed Staff #2 of the findings from the observation of staff handling "Clean" and "Soiled" equipment. The requested documentation was not received prior to exit related to the procedure, the effectiveness or contact time of the 1:10 bleach/water solution as a

T 175
Bottle brush to be sprayed with Cavicide and allowed to remain wet for 3 minutes. Staff will wear gloves prior to placing the disinfected stopper and glass jar in the designated container.
Staff trained to remove PPE prior to leaving soiled utility room. Infection Control Survey to be conducted quarterly and results reported to QA Committee
Completion date June 23, 2012
T 175
Sponges are not to be used. Disposable wipes to be used to disinfect surfaces contaminated with blood and other body fluids. Infection Control Survey to be conducted quarterly with results reported to QA Committee.
Completion date June 23, 2012
T 175
Training on infection control to be conducted initially and at least annually. Infection control policies to be reviewed at least annually. A designated staff member to receive certification in infection control and be available to review procedures and facilitate further staff training. Infection Control Survey to be conducted quarterly with results reported to Quality Assurance Committee.
Completion date June 23, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 18	T 175		

disinfectant for the stopper and glass jar.
Review of the facility's policy titled "Personal Protective Equipment" effective date January 1, 2012 read "...Perform hand hygiene immediately after removing gloves ..."
Review of the facility's policy titled Hand Hygiene" effective date January 1, 2012 read "... Key situations where hand hygiene should be performed include but are not limited to...after glove removal ... Soap and working sinks with hot and cold running water and disposable paper towels will be available near any area involving body fluids ..."
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 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

T 175
Sponges not to be used in patient areas.
Infection Control Survey to be conducted quarterly with results reported to Quality Assurance Committee.
Completion date June 21, 2012

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 19 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..." 9. The center staff failed to ensure development of procedures for the processing of each type of reusable medical equipment between uses on different patients, procedures for appropriate disposal of non-reusable equipment, and procedures for cleaning of environmental surfaces with appropriate cleaning products. On 5/15/12 at 10:00 a.m., the center "policy and procedures" were reviewed. The surveyor was unable to locate any procedural processes regarding reusable medical equipment, non-reusable medical equipment, and cleaning procedures. The "Infection Control Plan" identified the following: E. Laundry Procedures - Facility policies and procedures will outline the handling, processing and storage of clean and dirty linen, as well as the use of disposable supplies ..." No corresponding "procedure/outline " was found. On 5/16/12 at 10:15 a.m., Staff #2 was interviewed. He/she stated there were no procedures for the reusable equipment, non-reusable equipment and for the cleaning of environmental surfaces. No further information was provided by the end of the survey.	T 175	T 175 Policy and procedure for processing reusable equipment has been written. Policy manual to be reviewed annually by administrator. Completion date June 22, 2012 T 175 Policy and procedure for handling soiled linen has been written. Policy manual to be reviewed annually by administrator. Completion date June 22, 2012	
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 transmission to other personnel or patients;	T 180		

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-001	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 180	Continued From Page 20 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 employee record review and staff interview, the center staff failed to ensure documentation of screening for tuberculosis (TB/PPD) for 19 of 24 employee records reviewed. Employee # 1, 2, 3, 4, 7, 8, 9, 11, 12, and 14 through 23. The findings included: Employee records were reviewed on 5/15/12 at 1:00 p.m. For 19 of the 24 employee records reviewed, there was no evidence that employees had received TB/PPD screening. On 5/16/12 at 12:00 p.m., Staff #2 was apprised of the findings and no further information was provided by the end of the survey.	T 180	T 180 TB/PPD Screening to be completed for all employees who have not been screened elsewhere in the past year. Personnel files are to be reviewed by administrator for completeness. Completion date June 28, 2012	
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 temperatures in accordance with definitions in 18 VAC 110-20-10	T 275		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 275	Continued From Page 21	T 275		

This RULE: is not met as evidenced by:
Based on observations and staff interviews the facility failed to discard expired medications and medications that had not been dated when opened.

The findings included:

An observation and interview was conducted on May 15, 2012 from 10:20 a.m. to 11:18 a.m. with Staff #2 during the initial tour of the procedure room. The observation revealed the following medications were expired and available for administration:
Diazepam 10 mg (milligram)/ 2 ml (milliliter) syringe had expired (exp.) "2/2012";
Labetalol 20 mg/ 4 ml vial had exp. "4/2012";
Succinylcholine 100 mg/ 5 ml vial had exp. "1 May 12";
One tank of nitrous oxide had exp. "29 Mar (March) 2000."

The following medications were not dated when opened:

Pitocin 10 u (units)/ ml vial; and
One tube of KY jelly.

An interview was conducted with Staff #2 on May 15, 2012 from 10:20 a.m. to 11:18 a.m. during the observations. Staff #2 confirmed each finding and reported the expired medication should have been discarded. Staff #2 stated, "It is our practice to date each medication when it's opened. These have to be discarded."

T 275
Expired medications have been discarded. Expiration log to be completed monthly. Nitrous oxide tank has been removed from facility.
All opened medications are to be labeled with the date and the initials of staff who opened them.
Any opened medications found not to be properly labeled must be discarded. When setting up each procedure day, all items will be checked for proper labeling.
Staff trained to procedure.
Documentation of training in personnel files.
Administrator is responsible for monitoring expiration dates.
Completion date June 28, 2012

T 360 12 VAC 5-412-340 Policies and procedures T 360

The abortion facility shall develop, implement and maintain policies and procedures to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 360	Continued From Page 22	T 360		

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:
12 VAC 5- 412-340 (2)
Based on observation and interview the facility failed to secure six (6) portable oxygen tanks.

The findings included:

An observation conducted in the building that housed the procedure room on May 15, 2102 at 11:22 a.m. with Staff #2 revealed six (6) unsecured portable oxygen tanks. The oxygen tanks were located between a file cabinet and the wall in an office. Staff #2 reported Staff #1 did not want the the additional oxygen tanks stored in the procedure room. Staff #2 was aware the oxygen tanks needed to be secured.

Review of "Title 29 CFR 1926.350(a)(9) requires employers to store all compressed gas cylinders (including empty ones) upright at all times. This paragraph provides: Compressed gas cylinders shall be secured in an upright position at all times except, if necessary, for short periods of time while cylinders are actually being hoisted or carried. 1926.350(a)(11) Inside of buildings, cylinders shall be stored in a well-protected, well-ventilated, dry location, at least 20 feet (6.1 m) from highly combustible materials such as oil or excelsior. Cylinders should be stored in

Oxygen tanks to be secured in current setting. Administrator is responsible for ensuring that all gas cylinders are kept securely.
Completion date June 28, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 360	Continued From Page 23 definitely assigned places away from elevators, stairs, or gangways. Assigned storage places shall be located where cylinders will not be knocked over or damaged by passing or falling objects, or subject to tampering by unauthorized persons. Cylinders shall not be kept in unventilated enclosures such as lockers and cupboards..."	T 360		
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 observation and interview the facility failed to maintain the procedure table, recovery stretcher pads, and recovery recliners in good repair. The findings included: An observation and interview was conducted on May 15, 2012 from 10:20 a.m. to 11:18 a.m. with Staff #2. The observation in the procedure room revealed the procedure table's metal finish was not intact. The full length of the bilateral leg supports for the stirrups (used to position the patient during the procedure) had rust. The ledge of the table that surrounded the table's padded surface had multiple areas of rust. The pedestal of the procedure table had multiple areas of rest. The procedure table's armrest had multiple worn and non-intact areas. Staff #2 verbally	T 375	T 375 Procedure table replaced. Staff trained to routinely monitor equipment for tears and rust and to advise administrator if problems identified. Job descriptions reflect staff responsibility. Administrator ultimately responsible. Completion date June 26, 2012	

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 375	Continued From Page 24 acknowledged the procedure table was in need of re-finishing. The observation conducted with Staff #2 in the Recovery room revealed three (3) of three (3) Recovery room recliners had tears in their surface material. Two (2) recliners had torn armrest, one (1) recliner had a torn area on the sling between the seat and the footrest, and all three (3) recliners had torn areas on the back of the headrest. Staff #2 verbally acknowledged the Recovery room recliners were not in good repair. The observation conducted in the Recovery room with Staff #2 revealed that two (2) of two (2) Recovery Room stretcher pads had extensive torn areas with exposure of the inner padding. The observation revealed a zippered area that separated the upper and lower portion of the pads was torn the width of each pad. The torn area left the inner foam padding exposed on both pads. Both stretcher pads had multiple worn areas and non-intact surfaces, which would allow blood or body fluids to be absorbed into the underlying exposed foam. Staff #2 reported the pads on the Recovery room stretchers needed to be replaced.	T 375	T 375 One recliner has been replaced and 2 have been repaired. Completion date June 18, 2012 Stretcher pads replaced Completion date June 26, 2012 Staff trained to routinely monitor equipment and advise administrator if problems identified. Job descriptions reflect that responsibility. Administrator is ultimately responsible. Completion date June 28, 2012	
T 380	12 VAC 5-412-380 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.	T 380		

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 380	Continued From Page 25	T 380		

This RULE: is not met as evidenced by:
Based on observation, interview and record review the facility failed to develop a process to ensure equipment used in direct patient care underwent preventative maintenance (PM) and failed to document proof of preventative maintenance on required direct patient care equipment.

The findings included:

1. An observation on May 15, 2012 during the initial tour revealed the following equipment utilized during direct patient care did not have proof of preventative maintenance per the manufacturer's recommendations:
One of one anesthesia Co 2 (carbon dioxide) absorber;
One of one suction pump used during procedures;
One of one ultrasound devices;
One of two autoclaves; and
One of one glucometer.
Staff #2 acknowledged the findings and was not able to provide proof of preventative maintenance on the above direct care equipment. Staff #2 was not able to provide proof the glucometer was for single or multiple patient use.
A review of the facility's PM log revealed it did not include documentation for all direct care equipment that needed preventative maintenance. The PM log was reviewed with Staff #2, who reported the log was not up-to-date.

Suction pump, ultrasound machine, autoclave have had PMs performed. CO 2 absorber is a filter, not electrical equipment.. Glucometer has been removed from service until it can be researched for appropriate use in this facility. Administrator is responsible for preventive maintenance program.
Completion date June 28, 2012

T 400 12 VAC 5-412-380 Local and state codes and standards — T 400

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

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 400	Continued From Page 26	T 400		

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 interview and facility tour it was determined the facility failed to have an architect attestation and failed to meet FGI (AIA) Guidelines for Chapters 3.1 and 3.7.

The findings include:

1. On May 15, 2012 a facility tour was conducted with the Administrator and the Medical Director, between 9:00 a.m. and 11:30 a.m. During the facility tour there was no evidence that the facility met the state and local codes and building ordinances.

The facility failed to have an attestation from a licensed Architecture that the facility met the required FGI (AIA) guidelines. There was no over head shelter for Buildings #1 and #2 to protect patients from inclement weather. The Medication Distribution Station was located in the Procedure

Have been consulting architects and mechanical engineers to survey areas that need to be retrofitted to come into compliance. See attached
Completion date December 2013

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 400	Continued From Page 27	T 400		

Room, without a sink present for hand hygiene Nourishments were located within the Recovery Room; the staff failed to have documentation of a temperature log for the refrigerator. No temperature control or separate ventilation was seen in the Clean Storage Room. Chemicals were not secured and separated from clean supplies stored in the Clean Storage Room. Soiled Holding failed to have a flushing-rim clinical sink. The facility did not have a wheelchair present or a designated area for wheelchair storage. The facility was not able to provide proof of on-site laundry water temperature (which needs to be at 180 degrees Fahrenheit), prior to exit on 5/16/12 at 12:15 p.m. The facility's Public Corridors failed to meet the minimum 5 feet width. The facility's sinks failed to have valves that could be opened with hands (single handle or wrist blades at least 4 inches in length).

The Administrator was unable to provide documentation that insulation provided: conserve energy, protect personnel, prevent vapor condensation and reduce noise. Insulation have a flame-spread rating of 25 or less and a smoke-developed rating of 50 or less in accordance with NFPA 255. The facility was unable to provide any information for HVAC ductwork.
The facility's electrical receptacle (convenience outlets) were not grounded without use of adapters for three pronged equipment. No manual fire system was available as required.

2. On May 16, 2012 at 12:18 p.m., an interview was conducted with the Administrator in the agency's office. The Administrator acknowledged that the facility was unable to provide evidence that the facility met the state and local codes and building ordinances.

Purell dispenser in the procedure room for hand hygiene for medication preparation area. Completion date May 1, 2012
Temperature log started for refrigerator. June 28, 2012
Mechanical engineer to address ventilation in clean storage room.
Completion date July 30, 2012
Chemicals secured and separated from clean supplies.
Completion date May 17, 2012
Wheelchair purchased and stored in designated area.
Completion date June 28, 2012
New washing machine purchased.
Sink to be replaced with sink with knee operation.
Mechanical engineer and electricians being brought in to address ventilation and electrical concerns
Completion date October 2012
See attached for remainder of timeline.

RECEIVED
JUL 02 2012
VDH/OLC

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	12 VAC 5-412 Initial comments An announced Initial Licensure First Trimester Abortion Facility inspection was conducted at the above referenced facility on May 15, 2012 through May 16, 2012 by three (3) Medical Facilities Inspectors from the Virginia Department of Health's, Office of Licensure and Certification. The facility was out of compliance with the State Board of Health 12 VAC 5-412, Regulations for First Trimester Abortion Facility's effective December 29, 2011. Deficiencies were identified, cited, and will follow in this report.	T 000		
T 070	12 VAC 5-412-170 C Personnel C. Each abortion facility shall obtain a criminal 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 employee record review, center document review, and staff interview, the center staff failed to ensure a criminal record check was obtained for 8 of 10 employees who provided access to controlled substances. Employee #'s 3, 7, 8, 11, 15, 16, 20, and 21. On 5/15/12 at 1:00 p.m., employee records were reviewed. Ten records were included for employees who provided access to controlled substances within the center. For 8 (eight) of the 10 (ten) records, no criminal background check was found. The center policy and procedure "Personnel Policies" was reviewed and evidenced the following, in part: "Criminal history checks will be conducted for staff with access to controlled	T 070	T070 Criminal background checks will be obtained for all employees whose job duties provide access to controlled substances. An item will be added to the orientation checklist for every employee whose job duties provide access to controlled substances that a criminal background has to be obtained. Personnel policy revised to include need for criminal background checks. Job descriptions for those staff will also include need for a criminal background check. Personnel files will be reviewed for completeness on an annual basis. Completion date June 28, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7-2-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 070	Continued From Page 1 substances." On 5/16/12 at 9:30 a.m., Staff #2 was interviewed regarding the criminal record checks being completed for the 8 employees. Staff #2 stated the criminal background checks had not been done. No further information was provided by the end of the survey.	T 070		
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 employee record review and staff interview, the center staff failed to ensure cardiopulmonary resuscitation certification (CPR) training was received and documented for 7 of 10 licensed/certified employees. Employee #'s 3, 5, 7, 8, 15, 16, and #20. No evidence of CPR training/recertification was present in the employee records. The findings included: On 5/15/12 at 1:00 p.m., employee records were reviewed. Of the 10 (ten) licensed/certified employee records, 7 (seven) did not have evidence of CPR training/recertification. Employees # 5, 7, 8 and 16 were Certified Registered Nurse Anesthetists, #3 was a Nurse Practitioner, and # 15 and 20 were Registered Nurses. In an interview with Staff #2 on 5/16/12 at 12:00 p.m., he/she stated he/she knew each of the employees held current CPR certifications, however acknowledged the evidence of certification was not present in the employee records.	T 075	T 075 CPR documentation will be obtained for Certified Registered Nurse Anesthetist and Registered Nurses. CPR training will be added to the orientation list. CPR training will be added to the Personnel Policy. Personnel files will be reviewed for completeness annually. Job descriptions will also include need for CPR training. Completion date: June 21, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 080	Continued From Page 2	T 080	T 080	
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 employee record review, center document review, and staff interview, the center failed to ensure 16 of 24 employees participated in annual infection control training. Employee #'s 2, 3, 4, 5, 7, 8, 9, 11, 12, 14, 15, 16, 19, 20, 21, and 23. The findings included: Employee records were reviewed on 5/15/12 at 1.00 p.m. There was no evidence of annual infection control training for 16 employees. On 5/16/12 at 9:30 a.m., Staff #2 stated the employees had not received annual infection control training. "Most all of our employees have been here a long time and I guess we just became complacent ..." No further information was provided by the end of the survey.	T 080	Fire Safety and Infection Prevention In-Service Training will be conducted initially and annually for staff. This has been added to the orientation checklist. This has been added to Personnel Policy. Documentation of In-service training will be included in each staff member's personnel file as well as a manual dedicated to training documents. The Inservice Training manual will be reviewed annually. Personnel files will be reviewed annually for completeness. Administrator will ultimately be responsible but will assign Infection Control Officer (the Nurse Practitioner) the duty of coordinating training and documentation. Completion date June 28, 2012	
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.	T 085	T 085 Job descriptions will be included in every employee's personnel file. She will sign the job description to indicate that she is aware of the responsibilities of her position. Job descriptions will be reviewed at least annually with new copies given to the employee in the event of revisions. The personnel policy will include procedure for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 085	Continued From Page 3 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 employee record review and staff interview, the center staff failed to ensure job descriptions for employees were reviewed at least annually for 19 of 24 employee records reviewed. Employee #'s 1 through 9, 11, 12, 15, 16, 18 through 21, #23 and #24. The findings included: On 5/15/12 at 1:00 p.m., employee records were reviewed. Of the 24 records reviewed, 19 employees did not have evidence the job description was reviewed at least annually in their personnel record. The employees were as follows: Employee #1 - date of hire (DOH) 10/91, #2 - DOH 1/2008, #3 - DOH 9/2010, #4 - DOH 12/2009, #5 - DOH 8/2010, #6 - DOH 8/2006, #7 - DOH 1992 (no month listed), #8 - DOH 9/2008, #9 - DOH 1978 (no month listed), #11 - DOH 12/2010, #12 - DOH 4/2008, #15 - DOH 4/2011, #16 - DOH 5/2006, #18 - DOH 1992 (no month listed), #19 - DOH 12/2000, #20 - DOH 7/2008, #21 - DOH 1993 (no month listed), #23 - DOH 1/2006, and #24 - DOH 1999 (no month listed). On 5/16/12 at 12:00 p.m., Staff #2 was informed of the findings. No further evidence was provided by the end of the survey.	T 085	T085 cont'd reviewing job descriptions at least annually. Personnel files will be reviewed for completeness annually. Job descriptions will be revised to include the date that the employee received the job description. Completion date June 28, 2012	
T 090	12 VAC 5-412-170 G Personnel G. A personnel file shall be maintained for each staff member. The records shall be completely and accurately documented, readily available, and systematically organized to facilitate the	T 090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 090	Continued From Page 4 compilation and retrieval of information. The file shall contain a current job description that reflects the individual's responsibilities and work assignments, and documentation of the person's in-service education, and professional licensure, if applicable. This RULE: is not met as evidenced by: Based on employee record review and staff interview, the center staff failed to ensure all employee records contained a current job description for 6 of 24 employee records reviewed. Employee #'s 2, 3, 4, 11, 15, and #20. No job description was present in the employee records when reviewed. The findings included: On 5/15/12 at 1:00 p.m., employee records were reviewed. Of the 24 records reviewed, 6 employees did not have a job description contained in their personnel record: Employee #2 (Housekeeping), #3 (Nurse Practitioner), #4 (Housekeeping), #11 (Registered Nurse), # 15 (registered Nurse), and #20 (Registered Nurse). On 5/16/12 at 12:00 p.m., Staff #2 was informed of the findings. No further evidence was provided by the end of the survey.	T 090	Job descriptions have been added to the personnel files for those staff who did not have them. Orientation checklist includes job descriptions. Personnel policy includes job descriptions must be in the personnel file for each employee. Personnel files will be reviewed annually to ensure completeness. Completion date June 18, 2012	T090
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	T 170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 170	Continued From Page 5	T 170		

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 observations, interviews and record review the facility failed to ensure:

1. That staff wore the correct personal protective equipment (PPE) related to risk of exposure to blood and body fluids for one (1) of one staff observed in the "soiled" utility room.

2. The development of a procedure/process to monitor staff's adherence to the facility's infection prevention practices. The development of a process for retraining staff annually to infection prevention practices.

3. That staff had documented infection prevention training for sixteen (16) of twenty-four (24) employee records reviewed. (Employee # ' s 2, 3, 4, 5, 7, 8, 9, 11, 12, 14, 15, 16, 19, 20, 21, and 23)

The findings included:

1. Observations and interview were conducted on May 15, 2012 from 12:10 p.m. through 1:30 p.m. with Staff #5 in the "Soiled" utility room after two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	116 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 170	Continued From Page 6	T 170	T170 Staff member to be retrained in the proper use of PPE. Documentation of training to be included in the personnel file. Policy for monitoring infection control compliance written. Infection Control Survey written; to be performed quarterly. Results to be submitted to Quality Assurance Committee. Completion June 23, 2012	

(2) procedures. Staff #5 wore a blue cloth jacket over his/her scrub attire. When questioned related to the type of PPE needed to work or be in the "Soiled" utility room; Staff #5 stated, "I just wear this jacket over my clothes and gloves." Staff #5 denied the need for a mask, face shield or eye protection. Staff #5 did not wear a face shield or eye protection when cleaning soiled items in the utility room.

The observation revealed Staff #5 retrieved a re-usable glass suction jar from the pass through opening in the wall between the procedure room and the "Soiled" utility room. Staff #5 emptied the liquid contents, blood and other body fluids, from the glass jars into the utility sink. Staff #5 rinsed the jars with tap water and used a bottlebrush to "remove any clotted blood".

Staff #5 poured approximately one-forth (1/4) to one-third (1/3) cup of bleach into the glass bottle and swirled the bleach around the inner bottom of the jar. Staff #5 did not have a face shield or eye protection in place to guard against blood, body fluid or bleach splatter.

Staff # 5 used a bristled brush to remove blood and body tissues from the instruments utilized during the procedure. At the completion of the first of two-soiled equipment cleaning, Staff #5 had wet splatter areas on the front of his/her blue jacket.

A second post procedure cleaning process was observed with Staff #5 in the "Soiled" utility room. Staff #5 followed the same processes. Staff #5 previously confirmed the outside of the glass jar had been rinsed in water only and had not been disinfected prior to placing the jar on the "Clean" utility counter. Staff #5 did not put on gloves prior to placing the stopper into the glass jar and transporting the contaminated glass jar from the "Clean" utility room to the procedure room.

An interview was conducted on May 15, 2012 at 3:15 p.m. with Staff #2. The surveyor informed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 170	Continued From Page 7 Staff #2 of the findings from the observation of Staff #5's use of PPE and the handling of soiled equipment. Review of the facility's policy titled "Personal Protective Equipment" effective date January 1, 2012 read "... All staff will receive training on the proper selection of and use of PPE ... Wear mouth, nose, and eye protection during procedures that are likely to generate splashes or sprays of blood or other body fluids ..." 2. The center had no procedure for monitoring staff compliance of infection control procedures and had no documentation of annual retraining for infection control. The Center's "Policies and Procedures" were reviewed on 5/15/12 at 10:00 a.m. There was no policy or procedure regarding how staff would be monitored to ensure they were adhering to infection control practices. 3. Employee records were reviewed on 5/15/12 at 1:00 p.m. There was no evidence of annual infection control training for 16 employees. On 5/16/12 at 9:30 a.m., Staff #2 stated the employees had not received annual infection control training. When interviewed regarding how staff was being monitored to ensure they were following proper infection control practices, Staff #2 stated, "Most all of our employees have been here a long time and I guess we just became complacent ..." Staff #2 stated there was no policy/procedure which addressed the process for monitoring staff. No further information was provided by the end of the survey.	T 170	T 170 Policy for monitoring infection control compliance written. Infection Control Survey tool to be used quarterly to monitor adherence to plan. Infection control training to be done initially and at least annually. This has been added to orientation checklist and personnel policy. Personnel files to be reviewed annually for completeness. Completion date June 28, 2012	
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:	T 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 8	T 175		

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:
(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A BUILDING _____ B WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 9	T 175		

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, Interview and record review the facility failed to ensure the implementation of infection prevention practices as evidenced by:

1. Dried blood was observed on the sling between the seat and footrest on two (2) of three (3) Recovery recliners.

2. Three (3) of three (3) Recovery recliners had torn surfaces and could not be disinfected between patients. Two (2) of two (2) Recovery stretcher pads had multiple torn surfaces and could not be disinfected between patients. The metal finish and armrest pad were not intact and could not be disinfected between patients for one (1) of one (1) Procedure table.

3. The facility staff was not able to determine that linens laundered on-site were processed at the correct water temperature of 160 degrees Fahrenheit.

4. Staff failing to perform hand hygiene between glove changes and the lack of hand hygiene supplies.

5. Chemicals were stored on the shelves with "Clean" supplies; expired supplies were readily availability for access and supplies stored in opened packages.

6. The failure to perform preventative maintenance on equipment utilized in direct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 10	T 175		

patient care.
7. Snacks provided for patients were multiple unwrapped items in opened packages, which increased cross-contamination of the food products.
8. The staff's handling of clean and dirty equipment between patients and staff's knowledge of manufacturer's recommendations for cleaning re-usable equipment between patients. Staff re-used sponges for cleaning blood and body fluid spills post procedures.
9. A failure to develop procedures for the processing of each type of reusable medical equipment between uses on different patients, procedures for appropriate disposal of non-reusable equipment, and procedures for cleaning of environmental surfaces with appropriate cleaning products.
The findings included:
1. An observation and interview was conducted with Staff #2 on May 15, 2012 at 10:50 a.m. in the Recovery room. Staff #2 reported the Recovery recliners were cleaned between each patient use. Staff #2 reported the Recovery recliners had not been utilized since the last procedure day (May 5, 2012) and were ready for patients. Staff #2 and the surveyor placed the Recovery recliners in a raised foot position. The observation revealed two (2) of the three (3) Recovery recliners had an area of five (5) inches or greater of dark reddish brown substance on the sling between the seat and the footrest. Staff #2 identified the dark reddish brown substance as dried blood. Staff #2 reported understanding the infection risk related to blood left on the Recovery recliners between patients.
2. An observation and interview was conducted on May 15, 2012 from 10:20 a.m. to 11:18 a.m. with Staff #2. Staff # 2 reported the procedure table was wiped down with a 1:10 bleach/water solution between patients. The observation in the procedure room revealed the procedure table's

T 175

Staff retrained regarding need to disinfect surfaces between each patient use. Job descriptions revised to include disinfecting as a job responsibility. Infection Control Survey to be conducted quarterly to monitor adherence to infection control practices. Staff instructed to monitor condition of equipment and advise administrator in the event of a tear or other condition which would hinder disinfection. Completion date June 28, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 11 metal finish was not intact. The full length of the bilateral leg supports for the stirrups (used to position the patient during the procedure) had rust. The ledge of the table that surrounded the table's padded surface had multiple areas of rust. The pedestal of the procedure table had multiple areas of rust. The procedure table's armrest had multiple worn and non-intact areas. The non-intact surfaces prevented the disinfection of the procedure table and its armrest between patients. Staff #2 observed the findings and stated, "You're right the surfaces are not intact." Staff #2 verbally acknowledged the non-intact surfaces prevented disinfection of the procedure table between patients. The observation conducted with Staff #2 in the Recovery room revealed three (3) of three (3) Recovery room recliners did not have intact surfaces. Staff #2 reported the Recovery "recliners are cleaned between each patient use." Two (2) recliners had torn armrest, one (1) recliner had a torn area on the sling between the seat and the footrest, and all three (3) recliners had torn areas on the back of the headrest. Staff #2 verbally acknowledged the non-intact surfaces prevented the disinfection of the Recovery room recliners between patients. The observation conducted in the Recovery room with Staff #2 revealed that two (2) of two (2) Recovery Room stretcher pads had extensive torn areas with exposure of the inner padding. The observation revealed a zippered area that separated the upper and lower portion of the pads was torn the width of each pad. The torn area left the inner foam padding exposed on both pads. Both stretcher pads had multiple worn areas and non-intact surfaces, which would allow blood or body fluids to be absorbed into the underlying exposed foam. Staff #2 confirmed the pads on the Recovery room stretchers had non-intact surfaces with exposed foam, which prevented	T 175	T 175 Procedure table to be replaced. Staff retrained to monitor equipment routinely and advise administrator of problem areas. Infection control survey to be conducted quarterly. Completion date June 26, 2012 T 175 One recliner replaced. Two recliners repaired. Staff trained to monitor equipment routinely and advise administrator of problem areas. Infection control survey to be conducted quarterly. completion date June 18, 2012 T 175 Stretcher pads replaced. Staff trained to monitor equipment routinely and advise administrator of problem areas. Infection control to be conducted quarterly. completion date June 26, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 12 disinfection of the stretchers pads between patients. 3. An observation was conducted on May 15, 2012 during the initial tour. The observation revealed a standard washer and dryer used by the facility to launder linens. An interview was conducted on May 16, 2012 at 9:08 a.m. with Staff #2. Staff #2 reported the facility's linens were washed in hot water. Staff #2 was not able to confirm the linens were laundered at the correct water temperature of 160 degrees Fahrenheit. Staff #2 reported the facility had a single hot water heater, which supplied hot water to all areas (utility and hand washing sinks). Staff #2 reported the washer did not have a water temperature booster or separate water heating unit. 4. Observations and interview was conducted on May 15, 2012 from 12:10 p.m. through 1:30 p.m. with Staff #5. Observations were conducted with Staff #5 in the "Soiled" utility room for two (2) procedures. With two (2) surveyors present, Staff #5 washed his/her hands at the utility sink in the "Soiled" utility room and used his/her hand to turn off the water. Staff #5 did not have paper towel available to turn off the water at the sink or to dry his/her hands. Staff #5 with contaminated wet hands entered the "Clean" utility room and tore off paper towel from that roll. Staff #5 with contaminated hands pulled gloves from a box of gloves in the "Clean" utility room. Staff #5 did not wash his/her hands between three glove changes or when changing task between the "Soiled" and "Clean" utility rooms. Staff #5 stated, "This is the way I usually do things I hope I'm doing it right." The surveyor informed Staff #5 that his/her current practices introduced contaminates from the "Soiled" utility room into the "Clean" utility room. 5. An observation and interview conducted during the initial tour of the "Clean" utility and Procedure rooms on May 15, 2012 from 10:09 a.m. to 10:50	T 175	T 175 Washing machine being replaced. Replacement ordered with expected delivery date June 26, 2012. Preventive maintenance to be conducted annually and results to be forwarded to Quality Assurance Committee. T 175 Paper towel dispenser to be installed in "soiled" utility room. Retraining on proper hand hygiene and glove changing conducted. Infection Control Survey to be conducted quarterly. Completion date June 28, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A BUILDING _____ B WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 13 a.m. with Staff #2. Observations in the "Clean" utility room revealed opened gallon container of bleach, opened gallon container of Iodine and soap powder were stored on the shelf with "Clean" supplies. Staff #2 reported the chemicals were stored in the "Clean" utility room for easy excess to the "Soiled" utility and procedure rooms. Staff #2 was not aware that chemicals needed to be in a locked area and not stored with "Clean" supplies. The observation revealed two (2) -pathology collection kit stored under the autoclave; displayed evidence that liquids had damaged the boxes. The observation revealed the following expired supplies were available for use in the procedure room: Two (2) curettage instruments wrapped in sterilization packs, which did not have dates related to sterilization. [A curettage is a surgical instrument used to scrape or remove the lining of the uterus.]; One (1) 3/15 dilator wrapped in a sterilization pack, which did not have a date of sterilization. [A dilator is a surgical instrument used to dilate (widen) the opening of the cervix.]; Two (2) tracheal tubes (7.0 and 3.0) had expired (exp.) 12/31/1995; One tracheal tube (5.0) had exp. 06/30/1996; Four (4) ECG (electro cardiogram) monitoring pads had exp. March 2000; Five (5) packages of snap electrodes had exp. 05/2007; One container of Formalin had exp. 11/ 2004 [Formalin is an aqueous solution of the chemical compound formaldehyde used to preserve tissue samples for analysis.]; Six (6) packs of Ethicon 0.5 silk sutures had exp. 01/2009; One of one containers of glucometer test strips had exp. 05/2007; and One of one sets of glucometer test/calibration	T 175	T 175 Chemicals removed from clean utility area. Moved to locked area. Pathology kits discarded because of damage. Nothing to be stored under sinks to reduce risk of contamination. Completion date May 18, 2012. T 175 Instruments must have the date of sterilization and initials of staff person written on them. When setting up the procedure room each day, staff is to monitor appropriate dating and initialling of packs. Pack is to be rejected if not marked appropriately and re-sterilized. Completion date May 18, 2012 T 175 Expired tracheal tubes discarded. Expired ECG electrodes discarded. Expired Formalin container discarded. Expired ethicon discarded. Expired glucometer test strips discarded. Expiration dates to be checked monthly and logged. Completion date May 18, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 14	T 175		

solutions had exp. 07/2007.
Staff #2 reported facility staff had inspected the Procedure room and had missed the expired supplies. Staff #2 acknowledged the expired supplies were available for use, but should have been discarded by the expiration date.
The following items were stored in a cabinet next to the anesthesia cart. The tracheal tube packages were open, with an inserted guide stylus and left uncovered exposed to contaminates:
Two (2) tracheal tubes (7.0),
Two (2) tracheal tubes (7.5), and
One (8.5) tracheal tube.
Staff #2 reported the nurse anesthetists were aware that the tracheal tubes could not be stored in open packages with the guide stylus in place.
6. Observation on May 15, 2012 during the initial tour revealed the following equipment utilized during direct patient care did not have proof of preventative maintenance per the manufacturer's recommendations:
One of one anesthesia Co 2 (carbon dioxide) absorber;
One of one suction pump used during procedures;
One of one ultrasound devices;
One of two autoclaves; and
One of one glucometer.
Staff #2 acknowledged the findings and was not able to provide proof of preventative maintenance on the above direct care equipment. Staff #2 was not able to provide proof the glucometer was for single or multiple patient use. The facility failed to have an infection prevention process in place related to preventing the spread of hepatitis by glucometers, which have not been thoroughly disinfected.
7. An observation and interview was conducted on May 15, 2012 between 10:50 a.m. and 11:18 a.m. with Staff #2. The observation revealed a plastic container with opened packages of various cookies. The cookies were not individually

T 175
Anesthetists to change to a tracheal tube with an inserted guide stylus packaged with it. This will allow the anesthetists to be prepared but with an unopened package.
Completion date June 23, 2012

T 175
PM has been performed on suction pump, ultrasound machine, autoclave.
Tech to return to complete checks. Glucometer to be removed from service until it can be thoroughly researched whether it may be properly used in this setting.
Completion date June 28, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 15 wrapped and some cookies were scattered unprotected on the bottom of the container. Staff #2 reported the cookies were used as snacks for patients during their Recovery room wait. Staff #2 acknowledged the cookies were loose inside the plastic container and not protected from contaminates when staff or patients reached into the plastic container. 8. Observations and interview was conducted on May 15, 2012 from 12:10 p.m. through 1:30 p.m. with Staff #5 in the "Soiled" utility room after two (2) procedures. Staff #5 wore a blue cloth jacket over his/her scrub attire. Staff #5 placed three (3) sponges on the ledge of the opening between the procedure room and the "Soiled " utility room. Staff #5 reported the sponges were used to "wipe up after the procedures." Staff #5 reported the same sponges were reused. Staff #5 reported the sponges were rinse in tap water, then dipped in the 1:10 bleach/water solution and placed back on the ledge. Staff #5 collected the re-usable glass suction jars from the pass through opening in the wall between the procedure room and the "Soiled" utility room. Staff #5 emptied the liquid contents of the glass jars into the utility sink, rinsed the jars with water, used a bottlebrush to "remove any clotted blood", pour approximately one-forth (1/4) to one-third (1/3) cup of bleach into the glass bottle and swirled the bleach around the inner bottom of the jar. Staff #5 used tap water to rinsed the black stopper, utilized with the suction bottle during procedures then placed the stopper in a container with 1:10 bleach/water solution. The stopper was not submersed in the bleach/water solution. Staff #5 did not have a clock in the "Soiled" utility room. When asked regarding the length of time the bleach needed to be in the glass jar or the stopper needed to be in contact with the 1:10 bleach/water solution; Staff #5 stated, "Not long, a couple of minutes." Staff #5 acknowledged the "Soiled"	T 175	T 175 Staff is to wear gloves and package several cookies and crackers in individual sized baggies each day prior to seeing patients. Completion date June 14, 2012 T 175 Sponges are not to be used in the facility in patient areas. One time use saniwipes designated for medical facilities will be used. Staff trained on CDC Principles of Cleaning and Disinfecting Environment Surfaces. Documentation of training in personnel file. Infection control survey to be conducted quarterly. Completion date June 23, 2012 T 175 Stopper and glass bottle to be sprayed with Cavicide and allowed to remain wet for 3 minutes. A clock or timer to be used in soiled utility. Staff trained to procedure. Documentation of training in personnel file. Infection control survey to be conducted quarterly. Infection control training to be conducted initially and at least annually. Completion date June 23, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	116 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 16	T 175		

utility room did not have a clock. Staff #5 did not utilize a wristwatch to time the contact time of the stopper in the 1:10 bleach/water solution. Staff #5 did not turn the stopper to ensure all surfaces of the stopper had contact with the 1:10 bleach/water solution. Staff #5 removed the stopper from the bleach/water solution placed the stopper in a metal bowl for transport to the "Clean" utility room. Staff #5 emptied the bleach from the glass jar, removed one "Soiled" glove to open the door between the "Soiled" and "Clean" utility rooms. Staff #5 holding the jar with the other "Soiled" gloved hand placed the jar on the counter in the "Clean" utility room. Staff #5 did not remove the blue cloth jacket worn in the "Soiled" utility room during the cleaning process before he/she entered the "Clean" utility room. Staff #5 acknowledged the bleach poured into the glass jar did not contact the total inner surface of the jar. Staff #5 confirmed the outside of the glass jar had been rinsed in water only and had not been disinfected prior to placing the jar on the "Clean" utility counter.

The observation revealed after the first procedure was completed Staff #2 from the procedure side of the opening retrieved the sponges from the ledge. Staff #2 used the sponges in the procedure room and returned them to the ledge. The sponges were contaminated with bloody fluids. Staff #5 removed the sponges from the ledge, rinsed them in tap water, and dipped them in the 1:10 bleach/water solution. Staff #5 squeezed the sponges over the utility sink and placed the same sponges back on the ledge. The observation revealed the sponges were dipped into the 1:10 bleach/water solution for less that one (1) minute. Staff #5 was asked about the multiple re-using of the sponges and the amount of time the sponges needed to be in the bleach/water solution. Staff #5 stated, "I try to keep them (the sponges) as long as I can, but the

T 175
Stopper and jar to be placed in a closed container designated for the transport of equipment from soiled utility to clean utility. In the clean utility room the stopper and jar to be placed on the counter until ready to be used in the procedure room. It is then placed in a lidded container designated for transport from clean utility to procedure.
Staff to be trained in process. Documentation to be placed in personel file. Infection Control Survey to be conducted quarterly.
Completion date June 23, 2012

T 175
Sponges not to be used in patient areas. Bloody fluids to be cleaned according to CDC Principles of Cleaning and Disinfecting Environment Surfaces using disposable wipes.
Training to be documented in personnel file.
Infection Control Survey to be conducted quarterly.
Completion date June 23, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 17	T 175		

bleach makes them (the sponges) disintegrate." Staff #5 was not able to provide the amount of contact time needed to ensure the sponges were disinfected between uses.
A second post procedure process was observed with Staff #5 in the "Soiled" utility room. Staff #5 followed the same processes. The bottlebrush was not disinfected between usages. Staff #5 did not put on gloves prior to placing the stopper into the glass jar and transporting the contaminated glass jar to the procedure room. Staff #5 did not remove the blue jacket he/she wore in the "Soiled" utility room prior to entering the "Clean" utility room or the procedure room.
The observation after the second procedure revealed from the procedure side Staff #2 retrieved the sponges from the ledge. Staff #2 was observed from the opening by the surveyor to wipe down equipment then return the sponges to the ledge contaminated with bloody fluids. Staff #5 removed the sponges from the ledge, rinsed them in tap water, dipped them in the 1:10 bleach/water solution, squeezed the sponges over the utility sink and placed the same sponges back on the ledge. Staff #2 passed soiled suction pump lines through the opening and in the process dripped bloody fluids on the ledge. Staff #5 used one of the sponges to clean the ledge then cleaned the sponge in the above cited manner and replaced the sponge on the ledge for re-used.
An interview was conducted on May 15, 2012 at 3:15 p.m. with Staff #2. Staff #2 reported the purpose of separating the "Clean" and "Soiled" utility rooms was to reduce cross-contamination. The surveyor informed Staff #2 of the findings from the observation of staff handling "Clean" and "Soiled" equipment. The requested documentation was not received prior to exit related to the procedure, the effectiveness or contact time of the 1:10 bleach/water solution as a

T 175
Bottle brush to be sprayed with Cavicide and allowed to remain wet for 3 minutes. Staff will wear gloves prior to placing the disinfected stopper and glass jar in the designated container.
Staff trained to remove PPE prior to leaving soiled utility room.
Completion date June 23, 2012
T 175
Sponges are not to be used. Disposable wipes to be used to disinfect surfaces contaminated with blood and other body fluids.
Completion date June 23, 2012
T 175
Training on infection control to be conducted initially and at least annually. Infection control policies to be reviewed at least annually. A designated staff member to receive certification in infection control and be available to review procedures and facilitate further staff training. Infection Control Survey to be conducted quarterly.
Completion date June 23, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 18	T 175		

disinfectant for the stopper and glass jar.
Review of the facility's policy titled "Personal Protective Equipment" effective date January 1, 2012 read "...Perform hand hygiene immediately after removing gloves ..."
Review of the facility's policy titled Hand Hygiene" effective date January 1, 2012 read "... Key situations where hand hygiene should be performed include but are not limited to...after glove removal ... Soap and working sinks with hot and cold running water and disposable paper towels will be available near any area involving body fluids ..."
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 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

T 175
Sponges not to be used in patient areas
Completion date June 21, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 175	Continued From Page 19 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..." 9. The center staff failed to ensure development of procedures for the processing of each type of reusable medical equipment between uses on different patients, procedures for appropriate disposal of non-reusable equipment, and procedures for cleaning of environmental surfaces with appropriate cleaning products. On 5/15/12 at 10:00 a.m., the center "policy and procedures" were reviewed. The surveyor was unable to locate any procedural processes regarding reusable medical equipment, non-reusable medical equipment, and cleaning procedures. The "Infection Control Plan" identified the following: E. Laundry Procedures - Facility policies and procedures will outline the handling, processing and storage of clean and dirty linen, as well as the use of disposable supplies ..." No corresponding "procedure/outline " was found. On 5/16/12 at 10:15 a.m., Staff #2 was interviewed. He/she stated there were no procedures for the reusable equipment, non-reusable equipment and for the cleaning of environmental surfaces. No further information was provided by the end of the survey.	T 175	T 175 Policy and procedure for processing reusable equipment has been written. Completion date June 22, 2012 T 175 Policy and procedure for handling soiled linen has been written Completion date June 22, 2012	
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 transmission to other personnel or patients;	T 180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 180	Continued From Page 20 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 employee record review and staff interview, the center staff failed to ensure documentation of screening for tuberculosis (TB/PPD) for 19 of 24 employee records reviewed. Employee # 1, 2, 3, 4, 7, 8, 9, 11, 12, and 14 through 23. The findings included: Employee records were reviewed on 5/15/12 at 1:00 p.m. For 19 of the 24 employee records reviewed, there was no evidence that employees had received TB/PPD screening. On 5/16/12 at 12:00 p.m., Staff #2 was apprised of the findings and no further information was provided by the end of the survey.	T 180	T 180 TB/PPD Screening to be completed for all employees who have not been screened elsewhere in the past year. Completion date June 28, 2012	
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 temperatures in accordance with definitions in 18 VAC 110-20-10	T 275		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 275	Continued From Page 21	T 275		

This RULE: is not met as evidenced by:
Based on observations and staff interviews the facility failed to discard expired medications and medications that had not been dated when opened.

The findings included:

An observation and interview was conducted on May 15, 2012 from 10:20 a.m. to 11:18 a.m. with Staff #2 during the initial tour of the procedure room. The observation revealed the following medications were expired and available for administration:
Diazepam 10 mg (milligram)/ 2 ml (milliliter) syringe had expired (exp.) "2/2012";
Labetalol 20 mg/ 4 ml vial had exp. "4/2012";
Succinylcholine 100 mg/ 5 ml vial had exp. "1 May 12";
One tank of nitrous oxide had exp. "29 Mar (March) 2000."

The following medications were not dated when opened:

Pitocin 10 u (units)/ ml vial; and
One tube of KY jelly.

An interview was conducted with Staff #2 on May 15, 2012 from 10:20 a.m. to 11:18 a.m. during the observations. Staff #2 confirmed each finding and reported the expired medication should have been discarded. Staff #2 stated, "It is our practice to date each medication when it's opened. These have to be discarded."

T 275
Expired medications have been discarded. Expiration log to be completed monthly. Nitrous oxide tank has been removed from facility.
All opened medications are to be labeled with the date and the initials of staff who opened them.
Any opened medications found not to be properly labeled must be discarded. When setting up each procedure day, all items will be checked for proper labeling.
Staff trained to procedure.
Documentation of training in personnel files.
Completion date June 28, 2012

T 360 12 VAC 5-412-340 Policies and procedures — T 360

The abortion facility shall develop, implement and maintain policies and procedures to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 360	Continued From Page 22	T 360		

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:
12 VAC 5- 412-340 (2)
Based on observation and interview the facility failed to secure six (6) portable oxygen tanks.

The findings included:

An observation conducted in the building that housed the procedure room on May 15, 2102 at 11:22 a.m. with Staff #2 revealed six (6) unsecured portable oxygen tanks. The oxygen tanks were located between a file cabinet and the wall in an office. Staff #2 reported Staff #1 did not want the the additional oxygen tanks stored in the procedure room. Staff #2 was aware the oxygen tanks needed to be secured.

Review of "Title 29 CFR 1926.350(a)(9) requires employers to store all compressed gas cylinders (including empty ones) upright at all times. This paragraph provides: Compressed gas cylinders shall be secured in an upright position at all times except, if necessary, for short periods of time while cylinders are actually being hoisted or carried. 1926.350(a)(11) Inside of buildings, cylinders shall be stored in a well-protected, well-ventilated, dry location, at least 20 feet (6.1 m) from highly combustible materials such as oil or excelsior. Cylinders should be stored in

Oxygen tanks to be secured in current setting.
Completion date June 28, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 360	Continued From Page 23 definitely assigned places away from elevators, stairs, or gangways. Assigned storage places shall be located where cylinders will not be knocked over or damaged by passing or falling objects, or subject to tampering by unauthorized persons. Cylinders shall not be kept in unventilated enclosures such as lockers and cupboards.."	T 360		
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 observation and interview the facility failed to maintain the procedure table, recovery stretcher pads, and recovery recliners in good repair. The findings included: An observation and interview was conducted on May 15, 2012 from 10:20 a.m. to 11:18 a.m. with Staff #2. The observation in the procedure room revealed the procedure table's metal finish was not intact. The full length of the bilateral leg supports for the stirrups (used to position the patient during the procedure) had rust. The ledge of the table that surrounded the table's padded surface had multiple areas of rust. The pedestal of the procedure table had multiple areas of rest. The procedure table's armrest had multiple worn and non-intact areas. Staff #2 verbally	T 375	T 375 Procedure table to be replaced. Staff trained to routinely monitor equipment for tears and rust and to advise administrator if problems identified. Completion date June 26, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 375	Continued From Page 24 acknowledged the procedure table was in need of re-finishing. The observation conducted with Staff #2 in the Recovery room revealed three (3) of three (3) Recovery room recliners had tears in their surface material. Two (2) recliners had torn armrest, one (1) recliner had a torn area on the sling between the seat and the footrest, and all three (3) recliners had torn areas on the back of the headrest. Staff #2 verbally acknowledged the Recovery room recliners were not in good repair. The observation conducted in the Recovery room with Staff #2 revealed that two (2) of two (2) Recovery Room stretcher pads had extensive torn areas with exposure of the inner padding. The observation revealed a zippered area that separated the upper and lower portion of the pads was torn the width of each pad. The torn area left the inner foam padding exposed on both pads. Both stretcher pads had multiple worn areas and non-intact surfaces, which would allow blood or body fluids to be absorbed into the underlying exposed foam. Staff #2 reported the pads on the Recovery room stretchers needed to be replaced.	T 375	T 375 One recliner has been replaced and 2 have been repaired. Completion date June 18, 2012 Stretcher pads replaced Completion date June 26, 2012 Staff trained to routinely monitor equipment and advise administrator if problems identified. Completion date June 28, 2012	
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.	T 380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 380	Continued From Page 25 This RULE: is not met as evidenced by: Based on observation, interview and record review the facility failed to develop a process to ensure equipment used in direct patient care underwent preventative maintenance (PM) and failed to document proof of preventative maintenance on required direct patient care equipment. The findings included: 1. An observation on May 15, 2012 during the initial tour revealed the following equipment utilized during direct patient care did not have proof of preventative maintenance per the manufacturer's recommendations: One of one anesthesia Co 2 (carbon dioxide) absorber; One of one suction pump used during procedures; One of one ultrasound devices; One of two autoclaves; and One of one glucometer. Staff #2 acknowledged the findings and was not able to provide proof of preventative maintenance on the above direct care equipment. Staff #2 was not able to provide proof the glucometer was for single or multiple patient use. A review of the facility's PM log revealed it did not include documentation for all direct care equipment that needed preventative maintenance. The PM log was reviewed with Staff #2, who reported the log was not up-to-date.	T 380	Suction pump, ultrasound machine, autoclave have had PMs performed. Tech to return to check anesthesia cart. Glucometer has been removed from service until it can be researched for appropriate use in this facility. Completion date June 28, 2012	
T 400	12 VAC 5-412-380 Local and state codes and standards Abortion faculties 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	T 400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 400	Continued From Page 26	T 400		

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 interview and facility tour It was determined the facility failed to have an architect attestation and failed to meet FGI (AIA) Guidelines for Chapters 3.1 and 3.7.

The findings include:

1. On May 15, 2012 a facility tour was conducted with the Administrator and the Medical Director, between 9:00 a.m. and 11:30 a.m. During the facility tour there was no evidence that the facility met the state and local codes and building ordinances.

The facility failed to have an attestation from a licensed Architecture that the facility met the required FGI (AIA) guidelines. There was no over head shelter for Buildings #1 and #2 to protect patients from inclement weather. The Medication Distribution Station was located in the Procedure

Have been consulting architects and mechanical engineers to survey areas that need to be retrofitted to come into compliance. See attached
Completion date December 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 400	Continued From Page 27	T 400		

Room, without a sink present for hand hygiene Nourishments were located within the Recovery Room; the staff failed to have documentation of a temperature log for the refrigerator. No temperature control or separate ventilation was seen in the Clean Storage Room. Chemicals were not secured and separated from clean supplies stored in the Clean Storage Room. Soiled Holding failed to have a flushing-rim clinical sink. The facility did not have a wheelchair present or a designated area for wheelchair storage. The facility was not able to provide proof of on-site laundry water temperature (which needs to be at 160 degrees Fahrenheit), prior to exit on 5/16/12 at 12:15 p.m. The facility's Public Corridors failed to meet the minimum 5 feet width. The facility's sinks failed to have valves that could be opened with hands (single handle or wrist blades at least 4 inches in length).

The Administrator was unable to provide documentation that insulation provided: conserve energy, protect personnel, prevent vapor condensation and reduce noise. Insulation have a flame-spread rating of 25 or less and a smoke-developed rating of 50 or less in accordance with NFPA 255. The facility was unable to provide any information for HVAC ductwork.
The facility's electrical receptacle (convenience outlets) were not grounded without use of adapters for three pronged equipment. No manual fire system was available as required.

2. On May 16, 2012 at 12:18 p.m., an interview was conducted with the Administrator in the agency's office. The Administrator acknowledged that the facility was unable to provide evidence that the facility met the state and local codes and building ordinances.

Purell dispenser in the procedure room for hand hygiene for medication preparation area. Completion date May 1, 2012
Temperature log started for refrigerator. June 28. 2012
Mechanical engineer to address ventilation in clean storage room.
Completion date July 30, 2012
Chemicals secured and separated from clean supplies.
Completion date May 17, 2012
Wheelchair purchased and stored in designated area.
Completion date June 28, 2012
New washing machine purchased.
Sink to be replaced with sink with knee operation.
Mechanical engineer and electricians being brought in to address ventilation and electrical concerns
Completion date October 2012
See attached for remainder of timeline.

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	118 N. BOULEVARD RICHMOND, VA 23220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

Richmond Medical Center for Women
118 North Boulevard
Richmond, Virginia 23220
(804) 359-5066
(804) 353-2718 – fax

Orientation Checklist

Employee _____

Job Title(s) _____

Hire Date _____

	Emp Initials	Trainer init	Date	
1.	_____	_____	_____	Confidentiality Statement
2.	_____	_____	_____	Tour of Building
3.	_____	_____	_____	Job Description
4	_____	_____	_____	Signature Log
5	_____	_____	_____	Emergency Contact List
6	_____	_____	_____	Biweekly payday
7	_____	_____	_____	License if app
8	_____	_____	_____	Criminal Background Check if app
9	_____	_____	_____	CPR Training if app
10	_____	_____	_____	Policy and Procedures Manual
11	_____	_____	_____	Organizational Chart
12	_____	_____	_____	Disaster Preparedness
13	_____	_____	_____	HIPAA Training
14	_____	_____	_____	Bloodborne pathogen training
15	_____	_____	_____	Infection Control training
16	_____	_____	_____	Fire safety training
17	_____	_____	_____	Employee Health packet
18	_____	_____	_____	Keys

I have received the following keys: _____

Signature of Employee Date

Job Description

Front Desk

Front Desk responsibilities include, but are not limited to:

- Greeting Patients and guests
- Answering phones and Scheduling appointments
- Checking over patient paperwork
- Putting together charts (Patient information, consents, FDC's)
- Accepting and documenting payment
- Disinfect work area as needed
- Monitor work area for any need for repairs and advise administrator

Qualifications

1. Must be pro-choice.
2. Ability to multitask
3. Ability to maintain professional demeanor in high-stress environment.
4. Must be flexible.

Training

All staff will be trained in infection control and fire safety initially and annually

Signed _____

Date _____

Job Description

Lab Assistant

Qualifications:

- Must be pro-choice
- Must have previous medical experience

Under the general supervision of the clinic coordinator, the lab assistant is responsible for the daily operation of the laboratory including:

1. Drawing blood
2. Rh typing
3. Hemoglobin
4. Running pregnancy tests
5. Maintain patient test results log
6. Disinfect laboratory and reusable equipment after each clinic day
7. Inventory supplies and request restocking from clinic Administrator when necessary
8. Adhere to universal precautions per OSHA guidelines
9. Monitor work area for any need of repair and advise administrator
10. Cross train for other tasks where applicable
11. Other duties as assigned by clinic Administrator

Training: All staff will be trained in infection control and fire safety as well as training for her position. Training will be initially and annually.

Signed _____ Date _____

Job Description

Procedure Room

T 0 25

Staff responsible for assisting the Physician during the abortion procedure and reports directly to the physician and the Administrator.

Qualifications:

1. Must be pro-choice.
2. Must be appropriately trained by existing procedure room staff and then cleared for working.
3. Must be able to take direction.
4. Must be CPR certified

Responsibilities:

1. Act as physician's assistant and patient support person.
2. Proficient with sterile technique
3. Keep procedure room stocked
4. Cross train for recovery and other patient care areas.
5. Per physician instruction, assist in any emergency that may arise and get help immediately.
6. Disinfect procedure room at end of each procedure day
7. Disinfect reusable equipment per policy
8. Monitor work area for need for repairs and advise administrator
9. Other duties as assigned by the nursing supervisor or Administrator.

Training:

All staff will be trained in infection control and fire safety initially and annually

Signed _____Date_____

Job Description

Counselors

Qualifications:

- Must be Pro-Choice
- Knowledge of the Abortion Process, reproduction and birth control

The Abortion Counselor interacts with patients requesting pregnancy information in the following manner:

1. Interviewing each patient with respect to her motivations for seeking an abortion. The interview process should enable the counselor to determine if the patient has considered other options and feels secure with her decision, and if a support network exists.
2. Discussing any emotional or physical problems resulting from and associated with, this pregnancy or previous pregnancies and abortions.
3. Corroborating physician's impression as to whether continuation of the pregnancy will impair or jeopardize the patient's health.
4. Explaining in detail the contemplated surgical and non-surgical procedure, as well as any restrictions and potential after effects.
5. Discussing contraception extensively and comprehensively, and documenting contraceptive history and post-operative birth-control choice.
6. Informing patient of the availability of post abortion counseling
7. Reviewing consent forms and answering questions.
8. Following patient through surgical procedure, if necessary.
9. Checking patient in recovery, post-operatively for further counseling, if necessary.
10. Disinfect work area as needed
11. Monitor work area for any need for repairs and advise administratror

Training

All staff will be trained in inflection control and fire safety initially and annually as well as the training needed for her position.

Signed_____ Date_____

Job Description

Recovery Room Staff

Qualifications:

- Must be pro- choice
- Must have previous experience with patient care
- Must be certified in CPR
- Nurse must be licensed as licensed or registered nurse
- Nurse must have a criminal background check obtained

Recovery room staff is responsible for:

1. Emotional and physical support of each patient.
2. Meeting patient's needs during post-op observation.
3. Verification of patient identity.
4. Taking and recording vital signs.
5. Recording pertinent information on patients chart
6. Knowledge of sterile technique.
7. Assisting the physician in procedures if necessary.
8. Reporting changes in the patient's condition to person in charge or to the physician.
9. Maintenance and knowledge of use emergency equipment and medications.
10. Cleanliness and disinfection of assigned area.
11. Giving post-op care instructions.

Training: All staff will be trained in infection control and fire safety initially and annually

Signed _____ Date _____

RICHMOND MEDICAL CENTER FOR WOMEN

Job Description

HOUSEKEEPING

Qualifications:

- Able to be trained
- Able to take direction
- Understanding of waste management

Housekeeping is responsible for:

1. Disposing of routine waste
2. Placing biomedical waste in appropriate containers
3. Cleaning surface areas (window sills, baseboards, walls, floors)
4. Disinfecting areas as needed
5. Vacuuming carpeted areas
6. Assisting with laundry
7. Other duties at the request of administrator

Training: All staff will be trained in infection control and fire safety initially and annually

Signed _____ Date _____

RICHMOND MEDICAL CENTER FOR WOMEN

Job Description

CERTIFIED REGISTERED NURSE ANESTHETIST

Qualifications: Licensed as Certified Registered Nurse Anesthetist

CPR certified

Must submit a criminal history background check

CRNA's are responsible for:

Performing and documenting a pre-anesthetic assessment and evaluation of the patient, including drawing a blood sample for testing.

Obtaining informed consent for anesthesia

Developing and implementing an anesthetic plan.

Initiating MAC under the supervision of the physician

Monitoring the patient while under anesthesia

Managing the patient's airway and pulmonary status

Providing report to recovery nurse and providing post-anesthesia follow-up evaluation and care

Implementing acute pain management

Responding to emergency situations by providing airway management, administration of emergency fluids and drugs, and using basic or advanced cardiac life support techniques

Disinfecting work area

Monitoring work area for need for repairs and advising administrator

Training: All staff will be trained in infection control and fire safety initially and annually

Signed _____ Date _____

Richmond Medical Center for Women

Clinical Policies and Procedures Manual

Department: Personnel	**Policy Description:** Personnel Policies
Page: 1 of 1	**Replaces Policy Dated:**
Effective Date: 6/21/12	**Reference Number:** 12VAC5-412-170
Approved:	

Scope:	All Staff
Purpose:	To ensure personnel are hired, trained, and reviewed appropriately so that the center may function optimally to the satisfaction of the patients, the governing authority, and other staff
Procedure:	When filling a position, the new employee form will be utilized to ensure verification of qualifications for the position. An application will be obtained from all staff. Licensure will be confirmed for those staff with a license. Confirmation will be by going on line to the appropriate board's website and conducting license look-up. Criminal history checks will be conducted for those staff with access to controlled substances. Orientation checklist will be completed. A job description will be part of each personnel file. The staff member will sign and date the job description to indicate that she is aware of her responsibilities. Job descriptions will be reviewed annually. A copy will be given to each staff member initially and when revised. Fire safety training will be conducted initially and annually Infection prevention training will be conducted initially and annually Performance and competence will be evaluated annually; job descriptions will be reviewed at that time and revised as needed. CPR training will be kept up to date for staff working in the clinical areas. Violations of licensing or certification standards will be reported to the appropriate board within the Department of Health Professions. The administrator is responsible for reporting violations. A personnel file for each employee will be safeguarded against loss and unauthorized use. Employee health information will be maintained separately within the personnel file.
Reference:	12VAC5-412-170

Revised: Date & Initial:	6/12									
Reviewed: Date & Initial										

Richmond Medical Center for Women

Clinical Policies and Procedures Manual

Department: Infection Control	**Policy Description:** Infection Control Monitoring
Page: 1	**Replaces Policy Dated:**
Effective Date: 6/21/12	**Reference Number: 12VAC5-412-220B**
Approved:	

Scope:	Infection Control Officer; All Staff
Purpose:	To provide a tool to monitor the Center's infection control plan and to monitor compliance of the staff throughout the Center
Policy:	The Infection Control Officer shall use the Infection Control Survey quarterly to identify need for changes and corrective action.
Procedure:	Each quarter, the Infection Control Officer will conduct the Survey. Compliance issues will be identified and appropriate changes made. Findings will be reported to the Quality Assurance Committee. Retraining of staff will be performed as indicated by the survey.
Reference:	**12VAC5-412-220B**

T 120

Revised: Date & Initial:										
Reviewed: Date & Initial										

INFECTION CONTROL SURVEY

TO BE PERFORMED QUARTERLY TO MONITOR STAFF ADHERENCE TO INFECTION CONTROL PRACTICES

Performed by: Date:		
	YES	NO
Injection Practices		
Are needles used for only one patient?		
Are syringes used for only one patient?		
Are medication vials always entered with a new needle?		
Are medication vials always cleaned with alcohol before they are used?		
Are medications that are pre-drawn labeled with the medication name, initials of the person drawing, expiration date and time?		
Are single dose medication vials used for only one patient?		
Are bags of IV solutions used for only one patient?		
Is administration tubing an connectors used for only one patient?		
Are multi-dose vials dated and initialed when opened?		
Are they discarded according to manufacturers' recommendations?		
Are multi-dose vials stored away from immediate areas of direct patient contact?		
Are all sharps disposed in a puncture-resistant container?		
Are all sharps containers secure?		
Are all sharps containers replaced when the fill line is reached?		
Sterilization		
Is pre-cleaning always performed prior to sterilization?		
Does the staff use steam sterilization?		
Are all instruments inspected visually for proper cleaning prior to packaging and sterilization?		
Is there autoclave indicator tape or other indicator on each item?		
Is documentation of preventive maintenance present and up to date?		
Are all items contained and handled so as to assure sterility is not compromised?		
Are all instruments stored in a clean designated area?		
Are sterile packages inspected for tears, cracks, or damage prior to use?		
If a sterile package is compromised, are items resterilized prior to use?		
Are all packs initialed and dated?		

	Yes	No
Are items allowed to dry before use?		
Are sani-wipes used?		
Is Cavicide or equivalent used?		
Are timers used ?		
Environmental Infection Control		
Are procedure rooms terminally cleaned daily?		
Are all surfaces in procedure cleaned and disinfected with the proper approved disinfectant?		
Does the staff know the procedure to decontaminate gross blood spills?		
Are there rust spots or tears on equipment?		
Are chemicals stored AWAY from clean supply room?		
Program, System, Education		
Does the center have an explicit infection control program?		
Does the infection control follow national recognized infection control guidelines?		
Is there a person trained for infection control?		
Is there a complication log?		
Is there inservice or computer based infection control training for the staff?		
Does all of the staff receive infection control training?		
Is training conducted initially?		
Is training conducted annually?		
Is training documented?		
Hand Hygiene		
Do all areas have soap and water available to wash hands?		
Is there alcohol based hand rub available?		
Does staff perform hand hygiene after removing gloves?		
After direct patient contact?		
Before starting in IV?		
After removing gloves after contact with blood, body fluids, or contaminated surfaces?		
Does the staff wear gloves for procedures that might involve contact with blood or body fluids?		
Does staff wear gloves when handling contaminated patient equipment?		
Does staff remove gloves before moving to the next task and/or patient?		

Problems or issues		

[Reply] [Reply All] [Forward] [Mark Unread] Actions [Go] [Delete] [Spam]

Order confirmation - BuyRiteAppliances.com

From: Sales Department <orders@buyriteappliances.com>
To: William Fitzhugh <Peel1232@aol.com>
Date: Thu, Jun 21, 2012 10:08 am

BuyRite appliances
Your appliance **MEGA** store and more

Thank you for shopping www.BuyRiteAppliances.com This is to confirm that your order has been received and is being assigned to our sales division. Please allow 24-48 hours for your order to be processed.
Order #103559
Your order is subject to review. Once verified and approved your order will ship out via the shipping method selected. When your order will ship a tracking number will automatically be emailed to you.
Questions about your order? Please email us at customerservice@buyriteappliances.com or call us toll free at (888)400-8890.
Sincerely,

BuyRiteAppliances.com
facebook

Item	Sku	Qty	Subtotal
GE - GFWS3500LWW ***Signature Colors*** GE Profile: GFWS3500LWW	GFWS3500LWW -GFWS3500LWW	1	$849.00
		Subtotal	$849.00
		Shipping & Handling	$0.00
		Grand Total	**$849.00**

[Reply] [Reply All] [Forward] [Mark Unread] Actions [Go] [Delete] [Spam]

T 115

Expiration Date Log

Location: _____

Date: _____

Item	Expiration Date	Initials

T 175 / T 225

Richmond Medical Center for Women

Clinical Policies and Procedures Manual

Department: Infection Prevention	**Policy Description:** Processing of Reusable Medical Equipment
Page: 1 of 2	**Replaces Policy Dated:**
Effective Date: 1/1/12	**Reference Number: 12VAC5-412-220C7**
Approved:	

Scope:	All staff
Purpose:	To prevent the spread of infection via reusable medical equipment by detailing levels of cleaning and disinfecting each type of equipment.
Policy:	Reusable equipment shall be cleaned, disinfected, and sterilized to prevent infection from spreading from patient to patient or to staff
Procedure:	Reusable equipment will be processed accordingly: 1. Lab: a) Tourniquets: Use once. Place in container designated for used tourniquets. Wipe down with Cavicide wipe. Allow to dry for 3 minutes then return to the clean tourniquet container b) Vacutainers: Use once. Place in container designated for used vacutainers. At the end of the day, spray with Cavicide. Wait 3 minutes then rinse with clean water. 2. Ultrasound: a) Ultrasound probe: Abdominal: Wipe off gel after use. Spray with Transeptic. Vaginal: Cover with ultrasound probe cover before use. After use, wipe off gel. Spray with Transeptic. Allow to air dry b) Blood Pressure cuff: Wipe off cuff with Cavicide wipes after each use. Allow 3 minutes for cuff to dry. 3. Procedure: a) Tourniquets: see above b) Blood pressure cuff: see above c) Table: wipe off any visible blood with absorbent material and discard in red bag. Spray with Cavicide or use cavicide wipes. Allow to remain wet for 3 minutes. See manufacturer's recommendations. d) Instruments: Wash thoroughly with detergent. Wrap and sterilize. Single items will be placed in pouches. Sets will be wrapped in blue sterilization paper. Sterilize in autoclave according to manufacturers' instructions. Conduct Spore testing weekly (see Spore testing policy and procedure). Pouches are considered sterile if there are no rips or wet spots for a period of 2 years. Blue wrapped packs are sterile for one month. Rotate stock accordingly e) Glass bottle: Spray with Cavicide. Wait 3 minutes. Allow to dry in clean utility. f) Rubber stopper: Spray with Cavicide. Wait 3 minutes. Allow to dry in

Revised: Date & Initial:										
Reviewed: Date & Initial										

	clean utility. 4. Recovery a) Blood pressure cuff: see above b) Table: see above c) Recliners: treat same as table
Reference:	12VAC5-412-220C7; Cavicide surface disinfectant decontaminant cleaner: Metrex Research; Sani-Cloth Plus Germicidal Disposable Cloth: Professional Disposable International, Inc; Transeptic Cleansing Solution for Ultrasound Transducers/Probes, Parker Laboratories, Inc.

Revised: Date & Initial:										
Reviewed: Date & Initial										

Richmond Medical Center for Women

Clinical Policies and Procedures Manual

Department: Infection Control	**Policy Description:** Handling of Soiled Linen
Page: 1 of 1	**Replaces Policy Dated:**
Effective Date: 6/12	**Reference Number: 12VAC5-412-220-C4**
Approved:	

Scope:	All facility personnel
Purpose:	To ensure that linen is disinfected and handled so that it does not become contaminated
Policy:	Linens will be disinfected after each use and transported to patient care areas in a manner to ensure that it does not become contaminated
Procedure:	Soiled linen should be handled as little as possible to prevent contamination of the air and persons handling the linen. All soiled linen will be bagged in lidded containers at the location where it is used. Linens heavily contaminated with blood or other body fluids will be red bagged and transported in a manner to prevent leakage. Gloves will be worn when sorting laundry. Laundry will be sorted only in the laundry room, not in patient care areas. Linens will be washed in 160 water. Staff will wash hands thoroughly before folding clean, dried linens. Linens will be stored in a closed cabinet prior to transport to patient area. Clean linens will be transported in a closed container or bag. It will be stored in the patient area in a bag.
Reference:	**12VAC5-412-220-C4; CDC Laundry: Washing Infected Material**

T 175

Revised: Date & Initial:										
Reviewed: Date & Initial										

9253 Midlothian Turnpike
Richmond, VA 23235
(804) 897-8777

5147

CUSTOMER ORDER NO.	DEPT.	DATE
		6-18-2012

NAME Richmond medical Center for women

ADDRESS

	YEAR	VEHICLE DESCRIPTION	STOCK NO.	AMOUNT
1.		Repair + Redye cuts in 2 Recliners		200-
2.				
3.				
4.				
5.				
6.				
7.				
			TOTAL	200-

PAID ck #32562

NET 30 DAYS

CUSTOMER APPROVAL: _____

A service charge of 1.5%, 1.8 APR, will be added on overdue accounts.
Also, customers are liable for all legal and collection fees.
$25.00 Fee on all returned checks. No Warranties unless stated in writing.

The finding of deficiency for noncompliance with 12VAC5-412-380 is inappropriate because Richmond Medical Center for Women (RMCW) submitted a plan for coming into compliance with this regulation along with its application, as the regulation clearly allowed. If the Department refuses to remove the finding, it should grant RMCW a variance. The plan that RMCW submitted with its application for licensure continues to be the most accurate statement of its plans to comply with this regulation within two years of licensure. In an effort to provide the Department with an update on our implementation of that plan, following is a timeline for our recent work as well as our work over the next several months:

March 15, 2012 – Brought in an architect to do an assessment of RMCW's facility for compliance with 12VAC5-412-380.

May 8, 2012 – Fire marshal conducted site visit.

June 11, 2012 – Consulted with a second architect.

June 12, 2012 – Brought in a mechanical engineer to do an assessment of RMCW's facility for compliance with 12VAC5-412-380.

June 22, 2012 – Brought in an electrician to do an assessment of RMCW's facility for compliance with 12VAC5-412-380.

July-Oct. 2012

- Schedule inspections or evaluation visits as appropriate with mechanical engineer to obtain information on insulation rating, compliance with HVAC/ventilation requirements and to create a design for coming into compliance
- Building owner will contact the local building department to schedule an inspection to determine compliance with any section of the building code or the UCSB that may be applicable based on the date of the building's construction.

Nov. 2012 – Assess information gathered and create a timeline for gathering any outstanding information by the end of 2012.

Nov.-Dec. 2012 – Complete information-gathering process.

Jan.-April 2013 – In consultation with an architect, evaluate whether renovations are necessary and/or feasible. Assess availability and affordability of loans that would be necessary to complete such renovations. Evaluate whether seeking any variances from discrete requirements would allow RMCW to comply with 12VAC5-412-380 and consult Department for information about the process of seeking any such variances and the documentation required. Submit any requests with appropriate documentation.

Contingent on the feasibility, cost, and variances possible, if renovations can be done, establish a timeline for developing a plan for construction, submitting for bids, evaluating bids and hiring a contractor. Consult with Department of Health concerning timeline.

If renovations cannot be done, evaluate whether to move to a new location. Establish a timeline for talking to a broker, assessing the available commercial real estate stock, availability and affordability of loans that would be necessary to accomplish a move, and for deciding whether the costs of such a move would be affordable by RMCW in the long run. Consult with Department of Health concerning timeline.

May-Nov. 2013 – If renovations are possible, begin moving forward on the items in the timeline for renovations. If renovations are not possible, begin moving forward on the items in the timeline for evaluating whether to move.

Dec. 2013-July 2014 – If renovations are possible, attempt to complete all necessary work during this period. If renovations are not possible, attempt to complete the process of moving during this period. Evaluate and seek any variances necessary, depending on the rapidity of either process, in consultation with the Department.