STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AF-0009	A. BUILDING _____ B. WING _____	07/25/2018

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RICHMOND MEDICAL CENTER FOR WOMEN	118 NORTH BOULEVARD RICHMOND, VA 23220

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T 000	Initial Comments Two (2) Medical Facilities Inspectors from the Virginia Department of Health's Office of Licensure and Certification conducted an unannounced First Trimester Abortion Facility (FTAF) biennial licensure inspection on July 24, 2018 and July 25, 2018. The surveyors conducted observations, interviews and document reviews during the investigation process to determine compliance. The facility was not in compliance with 12 VAC-412 Regulations for the Licensure of Abortion Clinics. (Effective 03/22/2017). The deficiencies cited follow in this report.	T 000		
T 170	12 VAC5-412-210 B Quality Management The following shall be evaluated to assure adequacy and appropriateness of services, and to identify unacceptable or unexpected trends or occurrences: 1. Staffing patterns and performance; 2. Supervision appropriate to the level of service; 3. Patient records; 4. Patient satisfaction; 5. Complaint resolution; 6. Infections, complications and other adverse events; and 7. Staff concerns regarding patient care.	T 170		

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

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T 170	Continued From Page 1 This RULE: is not met as evidenced by: Based on interview and document review it was determined the agency's quality committee failed to evaluate staff concerns regarding patient care for adequacy and appropriateness of services or identify unexpected/unacceptable trends and occurrences. The findings included: Staff Member #1 and the surveyor reviewed the agency's quality program at 4:07 p.m. on July 24, 2018. Review of the quality meeting minutes revealed the committee held meetings on May 08, 2017, July 10, 2017, September 18, 2017, November 13, 2017 and January 8, 2018. Staff Member #1 reported the committee had one meeting for 2018, at the time of the inspection. Review of the minutes from the meeting on May 08, 2017, July 10, 2017, September 18, 2017, November 13, 2017 and January 8, 2018 did not include data related to "Staff concerns regarding patient care." Staff Member #1 reported four of the agency's staff completed the questionnaire. Staff Member #1 verified when the agency's staff failed to complete or turn in the questionnaires, the quality committee did not implement an action plan. Staff Member #1 reported the committee dropped the area for lack of feedback from staff. Staff Member #1 reported the committee did not evaluate the non-engagement of the staff as an issue to pursue through quality. Staff Member #1 reported the quality committee did not utilize the lack of response to implement actions to identify unacceptable or unexpected trends. A review of the agency's policy titled "Quality Management, Quality Assurance Process	T 170		

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T 170	Continued From Page 2 Improvement, QAPI" read in part "B. To ensure adequacy and appropriateness of services, and to identify unacceptable or unexpected trends or occurrences the following shall be evaluated: ...7. Staff concerns regarding patient care ...." Staff Member #1 verified the agency's quality committee failed the follow the established policy and procedure.	T 170		
T 175	12 VAC5-412-210 C Quality Management A quality improvement committee responsible for oversight and supervision of the program shall be established and at a minimum shall consist of: 1. A physician; 2. A nonphysician health care practitioner; 3. A member of the administrative staff; and 4. An individual with demonstrated ability to represent the rights and concerns of patients. The individual may be a member of the facility's staff. In selecting members of this committee, consideration shall be given to the candidate's abilities and sensitivity to issues relating to quality of care and services provided to patients. This RULE: is not met as evidenced by: Based on interview and document review it was determined the agency's quality committee failed to ensure it consisted of the required members. The membership of the agency's quality committee failed to include a physician and an individual with demonstrated ability to represent the rights and concerns of patients.	T 175		

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T 175	Continued From Page 3 The findings included: Staff Member #1 and the surveyor reviewed the agency's quality program starting at 4:03 p.m. on July 24, 2018. Review of the quality meeting minutes revealed the committee held meetings on May 08, 2017, July 10, 2017, September 18, 2017, November 13, 2017 and January 8, 2018. Staff Member #1 reported the committee had one meeting for 2018, at the time of the inspection. Review of the minutes from the meeting of May 08, 2017, July 10, 2017, September 18, 2017, November 13, 2017 and January 8, 2018 listed two (2) members Staff Member #1 and Staff Member #8. Staff Member #1 reported the quality committee did not have a physician or an individual to represent the right and concerns of the patients. Staff Member #1 verified awareness that the agency's quality committee should include a physician and an individual to represent patient's rights and concerns. Review of the agency's policy titled Quality Improvement Committee" read in part "The Quality Improvement Committee is responsible for oversight and supervision of the program shall consist of: Administrator, Medical Director, Nursing Supervisor, [and] Office Manager. Staff Member #1 verified the agency's quality committee failed the follow the established policy and procedure.	T 175		
T 185	12 VAC5-412-210 E Quality Management Results of the quality improvement program shall be reported to the licensee at least annually and shall include the deficiencies identified and recommendations for corrections and	T 185		

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T 185	Continued From Page 4 improvements. The report shall be acted upon by the governing body and the facility. All corrective actions shall be documented. Identified deficiencies that jeopardize patient safety shall be reported immediately in writing to the licensee by the quality improvement committee. This RULE: is not met as evidenced by: Based on interview and document review it was determined the agency's quality committee failed to provide evidence of an annual report to the governing body. The findings included: Staff Member #1 and the surveyor reviewed the agency's quality program at 4:18 p.m. on July 24, 2018. Review of the quality meeting minutes revealed the committee held meetings on May 08, 2017, July 10, 2017, September 18, 2017, November 13, 2017 and January 8, 2018. The surveyor requested evidence that the quality committee reported annual findings to the governing body, as well as proof the governing body reviewed and acted on the quality report. Staff Member #1 reported the proof of the annual report existed in an email. Staff Member #1 reported he/she could not access the information at the time of the interview and review. Review of the agency's policy titled Quality Improvement Committee" read in part, "This committee shall meet annually and shall submit its findings to the Governing Authority. The committee shall review any reports of concern or deficiencies identified during the year and shall make recommendations for corrections and	T 185		

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T 185	Continued From Page 5 improvements. All corrective actions shall be acted on by the Governing Authority and shall be documented. Any identified deficiencies that jeopardize patient safety shall be reported immediately in writing to the Governing Authority by the quality improvement committee." The agency provided no further information prior to exit on July 25, 2017.	T 185		
T 195	12 VAC5-412-220 B Infection Prevention Written infection prevention policies and procedures shall include, but not be limited to: 1. Procedures for screening incoming patients and visitors for acute infectious illnesses and applying appropriate measures to prevent transmission of community-acquired infection within the facility; 2. Training of all personnel in proper infection prevention techniques; 3. Correct hand-washing technique, including indications for use of soap and water and use of alcohol-based hand rubs; 4. Use of standard precautions; 5. Compliance with blood-borne 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;	T 195		

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T 195	Continued From Page 6 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 observation, interview and document review, it was determined the facility staff failed to ensure policies and procedures relating to infection control and prevention during one (1) of one (1) procedures observed and two (2) of two (2) procedure room cleanings observed. The findings include: An observation was conducted starting at 2:38 p.m. on July 24, 2018 as Staff Member #2 entered the Procedure Room to clean and disinfect between patients' procedures. The observation revealed Staff Member #2 obtained at least two (2) disposable disinfectant cloths from a container. Staff Member #2 used the cloths to wipe the top surface of the black pads on the procedure table, the seat of the rolling stool, one side of the gel pad in the stirrup attached to the procedure table and the surface of one arm rest attached to the procedure table. Staff Member #2 did not clean or disinfect the sides or base of the procedure table. Staff Member #2 did not clean and disinfect the cart at the end of the procedure table where clean supplies were prepared. Staff Member #2 did not clean and disinfect the suction machine and cart utilized during the previous procedure. At 2:45 p.m., Staff Member #2 prepared to exit the	T 195		

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T 195	Continued From Page 7 Procedure Room; Staff Member #2 informed the surveyor he/she had finished and Staff Member #3 would complete the set-up for the next patient. Staff Member #3 entered the room with clean linens for the procedure table. The surveyor inquired regarding the "wet contact time" for the disposable disinfectant cloths. Staff Member #3 stated, "Three (4) to four (4) seconds." Staff Member #3 allowed the top surface of the black pad to air-dry, then proceed to place the linens on the procedure table. Staff Member #3 place a disposable blue pad on the cart at the end of the procedure table, which had not been disinfected and set-up clean supplies. Staff Member #3 did not remove the blue disposable pad from the left-side armrest. The surveyor inquired regarding how Staff Member #3 knew which areas of the Procedure Room had been disinfected. Staff Member #3 reported he/she "set up the room" and Staff Members #1 or #2 actually cleaned and ensured disinfection of the room. At approximately 2:48 p.m,. Staff Member #1 entered the Procedure Room. Staff Member #1 picked up the right-side leg stirrup from the floor. Staff Member #1 disinfected the gel pad on both sides and reattached the stirrup to the procedure table with gel pad in place. Staff Member #1 did not clean or disinfect the metal stirrup. Staff Member #1 escorted the next patient into the Procedure Room. During the end of the day meeting on July 24, 2018 the surveyor inquired regarding what items/areas of the Procedure Room needed to be cleaned and disinfected between patients. Staff Member #1 reported the procedure table especially where the physician sat during the procedure related to high potential of blood and body fluid splatter. Staff Member #1 included the cart near the end of the procedure table, the	T 195		

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T 195	Continued From Page 8 suction machine and its cart and any other areas with visible blood/body fluid splatter. The surveyor informed Staff Member #1 of the findings during the observation and requested the policy. The surveyor reviewed of job descriptions for Staff Members #2 and #3. Staff Member #2's job description included "10. Disinfect work area as needed." Staff Member #2's job description did not specify or clarify "work area." Review of Staff Member #3's job description included responsibility for "10. Cleanliness of assigned area." Review of the agency's policy titled "Processing of Reusable Medical Equipment" stated the policy' "Purpose: To prevent the spread of infection via reusable medical equipment by detailing levels of cleaning and disinfecting each type of equipment." The policy presented did not differentiate between cleaning and disinfection post procedure versus terminal cleaning of the Procedure Room. On July 24, 2018 at 1:49 p.m., surveyors observed a surgical abortion procedure. Staff Member #1, the administrator of the facility, acted as the surgical assistant for the physician, Staff Member #4. Staff Member #1 stood beside the physician during the procedure and performed tasks such as assisting with medication preparation, removing tubing from the suction machine (with blood and body fluids contained inside), disposing of the tubing, and handling of products of conception (POC) contained in a glass jar. While acting as the assistant during the surgical procedure, Staff Member #1 wore scrubs and gloves with no outer gown or eye protection to guard against contact or splashes of blood or body fluids. On July 24, 2018 at 2:06 p.m., surveyors observed	T 195		

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T 195	Continued From Page 9 cleaning of the procedure room after the surgical abortion outlined above. One of the clinic counselors, Staff Member #7, performed the primary cleaning. Staff Member #7 wiped the surgical bed with a disinfecting wipe and then the top of the surgical rolling table used for the storage of medical tools. Staff Member #3, after less than thirty (30) seconds and while the surgical bed remained wet, placed a sheet on the bed without allowing for the necessary disinfecting solution dwell time. The staff members cleaned no other items in the room to include the stirrups used during the procedure, the surgical lamp manipulated by the physician, or the physician's rolling chair used during the procedure. Staff Members exited the room at 2:11 p.m. with five (5) minutes used to clean the area and a new patient entered the room at 2:15 p.m. with a nine (9) minute turn-around time from surgical patient to surgical patient. On July 24, 2018 at 2:15 p.m., surveyors asked Staff Member #3 if counselors are usually responsible for cleaning the procedure room between surgical procedures. Staff Member #3 advised "anyone" can clean the room but sometimes staff members help each other out. On July 25, 2018 at 11:18 a.m. during a telephone interview with Staff Member #1 with Staff Member #4 listening-in, Staff Member #1 advised counselors and other recovery room staff are capable of cleaning the procedure room. Staff Member #1 acknowledged the proper dwell time for the disinfection solution is two (2) minutes. Staff Member #1 further advised the following items should be cleaned in-between surgical abortion procedures: surgical bed, surgical tray with suction machine, floor near the area where the procedure occurs, and stirrups. Staff Member #1 further advised he/she does not wear a gown	T 195		

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T 195	Continued From Page 10 as the surgical assistant because he/she does not believe they are in the "splash zone." A review of the facility's policy titled, "Personal Protective Equipment" states in part: "Wear a gown to protect skin and clothing during procedures or activities where contact with blood or body fluids is anticipated." "Wear mouth, nose and eye protection during procedures that are likely to generate splashes or sprays of blood or other body fluids." A review of the facility's policy titled, "Environmental Surfaces Cleaning" states in part: "Cleaning of procedure room between procedures must be done with a facility-approved, EPA-registered disinfectant. Clean hands and put on gloves Collect and remove waste Collect and remove all soiled linen Remove gloves and clean hands Use a cloth dampened in disinfectant solution to clean and disinfect horizontal surfaces that have come in contact with a patient or body fluids, including blood pressure cuffs, tourniquets and leads Clean suction canisters Clean and disinfect bed When cleaning is complete, remove gloves and clean hands."	T 195		
T 355	12 VAC5-412-300 Health Information Records An accurate and complete clinical record or chart shall be maintained on each patient. The record or chart shall contain sufficient information to satisfy the diagnosis or need for the medical or	T 355		

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T 355	Continued From Page 11 surgical service. If medically indicated, it shall include, but not be limited to the following: 1. Patient identification; 2. Admitting information, including patient history and physical examination; 3. Signed consent; 4. Confirmation of pregnancy; 5. Procedure report to include: a. Physician orders; b. Laboratory tests, pathologist's report of tissue, and radiologist's report of x-rays; c. Anesthesia record; d. Operative record; e. Surgical medication and medical treatments; f. Recovery room notes; g. Physician and nurses' progress notes, h. Condition at time of discharge, i. Patient instructions (preoperative and postoperative); j. Names of referral physicians or agencies; and 6. Any other information required by law to be maintained in the health information record. This RULE: is not met as evidenced by: Based on interview and document review it was determined the facility staff failed to ensure: 1. Voluntary Termination of Pregnancy consents were complete for one (1) of thirteen (13) patients included in the survey sample. (Patient #8) 2. An accurate and complete medical record, namely proper physician orders, for four (4) out of thirteen (13) patients included in the survey sample (Patients # 1, 4, 8, 9).	T 355		

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T 355	Continued From Page 12 The findings included: 1. Review of Patient #8's medical record indicated the physician terminated Patient #8's pregnancy under monitored anesthesia care (MAC) on February 10, 2018. Patient #8 signed the back of the consent, but the front side of the form did not have the required initials by the patient. The form explained the patient's initials verify the facility's counselor had reviewed and explained each point as well as giving the patient time to ask questions. The front page included a verification by the patient related to past medical history, last menstrual period, notice of deemed consent for HIV (Human Immunodeficiency Virus) testing, risk associated with anesthesia, the provision of "Pain Killers", consent for collecting laboratory studies, and the complications associated with the termination of pregnancy. During an interview on July 24, 2018 at 1:18 p.m., Staff Member #1 verified the front of the form was blank. Staff Member #1 acknowledged Patient #8's consent for voluntary termination of pregnancy failed to provide proof facility staff had reviewed the risks and other information with the patient. 2. Incomplete discharge orders: a. Review of Patient #1's medical record indicated the physician terminated Patient #1's pregnancy under MAC on December 12, 2017. The physician failed to document the date and time of his/her signature on the discharge order. During an interview on July 24, 2018 at 1:23 p.m., Staff Member #1 verified the physician had failed to date and time his/her signature.	T 355		

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T 355	Continued From Page 13 b. Review of Patient #8's medical record indicated the physician terminated Patient #8's pregnancy under MAC on February 10, 2018. The physician failed to signed Patient #8's discharge order. The discharging nurse failed to sign with date and time related to Patient #8's discharge. During an interview on July 24, 2018 at 1:18 p.m., Staff Member #1 verified the physician had failed to sign Patient #8's discharge order and the discharging nurse failed to sign off on the discharge criteria, status and time of Patient #8's discharge. c. Review of Patient #9's medical record indicated the physician terminated Patient #9's pregnancy under monitored anesthesia care on February 24, 2018. The physician signed the discharge order but failed to document the date and time his/her signature During an interview on July 24, 2018 at 1:03 p.m., Staff Member #1 verified the physician had failed to date and time his/her signature on the discharge order. d. On July 24, 2018 at 12:03 p.m., surveyors conducted a review of the medical record for Patient #4. The review revealed a surgical abortion on March 10, 2018. Staff Member #4 performed the abortion but failed to issue a proper discharge order after the procedure as the discharge area in the medical record did not contain a signature or date.	T 355		
T 360	12 VAC5-412-310 Record Storage Provisions shall be made for the safe storage of medical records or accurate and eligible reproductions thereof according to applicable	T 360		

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T 360	Continued From Page 14 federal and state law, including the Health Insurance Portability and Accountability Act (42 USC § 1320d et seq.). This RULE: is not met as evidenced by: Based on observation, interview and document review, it was determined the facility failed to make provisions for the safe storage of medical records. The findings include: On Jul 24, 2018 at 9:15 a.m., surveyors entered the facility to begin an inspection. Staff Member #6 provided a greeting. Staff Member #6 walked surveyors back to the medical file storage room. Along the way, no locked doors or other security measures were encountered to obstruct someone from entering the area where medical files are stored. Additionally, surveyors found the door to the medical file storage room open and the file cabinets that contained the medical files unlocked. On the afternoon of July 24, 2018 surveyors realized there were times when this area had little, if any, staff in the area who could see if someone was in the file area. On July 24, 2018 at 3:00 p.m., the medical records remained in unlocked file cabinets within the unsecured room. On July 24, 2018 at 3:47 p.m. as surveyors reviewed paperwork inside the medical records room, they were startled by someone not associated with the facility, entering the staff lounge adjacent to the medical file room. A staff member did not escort this person and he/she stated staff allow him/her to enter the staff lounge (adjacent to the unsecured medical file storage	T 360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AF-0009	A. BUILDING _____ B. WING _____	07/25/2018

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

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T 360	Continued From Page 15 room) during the day to enjoy a soft drink. On July 25, 2018 at 11:18 a.m. during a telephone interview with Staff Member #1 while Staff Member #4 listened-in, Staff Member #1 acknowledged there are times when a staff member is not present at the front desk area. Staff Member #1 further advised the person who entered the staff lounge was familiar to the staff and they encourage him/her to come in to get a drink. Staff Member #1 further stated regarding the unlocked medical file storage room, "[the] door does lock, maybe they should use it [the lock] after hours or during." A review of the facility's policy titled "Health Information Records" states in part: "Medical records will be maintained consistently in accordance with state and federal guidelines."	T 360		
T 395	12 VAC5-412-330 Abortion Facility Security and Safety The abortion facility shall develop, implement and maintain policies and procedures to ensure safety within the abortion facility and on its grounds and to minimize hazards to all occupants. The policies and procedures shall include, but not be limited to safety rules and practices pertaining to personnel, equipment, gases, liquids, drugs, supplies and services. This RULE: is not met as evidenced by: Based on observation, interview and document review it was determined the facility failed to implement policies and procedures to ensure safety within the abortion facility and on its grounds.	T 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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T 395	Continued From Page 16	T 395		

The findings include:

On July 24, 2018 at 9:15 a.m., surveyors arrived at the abortion facility to begin a biennial survey. As the inspection began, the surveyors observed a lack of security of the facility.

On July 24, 2018 at 9:48 a.m., surveyors conducted a tour of the facility with Staff Member #2. Upon approaching the facility entrance, surveyors inquired about building security. Staff Member #2 advised the surveyors of the current process. During the tour, surveyors learned that patients and staff are sometimes in different parts of the facility, requiring them to be in/move through unsecured areas.

On the afternoon of July 24, 2018 surveyors [redacted] to observe an abortion procedure. During this time, [redacted]

On July 25, 2018 at 11:18 a.m. during a telephone interview with Staff Member #1 while Staff Member #4 listened-in, Staff Member #1 advised of some of the security plan. Staff Member #1 acknowledged there are times when a staff member is not present at the front desk area.

A review of the facility's policy titled "Abortion facility security and safety" states in part:

"Staff wil[redacted]

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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