| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLII<br>IDENTIFICATION NU   | ER/CLIA<br>JMBER:                               | 1   | LE CONSTRUCTION   |                 | (X3) DATE SURVEY<br>COMPLETED |  |  |
|--|--|---|---|---|-----------------|-------------------------------|--|--|
|  |  |   | A. BUILDING   |   |                 |                               |  |  |
| NAME OF PROVIDER OR SUPPLIER   | AF-0017  | Y   | B. WING 10/29/2014 T ADDRESS, CITY, STATE, ZIP CODE |   |                 |                               |  |  |
| FALLS CHURCH HEALTHCAR   | E CENTER   |   |   | TATE, ZIP CODE<br>TON ST SUITE 300  |                 |                               |  |  |
|  |  | FALLS CH  | URCH, VA 2  | 2046  |                 |                               |  |  |
| PREFIX (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>SC IDENTIFYING INFORM/  | FILL  | ID<br>PREFIX<br>TAG                                 | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE       | (X5<br>COMPL<br>DAT           |  |  |
| T 000 12 VAC 5- 412 Initia   | al comments  |   | T 000   | 22110121(01)  |                 |                               |  |  |
| Medical Facilities In Licensure and Cert Health conducted the The agency was no 412 Regulations for  | t in compliance with   | on 14. Two office of partment of                |   |   |                 |                               |  |  |
| Clinics. (Effective 06<br>T 035 12 VAC 5-412-150 F   | ,  | manual.   | T 035   |   |                 | 1                             |  |  |
| and maintain an approcedures manual. reviewed annually a the licensee. The mprovisions covering topics:  1. Personnel; 2. Types of elective that may be perform 3. Types of anesthethethethethethethethethethethethethet | The manual shall be not updated as necessianual shall include at a minimum, the foreand emergency properties that may be used discharges, including tient before admission informed consent of | e ssary by llowing cedures d; g criteria on and |   |   | ;               |                               |  |  |
| patient prior to the in 6. When to use ultra gestational age and v patient risk; 7. Infection preventi 8. Risk and quality r 9. Management and   | itiation of any proced<br>asound to determine<br>when indicated to ass<br>ion;<br>management;<br>I effective response t  | lures;<br>sess                                  |   | RECEIVE   | · ·             |                               |  |  |
| medical and/or surgion 10. Management an 11. Ensuring complifederal, state and location 12. Facility security;   | cal emergency;<br>ad effective response<br>ance with all applical<br>al laws;  | to fire;<br>ble                                 |   | DEC 15 201<br>VDH/OLO   |                 |                               |  |  |
| PRATORY DIRECTOR'S OR PROVIDER   | 1  |   | URE   | TITLE   | (.              | X6) DATE                      |  |  |
| EFORM  |  | 1   | ·   | linector  | 12-10-          | -14                           |  |  |
|  | 0;   | 21)99   |   | OS4L11  | If continuation | sheet 1 o                     |  |  |

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING \_\_ AF-0017 B. WING 10/29/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE FALLS CHURCH HEALTHCARE CENTER 900 SOUTH WASHINGTON ST SUITE 300 FALLS CHURCH, VA 22046 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) T 035 | Continued From Page 1 T 035 13. Disaster preparedness: 14. Patient rights: 15. Functional safety and facility maintenance; 16. Identification of the person to whom responsibility for operation and maintenance of the facility is delegated and methods established by the licensee for holding such individual responsible and accountable. These policies and procedures shall be based on recognized standards and guidelines. Policy and procedure manual 12 VAC 5 - 412-150 12/10/14 Correction: Notation of the Governing Body's December 2013 review of over 1000 pages of the 5 Policy Manuals is now posted in the Annual Review Documentation. Not been posted due to clerical issue of the form being revised to multivear and new form not returned to the Manual. This RULE: is not met as evidenced by: Notation of the Governing Body's December 2014 review of over 1000 pages of the 5 Policy Manuals Based on document review and interview the facility failed to implement their policies and is posted in the Annual Review Documentation. 12/11/14 Prevent recurrence of Deficiency: The corrective procedure to annually update the policy and actions taken will prevent recurrence of deficiency. procedure manual. Revised Annual Review Documentation form reviewed with QAC and Co-Administrators The findings included: Measures to maintain compliance: Governing Body will review annually and address any STATE FORM 021199 OS4L11 If continuation sheet 2 of 25

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER AND PLAN OF CORRECTION IDENTIFICA | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU  | R/CLIA<br>MBER:  |  | TIPLE CONSTRUCTION                           | (X3) DATE SURVEY<br>COMPLETED  |   |                          |
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|   |  |  |  | A. BUILDI                                    | NG   |   |                          |
| ·   |  | AF-0017  |  | B. WING                                      |  | 10/2  | 9/2014                   |
|   | PROVIDER OR SUPPLIER   |  |  |  | , STATE, ZIP CODE  |   | <del></del>              |
| FALLS   | HURCH HEALTHCAR  | RE CENTER  | 900 SOUTI<br>FALLS CH  | H WASHIN<br>URCH, VA                         | IGTON ST SUITE 300<br>22046  |   |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY<br>SC IDENTIFYING INFORMA | FULL '   | ID<br>PREFIX<br>TAG                          | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)  | ULD BE  | (X5)<br>COMPLETE<br>DATE |
| T 035   | Continued From Pa  | age 2  |  | T 035  |  |   |                          |
|   | evidence the policy been reviewed and Review of the policies for determine gestation assess patient risk.  |  | contain ual had did not nd to icated to  |  | emergent issues and take corrective actionutlined in existing policies. Policies will clarified as needed.  Revised Annual Review Documentation attached. No patients were affected by the paperwork deficiency  | l be<br>Form  |                          |
|   | An interview was conducted on 10/28/2014 at 6:30 p.m., with Staff #1. The surveyor requested documentation that the governing body or the administrator had reviewed the facility's policy and procedure manual annually. Staff #1 stated, "I didn't realize they needed to be reviewed annually. On 10/29/2014, Staff #1 reported the facility did not have policies and procedures to reflect the updated State licensure requirements for ensuring when to use ultrasound to determine gestational age and when indicated to assess patient risk and evidence the manual is annually reviewed and updated.  T 050 12 VAC 5-412-160 B Administrator  B. Any change in the position of the administrator shall be reported immediately by the licensee to the department in writing.  This RULE: is not met as evidenced by: Based on interview and document review it was determined the facility failed to notify the Office of Licensure and Certification of the appointment of a new administrator.  The Findings Included:  The Surveyors were informed on entering the |  | sted or the colicy and ted, "I I annually. ility did cct the ensuring stational t risk and |  | Administrator  12 VAC 5 – 412-160 B  6: Use of sonography to assess patient ri   | sk  |                          |
| T 050   |  |  |  | Γ 050  | PLAN OF CORRECTION: Review of updated State Licensure requi completed. A policy memorializing the F Practices of when to use ultrasound to de gestational age and assess patient risk of pregnancy when no sac seen will be deve These policies and procedures shall be be recognized standards and guidelines. FC | CHC Best<br>stermine<br>ectopic<br>eloped.<br>ased on | 12/08/14                 |
|   |  |  | Office of  | ;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;       | continue to utilize the Best Practices from ACOG currently used and these will be incorporated in the new policy. Copy of policies and procedures approved by the body and revisions thereto shall be made to the OLC upon request.  | the<br>governing<br>available                         | 01/01/15                 |
| TO I SEEMBLO ALC. O   |  |  | the  | *** **** **** **** **** **** **** ***** **** | Prevent recurrence of Deficiency: The coactions taken will prevent recurrence of actions taken will prevent recurrence of actions to maintain compliance: Staff trained to and Policies will be clarified as   | deficiency.<br>will be                                |                          |
| TATE FORM   | Λ  |  | )21199   | · · · · · · · · · · · · · · · · · · ·        | No patients were affected by this deficient OS4L11   | ncy   | n sheet 3 of 25          |







|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |   |                                  |   | TIPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED   |                          |
|--------------------------|---|---|----------------------------------|---|---|---|--------------------------|
| ****                     |   | AF-0017   | 7                                | B. WING   |   | 10/2  | 29/2014                  |
| NAME OF I                | PROVIDER OR SUPPLIER  |   | STREET AD                        | DRESS, CITY   | , STATE, ZIP CODE   |   |                          |
| FALLS C                  | HURCH HEALTHCAR   | E CENTER  | 900 SOU <sup>-</sup><br>FALLS CI | TH WASHII<br>HURCH, VA  | NGTON ST SUITE 300<br>\ 22046   |   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIE<br>MUST BE PRECEDED BY<br>SC IDENTIFYING INFORMA  | FULL                             | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHI<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)   | OULD BE   | (X5)<br>COMPLETE<br>DATE |
| T 050                    | Continued From Pa   | ge 3  |                                  | T 050   |   |   |                          |
| T 065                    | During an interview 12:30 PM, Staff #1 vevidence that notific Licensure and Certi Administrator.  12 VAC 5-412-170 E B. The licensee shafor employment from obtain and verify info as to education, train professional licensur health and personal member.   | cility on 10/27/14, that a new Administrator had been appointed.  To 50 Page 3 12 VAC 5-412-160 - B: Background: FCHC has been undergo reorganization and been September 2014, reasses positions and resultant joint modifications. The administrator.  VAC 5-412-170 B Personnel  The licensee shall obtain written applications remployment from all staff. The licensee shall tain and verify information on the application to education, training, experience, appropriate offessional licensure, if applicable, and the alth and personal background of each staff ember. |                                  | 12 VAC 5-412-160 - B: Administrator Change Background: FCHC has been undergoing a staffing reorganization and been in transition since September 2014, reassessing duties, leadership positions and resultant job descriptions modifications. The administrative changes will be finalized and staff trained to new alignments on December 9, 2014. After the changes and positions are finalized notification will be mailed. PLAN OF CORRECTION: The positions have been finalized and OLC will be notified of change. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Measures to maintain compliance: Staff will be trained to new organization chart. (see attached) and Policies will be updated and clarified as needed. No patients were affected by this |   | 12/09/14 12/15/14   |                          |
|                          | This RULE: is not met as evidenced by: Based on interview and document review, it was determined the facility failed to implement a mechanism to verify professional licensure of three (3) of three (3) staff licenses in the survey sample. (Employee file #1, #8, #13).  The findings included:  Review of personnel records on 10/28/14, revealed that the agency failed to provide evidence of license verification for three (3) of three (3) licensed employees. (Employee file # 1, #8, and #13).  During an interview on 10/28/14, at approximately 6:00 PM, Staff #1 acknowledged that professional licenses had not been verified, and that they were not aware this was required. |   |                                  |   | Personnel  12 VAC 5 – 412-170 B  Correction:  Verifications for professional licensure December on a yearly basis then place files. See attached policy. Prevent recu Deficiency: The corrective actions take prevent recurrence of deficiency. Verif professional licensure are located in the file. Measures to maintain compliance: Administrators will review annually and any emergent issues and take corrective outlined in existing policies. The gover will review biennially and address any issues and take corrective actions as out existing policies. No patients were affect deficiency. | n personnel<br>rrence of<br>n will<br>ications for<br>employee's<br>Co-<br>i address<br>actions as<br>ning body<br>emergent<br>lined in | 01/15/15                 |
| ATE FORM                 | ļ   |   | 021199                           |   | OS4L11  | If continuation   | n sheet 4 of 25          |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM |  |   | ' '   | TIPLE CONSTRUCTION  NG | (X3) DATE SURVEY<br>COMPLETED  |  |                          |
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|   |  | AF-0017   | ,   | B. WING                |  | 10/29/   | 2014                     |
|   | PROVIDER OR SUPPLIER HURCH HEALTHCA  |   | 900 SOU   |                        | , STATE, ZIP CODE<br>IGTON ST SUITE 300<br>22046   |  |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY<br>LSC IDENTIFYING INFORMA  | FULL  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | LD BE  | (X5)<br>COMPLETE<br>DATE |
| T 095   | Continued From F   | Page 4  |   | T 095                  | :  |  |                          |
| T 095 12 VAC 5-412-170 H Personnel  |  |   |   | T 095                  |  | th dotton.   |                          |
|   | include, but not be 1. Written job des responsibility, and classification; 2. Process for verifice employees or inde 3. Process for an performance and 4. Process for veremployees meet the facility; and 5. Process for rephealth care practitilicensing or certificappropriate board Health Professions. This RULE: is not Based on interview determined that the personnel policies. The findings include Review of the policies. The findings include Review of the policies. 1. Verifying current certification 2. Process for anniperformance 3. Process for verification 4. Process for report the facility 4. Process for report in the facility 4. Proc | rifying current professication and training of ependent contractors; nually evaluating emploompetency; rifying that contractors he personnel qualification standards to the within the Departments.  I met as evidenced by: and document reviewer agency did not have and procedures. | authority, n job  onal  loyee  and their tions of their et of  w, it was required  or were required  or were and their ions of tified |                        | Personnel  12 VAC 5 – 412-170 H  Correction:  Verifications for professional licensure are December on a yearly basis. Annual evaluation for employee performance are also done of yearly basis. We have policy and procedure place for these requirements. We will make adjustments to our policies and procedures further clarify. The corrective actions takes prevent recurrence of deficiency. We will the process for verifying contractors and the employees meeting personnel qualification facility. As well as clarify the process for a licensed and certified healthcare practition violations of their licensing or certification standards to the appropriate board within the Department of Health Professions. Measure maintain compliance: The governing body administrators will review annually and adainly emergent issues and take corrective accountlined in existing policies. VDH complaints by anti-choice individuals were unsubstant patients were affected by this deficiency. | uations on a res in se s to en will l include heir ns of our reporting ners for n the ures to y and co- ddress ctions as aints filed | 01/15/15                 |

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If continuation sheet 5 of 25

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|  | FATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU   |   |  | TIPLE CONSTRUCTION NG  | 1 ' '  | (X3) DATE SURVEY<br>COMPLETED |  |
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|  |  | AF-0017   | 7   | B. WING  |  | 40/0   | 0/2044                        |  |
| NAME OF F  | PROVIDER OR SUPPLIER   | A1-0011   | T   |  | STATE, ZIP CODE  | 10/2   | 9/2014                        |  |
|  | HURCH HEALTHCAR  | RE CENTER   | 900 SOU   |  | IGTON ST SUITE 300   |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>SC IDENTIFYING INFORMA   | 'FULL   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF O<br>(EACH CORRECTIVE ACTIVE<br>CROSS-REFERENCED TO THE<br>DEFICIENCY   | ON SHOULD BE<br>HE APPROPRIATE   | (X5)<br>COMPLET<br>DATE       |  |
| T 095  | Continued From P   | age 5   |   | Т 095  |  |  |                               |  |
|  |  | ation standards to the<br>within the Departmer  |   |  | Patients' rights   |  |                               |  |
| :  | During an interview on 10/29/14 at approxin 12:30 PM, Staff #1 acknowledged the findin   |   | oximately<br>ndings.  |  | 12 VAC 5 – 412-210 A Correction: Background: Patient given a summary copy of Patient   | s' Rights and  | -                             |  |
| T 135  | 12 VAC 5-412-210   | PVAC 5-412-210 A Patients' rights  T 135  Responsibilities including the complaint procure when they check in. They sign acknowledging the procure and had exponentially to read the procure and had exponentially to read the  |   | cknowledging they  |  |  |                               |  |
|  | protocol relating to<br>of patients consiste<br>the Joint Commissi<br>Care. The protoco<br>reasonably designe<br>rights and responsi<br>manner they under<br>a copy of their right<br>admission. | acility shall establish the rights and responsent with the current edon Standards of Ambi shall include a proceed to inform patients oblities, in a language stand. Patients shall s and responsibilities   | and responsibilities be current edition of ards of Ambulatory ude a process in patients of their a language or tients shall be given consibilities upon  full 7 page text is available in binders in the waiting room. The full 7 page text is available at the front desk to take if they want. Additionally, the Patient Rights are published on our website which an estimated 80% of our patients utilize. The patient signs the handout and it is included in her medical record (chart).  PLAN OF CORRECTION:  The Patient Rights Handout will be revised to include a check off box for the patient to request decline taking home a copy of the Patient Rights. |  | nders in the at is available at at. Additionally, the cour website which a utilize. The as included in her be revised to atient to request or                          |  |                               |  |
|  | Based on interview determined that pat their rights and resp   | met as evidenced by:<br>and document reviev<br>ients were not given<br>ponsibilities upon adn   | w, it was<br>a copy of  |  | Patient Rights Policies is on our attached). Additionally, the receppatient wants a copy. Copies of compliments or complaints" port Rights will be available on the re | website (see<br>otionist will ask if<br>the "How to file<br>ion of the Patient | 12/30/14                      |  |
| # H H H H H H H H H H H H H H H H H H H  | The findings include   |   |   |  | for patients to take home. Our bre<br>Rights and Responsibilities is als   | ochure of Patients'  |                               |  |
|  | (#1-#12) on 10/27/1 revealed there was received a copy of radmission. The adn  | t records for 12 of 12 patients 7/14 and 10/28/14, it was as no evidence that patients had of rights and responsibilities on admission packet did not contain ats and responsibilities for  waiting room and patient lounge.  Prevent recurrence of Deficiency: The correct actions taken will prevent recurrence of defici The chart now evidences that patients receive could have selected to take home a copy upon admission.  Measures to maintain compliance: The various Expanded forms and Staff training to Policies |   | The corrective ence of deficiency, ients receive and a copy upon |  |  |                               |  |
| During an interview on 10/28/14, at approxima 5:00 PM, Staff #1 stated that patients were giv laminated copy of rights and responsibilities to review upon admission, and that the rights and responsibilities were in a binder in the waiting |  |   | re given a<br>ties to<br>ts and   |  | maintain compliance.  No patients were affected by this  | deficiency   |                               |  |
| ATE FORM   | <u> </u>   |   | 021199  | 3  | OS4L11   | If continuation  | on sheet 6 of 2               |  |

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|   | ATEMENT OF DEFICIENCIES<br>D PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU                                    |   | 1                   | TIPLE CONSTRUCTION  |                                | (X3) DATE SURVEY<br>COMPLETED |  |
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|   |   | AF-0017  | 7   | B. WING             |   |                                |                               |  |
| NAME OF   | PROVIDER OR SUPPLIER  | AF-0017  | ·   |                     | , STATE, ZIP CODE   | 10/2                           | 29/2014                       |  |
|   | HURCH HEALTHCAF   | RE CENTER  | 900 SOU   |                     | IGTON ST SUITE 300  |                                |                               |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>LSC IDENTIFYING INFORMA | FULL  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIVE<br>CROSS-REFERENCED TO THE<br>DEFICIENCY  | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE       |  |
| T 135   | Continued From P  | age 6  |   | T 135               |   |                                |                               |  |
|   | room. Staff #1 ack<br>not given a copy a<br>required.   | nowledged that patiend did not know that t                                 | nts were<br>this was  |                     |   |                                | 104 A                         |  |
| T 165   | D. The patient shall be given a copy of the complaint procedures, in a language or manner she understands, at the time of admission to service.  This RULE: is not met as evidenced by: Based on interview and document review, it was determined that 12 of 12 patient files (#1-#12) did not provide evidence that a copy of the complaint procedure was given at the time of admission to service.  The findings include:  Review of patient records for 12 of 12 patients (#1-#12) on 10/27/14 and 10/28/14, it was revealed there was no evidence that patients had received a copy of the complaint procedure on admission. The admission packet provided to the surveyors did not contain a copy of the complaint procedure.  During an interview on 10/28/14, at approximately 5:00 PM, Staff #1 stated that patients were given laminated copy of the complaint procedure upon admission to review. Staff #1 acknowledged that patients were not given a copy. |  | manner on to  w, it was 1-#12) did complaint ission to  atients had ure on led to the omplaint oximately are given a led that | T 165               | Patient's rights  12 VAC 5 – 412-210 D  Correction: Background: Patients, as noted, are given a summary copy of Patients' Rights and Responsibilities including the complaint processes when they check in. They sign acknowledging they have reviewed and had opportunity to read the more detailed information on the clipboard. The full 7 page text is available in binders in the waiting room. The full 7 page text is available at the front desk to take if they want. Additionally, the Patient Rights are published on our website which an estimated 80% of our patients utilize. The patient signs the handout and it is included in her medical record (chart). Additionally the Complain process is posted on bulletin boards in the waiting room and patient lobby.  PLAN OF CORRECTION:  The Patient Rights Handout will be revised to include a check off box for the patient to request o decline taking home a copy of the Patient Rights. I also includes a reminder that the full text of our Patient Rights Policies is on our website (see attached). The receptionist additionally will ask if patient wants a copy. Copies of the "How to file compliments or complaints" portion of the Patient Rights will be stacked on the reception counter available for patients to take home. Our brochure of Patients' Rights and Responsibilities is also available in the waiting room and patient lounge. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency The chart now evidences that patients receive and could have selected to take home a copy upon admission.  Measures to maintain compliance: The various |                                | 12/30/14                      |  |
| A. The abortion facility shall have an infection prevention plan that encompasses the entire facility and all services provided, and which is consistent with the provisions of the current | ntire<br>ch is  | 77 h   | maintain compliance.  No patients were affected by this   | deficiency          |   |                                |                               |  |
| ATE FORM  | 1   |  | 021199  | ·                   | OS4L11  | If continuation                | n sheet 7 of 2                |  |







|                          | (X1) PROVIDER/SUPPLIE<br>IDENTIFICATION NU   |  |  | FIPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED  |  |                          |
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|                          |  | AF-0017  | ,  | B. WING             |  | 10/  | 20/2044                  |
| NAME OF E                | PROVIDER OR SUPPLIER   |  | ·  |                     | STATE, ZIP CODE  | 10/  | 29/2014                  |
|                          | HURCH HEALTHCA   |  | 900 SOUT   |                     | GTON ST SUITE 300  |  |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY<br>LSC IDENTIFYING INFORMA   | FULL   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)   | N SHOULD BE  | (X5)<br>COMPLETE<br>DATE |
| T 165                    | Continued From F   | Page 7   |  | T 165               |  |  |                          |
|                          | Outpatient Setting Safe Care", publis Disease Control a with training and e shall participate in prevention policies review them to assapplicable regulation. The process for implementation and prevention policies regulations or guid they are based shall be the administrator at the clinical staff. To recommendations documented in writing. A designated perceived training in and shall also be in This RULE: is not Based on documentation and shall also be in This RULE: is not Based on documentation and the designated annual review.  Note: This is a rectailure to ensure inforcedures will be adocumented recomposition. The findings include An interview and reprevention plan was | and maintenance of infers and procedures and lance documents on wall be documented evention policies and the reviewed at least and appropriate members for changes/updates of the annual review procedures on in the facility shall be be a provided in the annual review and interviewed and infection preventions are reviewed and person shall participate the facility of the facility with the mendations changes are reviewed annually with the mendations changes are conducted on 10/28/ | ons for ers for lividual revention of shall ction the which cess and shall be all have notion, review.  If the inthe contion of the shall be all have notion, review.  If the inthe contion of the shall be all have notion, review.  If the inthe contion of the shall be all have notion of the shall be all have not shall be all |                     | Infection prevention  12 VAC 5 – 412-220 A  Correction: All infection prevention procedures will be reviewed annual Governing Body. The ongoing resp the program is assigned to the Nurs Administrator who is trained in infection prevented to the Quality Assurance This committee includes OB/GYN Documentation in writing in our Ald Documentation. Prevention Recurredeficiency: The corrective action were currence. The Nursing Administremonitor and report to the Governing emergent issues that need corrective Policies will be expanded to clarify infection control staff. Measures to Compliance: The surgical and gyne coordinators will continue to train seprocess or procedure. The staff will training through CDC, BLR webina NAF. OSHA and Blood borne Path will continue to be required of all etraining documented. No patients we evidenced by no increase in adverse the period of this paperwork deficients. | lly by the consibility for sing ection control. ations will be Committee. physicians. In the control of the con | 01/01/15                 |
| ATE FORM                 | 1  | 1  | 021199   |                     | OS4L11   | If continuati  | on sheet 8 of 25         |

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| -                        |  | T   |   |                          |   |                   |                          |
|--------------------------|--|---|---|--------------------------|---|-------------------|--------------------------|
|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIE<br>IDENTIFICATION NUI   |   | (X2) MULTI<br>A. BUILDIN | IPLE CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY                   |
|                          | ,  | AF-0017   | 7   | B. WING                  |   | 10/2              | 29/2014                  |
| NAME OF                  | PROVIDER OR SUPPLIER   | -   | 7   |                          | STATE, ZIP CODE   | 10/-              | 23/2014                  |
|                          | CHURCH HEALTHCAR   | E CENTER  | 900 SOUT  |                          | GTON ST SUITE 300   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY<br>SC IDENTIFYING INFORMA  | S<br>/ FULL   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE            | (X5)<br>COMPLETE<br>DATE |
| T 165                    | Continued From Pa  | age 8   |   | T 165                    |   |                   |                          |
|                          | acknowledged the innot include the adm members of the clin qualified person wo prevention policies a required in the Virgin Review of the facility 10/27/2014 through evidence the policy been reviewed and An interview was cop.m., with Staff #1. documentation that body or the administ facility's policy and p Staff #1 stated, "I did reviewed annually. The reported the facility of procedures to reflect requirements for ensieviewed and updates." | p.m., with Staff #5. Sinfection prevention prinistrator, appropriate inical staff and the described review the infection and procedures annuinia licensure regulation of the surveyor request demonstrated the gostrator had reviewed to procedure manual and in the realize they need to 10/29/2014, Staff did not have policies of the updated State list suring the manual is sed by the administration of the clinical staff it person. | plan did te esignated tion tually as tions.  cedures on contain ual had  014 at 6:30 sted overning the nually. ded to be ff #1 s and licensure annually ttor, |                          |   |                   |                          |
| T 175                    | 12 VAC 5-412-220 C   | Infection prevention  | n .   | T 175                    |   |                   |                          |
|                          | supplies shall addres 1. Access to hand-w adequate supplies (e hand rubs, disposabl 2. Availability of utilit and other materials f storage and transpor 3. Appropriate storage  | facility, equipment ar  | and<br>ased<br>dryers);<br>ipplies<br>al,<br>supplies;<br>ints (e.g.,   |                          |   |                   |                          |

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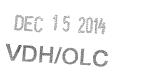
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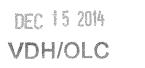
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPP  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                                | PLE CONSTRUCTION  |                                      | (X3) DATE SURVEY<br>COMPLETED |  |  |
|---|---|---|--------------------------------|---|--------------------------------------|-------------------------------|--|--|
|   | 1   |   |                                |   |                                      |                               |  |  |
|   | AF-00   | ·····   | B. WING                        |   | 10/:                                 | 10/29/2014                    |  |  |
| NAME OF PROVIDER OR SUPPLIER  |   | 1   | ADDRESS, CITY, STATE, ZIP CODE |   |                                      |                               |  |  |
| FALLS CHURCH HEALTHCAF  | RE CENTER   |   | JTH WASHING<br>CHURCH, VA 2    | TON ST SUITE 300<br>22046   |                                      |                               |  |  |
| PREFIX (EACH DEFICIENC  | ATEMENT OF DEFICIENC<br>Y MUST BE PRECEDED I<br>LSC IDENTIFYING INFOR   | BY FULL   | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN (<br>(EACH CORRECTIVE A<br>CROSS-REFERENCED TO<br>DEFICIE | CTION SHOULD BE<br>O THE APPROPRIATE | (X5)<br>COMPLET<br>DATE       |  |  |
| T 175 Continued From P  | age 9   |   | T 175                          |   |                                      |                               |  |  |
| use of cleaning agrime, management 4. Procedures for transporting clean and equipment; 5. Procedures for storage/transport of transporting reaccordance with agriculture accordance with agriculture accordance with agriculture accordance with agriculture for reusable medical edifferent patients.  (i) the level of cle to be used for each (ii) the process (edisinfection, heat stand (iii) the method for recommended level has been achieved reference the manual and any applicable control guidelines; | handling, storing, pregulated medical was explicable regulations the processing of exquipment between The procedure shall aning/disinfection/sont type of equipment age, cleaning, chemisterilization); and or verifying that the of disinfection/stell. The procedure shall acturer's recommentate or national informations for of equipment in acceptaning of environ priate cleaning process control program, local health and lations; and prevention procedunt/control transmiss | contact sures); and supplies  rocessing iste in s; ach type of uses on I address: terilization all endations ection I of  cordance mental ducts; managed  res ion of an |                                |   |                                      |                               |  |  |
| or required by the de<br>This RULE: is not n<br>Based on observation  | net as evidenced by   | /:<br>locument  |                                |   |                                      |                               |  |  |
| ATE FORM  | <del></del>   | 021199  | <del></del>                    | OS4L11  | If continuation                      | n sheet 10 of 2               |  |  |





| STATEMENT<br>AND PLAN C  | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU  | R/CLIA<br>MBER:  | 1                   | TIPLE CONSTRUCTION   | (X3) DATE<br>COMP   | SURVEY                           |
|--------------------------|---|--|--|---------------------|--|---|----------------------------------|
|                          |   | AF-0017  | ,  | B. WING             |  | 40/   | 20/2044                          |
| NAME OF F                | PROVIDER OR SUPPLIER  | 7.001  |  |                     | , STATE, ZIP CODE  | 10/2  | 29/2014                          |
| FALLS C                  | HURCH HEALTHCAR   | E CENTER   | 900 SOUT   |                     | IGTON ST SUITE 300   |   |                                  |
| (X4) ID<br>PREFIX<br>TAG | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FUL TAG REGULATORY OR LSC IDENTIFYING INFORMATION  |  | FULL .   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC   | ION SHOULD BE<br>THE APPROPRIATE  | (X5)<br>COMPLETE<br>DATE         |
| T 175                    | T 175 Continued From Page 10  |  | :  | T 175               |  |   |                                  |
|                          | review it was determed a manner to prevent washed at the correspread of infections 2. Develop policies encompassed the pand transporting clessencompassed the pand transporting clessencompassed the pand transporting clessencompassed the pand transporting clessencompassed the pand transporting has be the recommended lessenced and 4. Perform appropring procedures necessations transmission of an in the lessenced in a manner to prevent the spread prevention polices a lessenced in a manner to prevent the spread prevention polices a lessenced in a manner to prevent the spread prevention polices a lessenced in a manner to prevent the spread prevention polices a lessenced in a manner to prevent the spread prevention polices a lessenced in a manner to prevent the spread prevention polices a lessenced in the lessenced in | mined that the facility and other items were in the contamination and ect temperature to profit and procedures for handling an and soiled linens; as of cleaning, disinguen achieved accordivel of disinfection/strate infection prevent any to prevent/control infectious agent.  It from 2012 related and other items were to prevent contamined of infections; and in and procedures are defined and procedures are defined and procedures are defined and other items were contamined of infections; and in and procedures are defined and procedures are defined and procedures are defined and procedures are defined and oxygen tank attached to the cylinder key to open the oxid, "They tie this gauzest." In the "Surgical State" observation revealed to observation revealed to cylinder wrenches as Staff #1 affirmed | andled in were event the event to staff's everenation and afection eveloped ev |                     | Infection prevention  12 VAC 5 – 412-220 C  Correction:  1. The small gauze tie was re tanks. Only items that can according to existing FCH to minimize cross contamining the surgical suites.  2. All PPE will be stored in the protective plastic bags. The cross contamination from a sources.  3. The metal cart in the clean has been removed. A cart surface that can be disinfed Personnel entering the clean will don full PPE including mask, head cover and shoe minimize contamination from the sources.  4. The surgical straps in the subereplaced with ones that the between patients or disposal Nursing Administrator is in different options to assist in patients for their safety and | be cleaned C policies in order nation will be used he cabinets or in his will minimize environmental autoclave alcove with an intact eted has replaced it. he autoclave alcove gown, gloves, cover. This will om environmental urgical suites are to can be disinfected able straps. The hvestigating in immobilizing the | 10/29/14<br>01/01/15<br>12/10/14 |
| j :                      | #1 verified the findings. Staff #1 affirmed the gauze strip could not be disinfected and that it would present a mode of cross-contamination and  |  |  |                     | meet infection control prote jeopardizing patient health.  | ocols without   | 01/01/15                         |
| ATE FORM                 |   | 0  | 21199  |                     | <ol> <li>The soiled linen container v</li> <li>OS4L11</li> </ol>   |   | sheet 11 of 25                   |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |   | (X2) MUL  | TIPLE CONSTRUCTION  | (X3) DATE S  |   |                          |
|--|---|---|---------------------|--|---|--------------------------|
|  |   | TOMBET.   | A. BUILD            | ING  | COMPL   | בובט.                    |
|  | AF-00   | )17   | B. WING             | Charles Art.   | 10/2  | 9/2014                   |
| NAME OF PROVIDER OR SUI  | PPLIER  | STREET AD   | DRESS, CITY         | , STATE, ZIP CODE  | <u> </u>  |                          |
| FALLS CHURCH HEALT   | THCARE CENTER   | 900 SOUT  | TH WASHIN           | NGTON ST SUITE 300<br>. 22046  |   |                          |
| PREFIX (EACH DEF   | ARY STATEMENT OF DEFICIEN:<br>FICIENCY MUST BE PRECEDED<br>RY OR LSC IDENTIFYING INFOR  | BY FULL   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THI<br>DEFICIENCY)   | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETE<br>DATE |
| T 175 Continued F  | rom Page 11   | -   | T 175               |  |   |                          |
| a means for agents.  2. Observation 10/27/201 #1. The obspersonal proopen shelf uncontamination A stack of he covers in the room and mathe "Surgical An interview p.m., with Stathis supply of to prevent cosources until the surveyor. in cabinets.  3. On 10/29/was conducted instruments a appropriate for observation round #2 covers instruments poserved the series of t | transmission of potential ons and interviews were 4 at 1:00 p.m. to 1:30 p. ervations revealed the fotective equipment (PPE) n-protected from environ | conducted m., with Staff illowing stored on an mental and shoe procedure room. A at 1:15 as not aware be covered imental attention by are stored as 9. The shelf #1 and metal ple tears in shelf #2. If gown, overs prior to aff #9 are ready to ne quipment h pressure cted with the full PPE incleaning to a shelf incleaning the |                     | with one that is labeled, has disposable transport bag. So be transferred to the janitor's closed disposable bag. This updated in the Policy for pro and Guidelines for Best Prac A thermometer will be purchased hot water temperature. The temp maintained at 160 degrees by the temperature log will be maintained by the MA staff. Any deviations fidegree temperature will be reported Administrator and corrective action Offsite laundry services and dispose ing explored as an alternative. Prevention Recurrence Deficiency The corrective action will prevent reoccurrence. The Nursing Admin monitor and report to the Governitemergent issues that need corrective Measures to maintain Compliance Update to laundry manual to reflet trained/retrained to new process/p Governing Body will review infect policy annually, address any emer take corrective actions. Document shared with QAC as part of their a No patients were affected evidence in adverse events during the period. | iled laundry will is room in this policy will be ocessing laundry etices manual. It to monitor the erature is landlord. A did and reviewed from the 160 etit to the Nursing ons will be taken, sable supplies are of the same | 01/01/15                 |

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|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU  |  | (X2) MULTIP                    | LE CONSTRUCTION  |                                      | SURVEY                   |
|--------------------------|---|--|--|--------------------------------|--|--------------------------------------|--------------------------|
|                          |   | AF-0017  | ,  | B. WING                        |  | 10/                                  | 29/2014                  |
| NAME OF P                | PROVIDER OR SUPPLIER  |  |  | ADDRESS, CITY, STATE, ZIP CODE |  |                                      | 23/2014                  |
| FALLS CI                 | HURCH HEALTHCA  | RE CENTER  |  | TH WASHING<br>HURCH, VA 2      | TON ST SUITE 300<br>2046   |                                      |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIE  OY MUST BE PRECEDED BY LSC IDENTIFYING INFORMA  | FULL   | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN C<br>(EACH CORRECTIVE A<br>CROSS-REFERENCED TO<br>DEFICIEI | CTION SHOULD BE<br>O THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| T 175                    | Continued From F  | Page 12  |  | T 175                          |  |                                      |                          |
|                          | was only aware glaworking in that are with Staff #1 on 10 11:00 a.m. Staff # surface prevented the cart really had could be moved. So not be cleaned and means for transmit agents. Staff #1 repolicy to don full P sterilized instrume.  4. Observations a on 10/28/2014 from an abortion procedure and Staff #6. The blue cloth strips attused to hold the paverified the findings cloth strips could in between patients.  5. Observations are on 10/28/2014 from Staff #5. An observation revealed a verilabel and several plocated in the hallw "Surgical Suite-IV Staff #5 in the procedure in the "Staff #5 in the procedure in the "Staff #5 in the hallw "Surgical Suite-IV Staff #5 in the hallw "Surgical | oves were to be donned. An interview was on 2/29/2014 at approximate a concentration of the call no purpose in this are staff #1 reported the od could see why this obsion of potentially inferenced it was not the PE during the removants from the autoclave and interviews were concentrated in the "Surgical Street of the proceduration of the proce | conducted ately non-intact rt; however a and cart could be a ectious facility's all of e. nducted m. during uite - IV Staff #5 two (2) re table taff #1 ne blue cleaned cleaned nducted m., with ly 5:30 er with no red for of the post tion" colled linen Room se that is |                                |  |                                      |                          |
|                          | placed under the pa<br>assist staff with trar<br>procedure from the<br>Staff #5 reported at   | atient during the proce<br>nsferring the patient po<br>procedure table to a<br>the end of the proced<br>is full, it is then transp   | edure to<br>ost<br>stretcher.<br>dures or  |                                |  |                                      |                          |
| ATE FORM                 |   |  | 021199   | ,                              | OS4L11   | If continuation                      | n sheet 13 of 25         |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED   |  |
|---|--|---|---|---------------------|--|---------------------------------|--|
|   |  | AE 0015   | 7   | A. BUILDING         |  |                                 |  |
| NAME OF I   | PROVIDER OR SUPPLIER   | AF-0017   | <del></del>   | B. WING             |  | 10/2                            | 29/2014  |
|   | HURCH HEALTHCAR  | RE CENTER   | 900 SOUT<br>FALLS CH  |                     | STATE, ZIP CODE<br>STON ST SUITE 300<br>22046  |                                 |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY<br>LSC IDENTIFYING INFORMA   | FULL  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENCY | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE   |
| T 175   | Continued From P   | 'age 13   |   | T 175               |  |                                 | The state of the s |
| :   | all linens were was revealed a standar unit. Staff #5 reported the washer the appropriate set temperature of 160 reported the washer thermometer to ver An interview conduration. Stanot have a written phandling, storing ar soiled linen.  An exit interview was approximately 11:30 findings were review realize the soiled line covered. Staff #1 readdress the issues | I janitor. Staff #5 reportshed on site. The observed the linens were welting for the material. Her was connected to the property of the building and hele to the required hot was 0 degrees Fahrenheit. Her did not currently have rify the required temper ucted on 10/28/2014 were was not aware the series are covered to prevent aff #1 reported the fact policy and procedure read transporting clean are conducted on 10/28 as conducted on 10/28 | ervation bination vashed on Staff #5 he general /she iter Staff #5 ve a erature. vith Staff oiled linen bility did related to and/or  9/2014 at The "I didn't to be eded to ream. |                     |  |                                 |  |
|   |  | D Infection prevention  |   | T 180               |  |                                 |  |
|   | program that include<br>1. Access to recom<br>2. Procedures for a<br>communicable disea<br>prevented from work<br>transmission to othe<br>3. An exposure con<br>pathogens;<br>4. Documentation of  | des: mmended vaccines; assuring that employed eases are identified and rk activities that could er personnel or patien ntrol plan for blood-bood of screening and red/received by emplo   | res with<br>nd<br>result in<br>nts;<br>ourne  |                     |  |                                 |  |

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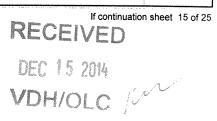




| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) F |  | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                               |  | TIPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED  |                          |  |  |
|--|--|--|--|--|--|--|--------------------------|--|--|
| MINUTERS   |  | AF-0017  | ı  | B. WING  |  | 10/29/2  | 014                      |  |  |
| NAME OF  | PROVIDER OR SUPPLIER   |  | STREET AD  | DRESS, CITY                                      | , STATE, ZIP CODE  |  |                          |  |  |
| FALLS C  | HURCH HEALTHCAI  | RE CENTER  |  | OUTH WASHINGTON ST SUITE 300<br>CHURCH, VA 22046 |  |  |                          |  |  |
| (X4) ID<br>PREFIX<br>TAG                                 | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY LSC IDENTIFYING INFORMA  | FULL   | ID<br>PREFIX<br>TAG                              | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | LD BE C  | (X5)<br>COMPLETE<br>DATE |  |  |
| T 180  | Continued From P   | 'age 14  |  | T 180  |  |  |                          |  |  |
|  | including documer tuberculosis and a 5. Compliance wit Occupational Safe reporting of workp exposure to infection This RULE: is not Based on docume determined that the evidence that screen offered/received by   | met as evidenced by:<br>ntation and interview,<br>e facility failed to provi<br>ening and immunization<br>of 13 employees.   | r<br>accine;<br>U.S.<br>ation for<br>es or<br>it was<br>de<br>ons were           |  |  |  |                          |  |  |
|  | The findings includ  | , <del>-#4</del> , #6-#8, and #11-#<br>led:  | :13)   |  |  |  |                          |  |  |
| T 290  | facility failed to docimmunizations offer accordance with strecommendations. 11 of 13 employees  During an interview 6:00 PM, Staff #1 stuberculosis and imflu are offered to all and annually therea immunization informhealth file, but has located at this time.  12 VAC 5-412-270  An abortion facility sequipment and supadequate to care for | of public health authors.  on 10/28/14, at approstated "Screening for amunization for Hepatil employees, once whafter." Staff #1 stated thation is kept in the element of t | and byees in rities for eximately tis B and en hired hat the mployee annot be es | T 290  | Infection prevention  12 VAC 5 – 412-220 D  Correction: Background: our SSHP (Staff and Health Program) staff medical files an renewed each September — October or with Orientation Program for new Staff. That rewas completed. But as noted in the deficient report the "files" were misplaced. NOTE: member #13 was cited but there was not at #13. Staff member #6 is a new employee at orientation. Staff #8 and #11 are consultant PLAN OF CORRECTION:  The staff file of their various testing's and declinations have been located. The staff if files have been updated and are current. The Staff member's SSHP orientation is now scheduled. The Consultants medical files we completed and brought to consistency with policies. Prevent recurrence of Deficiency. corrective actions taken will prevent recurred efficiency. Measures to maintain compliant various steps for the staff medical charts he consolidated to the activity of one staff per Gynecology Coordinator. No patients were by this deficiency | thin the enewal may the staff staff and still in mats.  For enedical enew will be a staff: The rence of mace: The ave been ason, our | /01/15                   |  |  |
| ATE FORM   | Λ  |  | 021199   |  | OS4I 11  | continuation she   | ot 15 -505               |  |  |

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|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU   |   | (X2) MUL<br>A. BUILD | TIPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED   |  |
|--------------------------|--|---|---|----------------------|--|---|--|
|                          |  | AF-0017   | •   | B. WING              |  | 10/2  | 29/2014                                      |
| NAME OF F                | ROVIDER OR SUPPLIER  |   | STREET AD   | DRESS, CITY          | , STATE, ZIP CODE  |   |  |
| FALLS C                  | HURCH HEALTHCAR  | E CENTER  | 900 SOUT  |                      | IGTON ST SUITE 300   |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>SC IDENTIFYING INFORMA  | FULL  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)  | SHOULD BE   | (X5)<br>COMPLETE<br>DATE                     |
| T 290                    | Continued From Pa  | age 15  |   | T 290                |  |   |  |
|                          | 1. A bed or recline 2. Oxygen with flow equivalent; 3. Mechanical such 4. Resuscitation ed minimum, resuscitation ed and related supplie 6. Sterile suturing ed 7. Adjustable exam 8. Containers for simaterials with cove 9. Refrigerator.  This RULE: is not right and staff and on observation of Simulation of Sim | r suitable for recovery meters and masks ition; quipment to include; attion bags and oral attications, intravenous and equipment; equipment and supplaination light; ciled linen and wasters; and met as evidenced by: on and interview, the equipment and medical suitable. The principle of the procedure tability to disinfect and iff #1 stated that the part of the procedure tability to disinfect and iff #1 stated that the part of the procedure tability to disinfect and iff #1 stated that the part of the procedure to a principle of the procedure | as a rways; s fluids, ies; facility lical oom, on a Staff #1 nd right ble. Tears can badding not in a gen tank. In a gen tank. In a staff #1 Staff #1 ) on Staff #1, ie metal |                      | Equipment and supplies  12 VAC 5 – 412-270  Correction:  1. The vendor for the surgical prowill be contacted to repair the the recently recovered procedu oxygen masks are in a bag or protopen to air. Consistent with event related expiration policy. All medical supplies such as gill IV solutions, needles, cannulas event related shelf-life guideling sterile indefinitely, unless an experiment them to become contaminated, wet packaging or if the manufactorewise. Sterile items will not evaluated by manufacturers' experiment of the properties.  2. The tape on the gurney was remained of the properties. The suction catheter aspirator was bagged and not on the sum of the properties.  3. All oxygen masks are in a bag and not open to air.  4. The soiled linen container will with one that is labeled, has a continuous disposable transport bag. Soile be transferred to the janitor's reclosed disposable bag. This polliphed in the Policy for proce and Guidelines for Best Practice.  Prevent recurrence of Deficiency: The actions taken will prevent recurrence and ensure that all items used in patients of the process of | small tears on re table. All ackaged and a our approved See attached. Oves, syringes, will follow ack recognizing vent causes e.g., torn or cturer specifies a longer be appraised on the mey was attached to an pen to air. For packaged be replaced over, and a diaundry will be ssing laundry es manual. The corrective of deficiency ent care will be patient care. Taff trained to tody and Cond address any | 01/01/15<br>11/02/14<br>11/02/14<br>01/01/15 |
| 1                        | plate under the pad on the first gurney when entering the room. Tape was wrapped around the metal joints on both sides at the foot of the  |   |   |                      | emergent issues and take corrective a<br>patients were affected evidenced by<br>adverse events during the period of d  | no increase in  |  |
| ATE FORM                 | <u> </u>   |   | 021199  | <del></del>          | OS4L11   | If continuation   | n sheet 16 of 25                             |



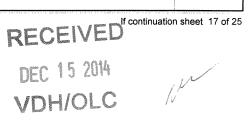
DEC 15 2014 VDH/OLC



| AND PLAN OF CORRECTION IDENTIFICA |  | (X1) PROVIDER/SUPPLI<br>IDENTIFICATION NU  | JMBER:   | <u> </u>   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                                | SURVEY<br>LETED          |
|-----------------------------------|--|--|--|--|--|--------------------------------|--------------------------|
|                                   |  | AF-001   | 7  | B. WING  |  | 10/2                           | 29/2014                  |
|                                   | PROVIDER OR SUPPLIEF   |  | 900 SOU  |  | STATE, ZIP CODE<br>STON ST SUITE 300<br>22046  |                                |                          |
| (X4) ID<br>PREFIX<br>TAG          | (EACH DEFICIENCY MUST BE PRECEDED  |  | / FULL   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| T 290                             | Continued From I   | Page 16  |  | T 290  |  |                                |                          |
|                                   | hold it down. The the ability to disinipillow roll was sto and was dusty. Stono longer used. To an aspirator, was that was open to acknowledged the statement of 10/27/14, from 2: revealed an oxygen anesthesia equipment bagged. Staff #1 at 4. Observations at on 10/28/2014 fro Staff #5. An observation revealed and several located in the hall "Surgical Suite-IV observation reveal procedure in the "procedure room. items included: a #1;" a patient clother placed under the passist staff with traprocedure from the Staff #5 reported a when the contained the closet marked all linens were was revealed a standar unit. | F Surgical Suite-Sedation of the mask placed on the ment was open to air, acknowledged the find and interviews were composed of the ment was open to air, acknowledged the find and interviews were composed of the ment of the surgical storage contains pieces of linen uncovery by the entrance of Sedation" procedure alled soiled linen from a Surgical Suite-IV Seda Staff #5 reported the subject of the subject of the procedure table to a staff the end of the procedure table to a staff the end of the procedure is full, it is then transition. Staff #5 reported on site. The obsert washer/dryer combord washer/dryer combord in the procedure table to a staff washer/dryer combord washe | restricts acteria. A had tears pillow was attached to packaging #1 fon on h Staff #1, e not lings.  In on on h Staff #1, e not lings.  In onducted m., with ely 5:30 er with no ered foor of the room. The post ation Room as that is redure to cost stretcher. Edures or sported to red that ervation ination |  |  |                                |                          |
|                                   | #5 revealed he/she   | ucted on 10/28/2014 we was not aware the see covered to prevent  |  | TO THE RESIDENCE OF THE PARTY O |  |                                |                          |

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|  | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU  |  |                        | TIPLE CONSTRUCTION   | (X3) DATE<br>COMF                       | SURVEY                   |
|--|--|--|--|------------------------|--|---|--------------------------|
|  |  | AF-0017  | •  | B. WING                |  | 10/                                     | 29/2014                  |
| NAME OF  | PROVIDER OR SUPPLIER   |  | STREET AD  | DRESS, CITY            | , STATE, ZIP CODE  |   |                          |
| FALLS C  | CHURCH HEALTHCAR   | RE CENTER  | 900 SOUT   | TH WASHIN<br>HURCH, VA | IGTON ST SUITE 300<br>. 22046  |   |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>.SC IDENTIFYING INFORMA   | FULL   | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)   | OULD BE                                 | (X5)<br>COMPLETE<br>DATE |
| T 290  | Continued From P   | age 17   |  | T 290                  |  |   | 7                        |
|  | contamination.   |  |  |                        |  |   | mana un commence co      |
|  | approximately 11:3<br>findings were revie<br>realize the soiled lin<br>covered. Staff #1 re  | onducted on 10/29/20<br>0 a.m., with Staff #1.<br>wed. Staff #1 stated,<br>nen container needed<br>eported the facility ne<br>found by the survey to | The "I didn't I to be eded to  |                        |  |   |                          |
| T 320  | 12 VAC 5-412-300   | B Quality assurance  | to common the control of the control | T 320                  |  |   |                          |
|  | adequacy and appr<br>to identify unaccept<br>occurrences:  1. Staffing patterns 2. Supervision app<br>service; 3. Patient records; 4. Patient satisfacti | ropriate to the level o  | es, and<br>rends or  |                        |  |   |                          |
| :  | <ul><li>5. Complaint resolutions, complevents; and</li></ul>   | ition;<br>lications and other ac   | dverse   |                        | Quality Assurance<br>12 VAC 5 – 412-300 B  |   | 01/01/15                 |
|  |  | egarding patient care  |  |                        | Correction: We will continue to use the Review Documentation which allows us   | s to collect                            | 01/01/15                 |
| To make the second seco | Based on document quality committee father adequacy and a required by the State  | net as evidenced by:<br>t review and interview<br>alled to ensure an eva<br>ppropriateness of sel<br>e licensure regulation                          | lluation of<br>vices as<br>is.   |                        | the necessary data of the seven required and/or identified unexpected trends/occupuring our QAC meetings, we will use Review Documentation to help evaluate collected in the documentation. Trends, and relative data will be part of the QAC The corrective actions taken will preven recurrence of deficiency. We will evalu | the Annual the data actions, C minutes. |                          |
|  | failure to ensure all  | ite from 2012 related<br>subjects of the quality<br>ittee would be addres  | <i>,</i>   |                        | data that is collected and document revieweeting minutes. Revised Annual RevieDocumentation form reviewed with QA  | ew in QAC<br>ew<br>C, Co-               |                          |
| 1  | The findings include   | d:   | man of the state o |                        | Administrators, and the governing body<br>to maintain compliance: The QAC will rannually and address any emergent issue  | review                                  |                          |
|  | program documents  | riew of the facility's qui<br>were conducted on<br>p.m., with Staff #2.  | 1  | į                      | corrective actions as outlined in existing No patients were affected by this deficie   | policies.                               |                          |
| ATE FORM   | 1  | ······································   | D21199   | 1                      | OS4L11   | If continuation                         | n sheet 18 of 25         |

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|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU  | ER/CLIA<br>MBER:  | (X2) MULT                       | PLE CONSTRUCTION  | (X3) DATE<br>COMF              | SURVEY                   |  |  |
|--------------------------|---|--|---|---------------------------------|---|--------------------------------|--------------------------|--|--|
|                          |   | AF-0017  | •   | B. WING _                       |   | 10/2                           | 29/2014                  |  |  |
| NAME OF                  | PROVIDER OR SUPPLIER  |  | STREET AD   | TADDRESS, CITY, STATE, ZIP CODE |   |                                |                          |  |  |
| FALLS C                  | HURCH HEALTHCAR   | E CENTER   |   | TH WASHING<br>HURCH, VA         | GTON ST SUITE 300<br>22046  |                                |                          |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIE<br>MUST BE PRECEDED BY<br>SC IDENTIFYING INFORMA   | FULL  | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |  |  |
| T 320                    | Continued From Pa   | ige 18   |   | T 320                           |   |                                |                          |  |  |
|                          | program documentation did in (7) elements of: staffing patterns and supervision appropriation records; patient satisfaction; complaint resolution infections, complicate events; and staff concerns regain reported the quality but had not evaluate areas or identified untrends or occurrence 1:30 p.m. the survey reviewed the Regular Abortion Facilities E #2 denied awareness licensure regulations committee had colle | d performance; riate to the level of seriate to the level of seriations and other advertises.  Trigonal patient care. So committee had colleged data for the sever nacceptable or unexpess.  Conducted on 10/28 yor inquired if Staff # ations for the Licensuffective June 20, 2016 is of the updated Staff seriations for the reported series at the serial patients of the updated staff the required data for the required seriate to the serial patients. | red seven ervice; erse staff #2 cted data a required epected 8/2014 at 2 had ure of 13. Staff ete the quality ot d areas to |                                 |   |                                |                          |  |  |
| T 330                    | 12 VAC 5-412-300 E  | Quality assurance  |   | T 330                           |   |                                |                          |  |  |
|                          | D. Measures shall be problems or concern  |  |   |                                 |   |                                |                          |  |  |
|                          | This RULE: is not m<br>Based on document<br>quality committee fai<br>implemented to reso<br>concerns.   | review and interview<br>iled to ensure measu   | ires were   |                                 |   |                                |                          |  |  |
|                          | Note: This is a re-cit failure to ensure how  |  |   |                                 |   |                                |                          |  |  |

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|                          | OF DEFICIENCIES OF CORRECTION  |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | TIPLE CONSTRUCTION   |                          | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|--|---|--|--------------------------|-------------------------------|--|
|                          |  | AF-001   | 7  | B. WING   |  |                          |                               |  |
| NAME OF I                | PROVIDER OR SUPPLIER   | ·····  | <del></del>  |   |  | 10/2                     | 10/29/2014                    |  |
|                          | HURCH HEALTHCAI  |  | 900 SOU  |   | , STATE, ZIP CODE<br>IGTON ST SUITE 300<br>. 22046   |                          |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | REGULATORY OR LSC IDENTIFYING INFORMATION)  REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX  CROSS-REFERENCED TO DEFICIE  |  | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC  | ION SHOULD BE<br>HE APPROPRIATE  | (X5)<br>COMPLETE<br>DATE |                               |  |
| T 330                    | Continued From F   | Page 19  |  | T 330   | b  |                          |                               |  |
|                          | by the quality impr  | ovement committee.   |  |   |  |                          |                               |  |
|                          | The findings include   | ded:   |  |   |  |                          |                               |  |
|                          | An interview and review of the facility's quality program was conducted on 10/28/2014 at 12:15 p.m., with Staff #2. Staff #2 initially acknowledged the quality improvement committee did discuss concerns/problems that had been identified by services provided, appropriateness of care including reports from staff, patients, performance patterns, or any other sources of data collected.  The review revealed documents titled "Quality Meeting," which listed items discussed as part of the facility's quality program meeting. Staff #2 identifies the items as concerns that were discussed during the meeting. The surveyor asked Staff #2 for documentation that measures were implemented to correct the concerns. Staff #2 reported the quality committee did not document any corrective actions that were implemented. |  | 2  | Quality Assurance  12 VAC 5 – 412-300 D  Correction: We will document in any corrective actions that we in response to any concerns that macenter. The corrective actions tal recurrence of deficiency. Measur compliance: The QAC will revie documentation annually and add issues and take corrective actions existing policies. The QAC will | replement in ay arise at the ken will prevent res to maintain we all ress any emergent is as outlined in also document all | 01/01/15                 |                               |  |
|                          | approximately 11:3 findings were review facility's quality progressues found by the acknowledged the   | onducted on 10/29/20<br>0 a.m., with Staff #1.<br>wed. Staff #1 reporte<br>gram needed to addre<br>survey team. Staff<br>quality program's fail<br>es to resolve problem<br>been identified. | The ed the ess the #1 ure to                       |   | evaluation from the data collecte will be the QAC minutes. No part by this deficiency.                                     | d documentation          |                               |  |
| T 335                    | 2 VAC 5-412-300 E  | Quality assurance  |  | T 335   |  |                          |                               |  |
|                          | E. 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 improvements. The report shall be acted upon   |  |  |   |  |                          |                               |  |
| TATE FORM                | 1  |  | 021199   |   | OS4L11   | If continuation          | n sheet 20 of 25              |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   |   | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU   | ER/CLIA<br>MBER:  |  | TIPLE CONSTRUCTION ING  | (X3) DATE SURVEY<br>COMPLETED   |                          |
|---|---|---|---|--|---|---|--------------------------|
|   |   | AE 0047   | ,   |  |   |   |                          |
| NAME OF P   | ROVIDER OR SUPPLIER   | AF-0017   | T   | B. WING  | , STATE, ZIP CODE   | 10/2  | 29/2014                  |
|   | HURCH HEALTHCA  |   | 900 SOU   |  | IGTON ST SUITE 300  |   |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY LSC IDENTIFYING INFORMA   | FULL  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)   | SHOULD BE   | (X5)<br>COMPLETE<br>DATE |
| T 335   | Continued From F  | age 20  |   | T 335  |   |   |                          |
|   | corrective actions<br>Identified deficient<br>safety shall be rep                     | pody and the facility. A<br>shall be documented.<br>cies that jeopardize pa<br>ported immediately in v<br>e quality improvement     | atient<br>writing to  |  |   |   |                          |
|   | Based on docume quality committee   | met as evidenced by:<br>nt review and interview<br>failed to compile result<br>or corrective action<br>e governing body.            | w the   |  |   |   |                          |
| a se us   | failure to ensure re<br>improvement prog<br>licensee at least a<br>identified, recomm | cite from 2012 related esults of the quality ram would be reported nually and deficiencie endations and improvupon by the governing | d to the<br>es<br>ements  |  | Quality Assurance   |   |                          |
| 1   | The findings includ   | led:  | 10 to |  | 12 VAC 5 – 412-300 E<br>Correction: A report for the govern   | ng body is  | 01/01/15                 |
| An interview and review of the facility's of program was conducted on 10/28/2014 p.m., with Staff #2. Staff #2 initially acknow the quality improvement committee did concerns/problems that had been identified services provided, appropriateness of coincluding reports from staff, patients, per patterns, or any other sources of data concerns.                           |   | at 12:15<br>owledged<br>iscuss<br>ied by<br>re<br>formance;   |   | compiled annually on the Annual R Document and any details of correct noted in QAC minutes. As per exist report is part of the QAC minutes the deficiencies, recommendations, and improvements. The corrective action prevent recurrence of deficiency. We report to the governing body annual documentation on the Annual Review Measures to maintain compliance: | eview tive actions ing policy, this nat includes any /or ns taken will /e will submit a ly as w Document. The QAC will  |   |                          |
| The review revealed documents titled "Quality Meeting," which listed items discussed as part of the facility's quality program meeting. Staff #2 identifies the items as concerns that were discussed during the meeting. The surveyor asked Staff #2 for documentation that measures were implemented to correct the concerns. Staff #2 reported the quality committee did not |   |   |   |  | review all documentation annually, emergent issues, take corrective action existing policies, and document a actions, deficiencies, recommendati improvements. With the following i QAC will compile a report for the g to review annually through the QAC patients were affected by this deficient | address any ons as outlined Il corrective ons, and/or nformation, the overning body minutes. No |                          |
| ATE FORM  |   |   | 021199  |  | OS4L11  | If continuation   | n sheet 21 of 25         |

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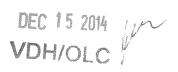


|                          | F CORRECTION   | IDENTIFICATION NU  | MBER:  |   | LE CONSTRUCTION  G                 | (X3) DATE<br>COMF  | SURVEY                   |
|--------------------------|--|--|--|---|------------------------------------|--|--------------------------|
|                          |  | AF-0017  | ,  | B. WING   |                                    | 10/  | 29/2014                  |
|                          | ROVIDER OR SUPPLIER  |  | ł  |   | TATE, ZIP CODE                     |  |                          |
| FALLS CI                 | HURCH HEALTHCARI   |  | FALLS C  | TH WASHING<br>HURCH, VA 2   | TON ST SUITE 300<br>2046           |  |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIE<br>YMUST BE PRECEDED BY<br>SC IDENTIFYING INFORMA  | FULL   | ID<br>PREFIX<br>TAG   | (EACH CORRECTIV<br>CROSS-REFERENCE | AN OF CORRECTION<br>YE ACTION SHOULD BE<br>D TO THE APPROPRIATE<br>CIENCY) | (X5)<br>COMPLETE<br>DATE |
| T 335                    | Continued From Pa  | ige 21   |  | T 335   |                                    |  |                          |
|                          | implemented. Staff committee did not committee did not committee did not composed provide a committee did not composed provide a composed provide a committee did not composed provide a committee deficiencia recommendations for improvements.  12 VAC 5-412-320 Form the deficiencia recommendations for improvements.  12 VAC 5-412-320 Form the deficiencial records or a reproductions thereof federal and state law Insurance Portability USC 1320d et seq.). The facility, the facility concerning the location records are stored.  This RULE: is not more assessed on document facility failed to provide storage of medical reeligible reproductions applicable federal and closure of the facility, of Licensure and Certhe location where pastored. | ram needed to addresurvey team. Staff a puality program's failures identified and or corrections and record storage made for the safe storage made for the event of close y shall notify OLC ion where patient medical records or accurate a storage for the ecords or accurate a storage for the ecord | ity he illy.  D14 at The ed the est the #1 ure to  prage of cable th Act (42 sure of edical  / the safe nd o event of ify Office cerning   | T 345   |                                    |  |                          |
| - vanna vanna v          | The findings included  | l:   | Annual Control of the | TOTAL PROPERTY OF THE PARTY OF |                                    |  |                          |
| ATE FORM                 |  |  | D21199   |   | OS4L11                             | DEAE Micontinuation  |                          |

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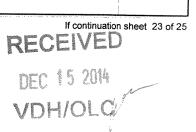
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| STATEMENT<br>AND PLAN ( | TOF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |  | (X2) MUL   | TIPLE CONSTRUCTION   |   | (X3) DATE SURVEY<br>COMPLETED |  |
|-------------------------|---|---|--|--|--|---|-------------------------------|--|
|                         |   |   |  | A. BUILD   | ING  | COIVIE  | CETED                         |  |
|                         |   | AF-0017   |  | B. WING  |  | 10/2  | 29/2014                       |  |
|                         | PROVIDER OR SUPPLIER  |   | STREET AD  | DRESS, CITY  | , STATE, ZIP CODE  |   |                               |  |
| FALLS C                 | HURCH HEALTHCAI   | RE CENTER   | 900 SOU<br>FALLS C   | TH WASHIN<br>HURCH, VA   | IGTON ST SUITE 300   |   |                               |  |
| (X4) ID                 | SUMMARY ST  | ATEMENT OF DEFICIENCIE  | S  | ID   | PROVIDER'S PLAN OF CORR  | ECTION  | (VE)                          |  |
| PREFIX<br>TAG           | REGULATORY OR   | CY MUST BE PRECEDED BY<br>LSC IDENTIFYING INFORMA   | FULL<br>ATION)   | PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |  |   | (X5)<br>COMPLETE<br>DATE      |  |
| T 345                   | Continued From P  | age 22  |  | T 345  |  |   |                               |  |
|                         | evidence the policy been reviewed and facility failed to have be made for the say or accurate and eliaccording to applice the event of closur notify Office of Lice concerning the locarecords are stored.  An interview was concerning to applice Staff #1 stated, "I'm the facility has then that matter." On 10 #1 reported he/she information for the provisions of the say because he/she had responsibilities and 12 VAC 5-412-330  B. Abortion facilities or visitor deaths to the concurrence.  This RULE: is not reporting to the Office Certification (OLC) to occurrences, which | onducted on 10/28/20 aff #1. The surveyor is trecords were being sable federal and state not sure where the conlocated, but I will lood/29/2014 at 11:30 a.n did not have any furth surveyor regarding the storage of medicals been busy with other duties regarding the state of Licensure and within 24 hours any involved: | contain ual had The sions shall records ereof e law. In cility shall on (OLC) edical  14 at requested e law. owner of ok into n., Staff ner e records r survey.  ht, staff irs of  the edure for | 77 7 200 100 100 100 1   | Record Storage  12 VAC 5 – 412-320  Correction: Notation of the governing December 2013 review of over 1000 Policy Manuals is now posted in the Review Documentation. It was not perferical issue of the form being revise multiyear. The new form was not return Manual by the time of the unannounce Notation of the Governing Body's self December 2014 review of over 1000 Policy Manuals is posted in the Annu Documentation. See attached form. Safe and secure storage of Patient Recontinually maintained on and off site FCHC's record retention and destruct Revising storage of archived medical of FCHC's ongoing administrative trabegan in September 2014. Since May entered into and are presently in final negotiations with the landlord to obtastorage space. This will facilitate full storage. As well, initial planning to make copies of archived files is underway. Currently consolidating the archived recurrently consolidating the archived recurrence of Deficiency. The actions taken will prevent recurrence Measures to maintain compliance: Go Body will review annually and addressemergent issues and take corrective acoutlined in existing policies. Policies clarified as needed. Staff will be train-procedures including assisting with melectronic copies. No patients were af | pages of the 5 Annual sted due to d to rned to the ed inspection. deduled pages of the 5 al Review cords has been according to ion policy. records is part insition that of 2014, we stages of in additional on-site record ake electronic staff is ecords on site e new d reported to e corrective of deficiency. overning s any etions as will be ed in the new aking | 12/11/14                      |  |
| ATE FORM                | i. Genous patient if  | njury, medication error   | s, death   |  | deficiency.  | -   |                               |  |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  | (X2) MUL <sup>-</sup><br>A. BUILDI   | FIPLE CONSTRUCTION   |   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|--|--|--|---|-------------------------------|--|
|   |   | AF-0017  | ,  | B. WING  |  | 10/2  | 9/2014                        |  |
|   | ROVIDER OR SUPPLIER<br>HURCH HEALTHCAR  |  | STREET AD  | DDRESS, CITY, STATE, ZIP CODE  JTH WASHINGTON ST SUITE 300  CHURCH, VA 22046 |  |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>.SC IDENTIFYING INFORMA   | FULL   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)   | SHOULD BE   | (X5)<br>COMPLETE<br>DATE      |  |
|   | assault, any other imalpractice insurar  2. What the notific  3. The facility's resoccurrences to law develop policies are compliance with; a  4. Confidentiality of the findings includ  1. Review of the famanual on 10/27/20 reveal the following  (B). The abortion frevents to OLC:  1. Any serious injue  2. Medication error intervention other than the following froccurs within or on and  4. Any other incide insurance carrier or Safe Medical Devic  2. Review of the famanual on 10/27/20 reveal the following  (C). Notification of B shall be required from the famanual on 10/27/20 reveal the following  (C). Notification of B shall be required from the famanual on facility in the famanual on facility | resulting from a physincident reported to the nee carrier; sation to OLC should is sponsibility to report of enforcement and the need procedures to ensure the end procedure acility's policy and procedure acility shall report the ry to a patient; and monitoring; ficant injury of a patient of a physical assauthe abortion facility gent reported to the materian in compliance with the estant and procedure the events listed in sure within 24 hours of occupation in the following: | include; e failure to ure n OLC. cedure 114 did not es: following clinical nt or staff It that rounds; Ilpractice he federal cedure 14 did not es: ubsection currence. | T 355  | Reports  12 VAC 5 – 412-330 B  Correction: NOTE: There have been serious injury to a patient, medication necessitate clinical intervention, deat significant injury resulting from assa incident reported to malpractice insureporting of NO incidents will be increquested to OLC. The existing Polic deaths to the Office of Licensure wit will be expanded to clarify reporting process. An additional line for Report added to the Annual Review Doct The current policies previously apprare attached.  Prevent recurrence of Deficiency: The actions taken will prevent recurrence Measures to maintain compliance: Cannually in December to OLC as requore reportable events were experience continue to review the OLC website noticed changes. The GB will also relicensure regulations that may have continue to retrieve the OLC. Newere affected by this deficiency. | n errors that h or ult at FCHC or rance. The luded as ey for reporting hin 24 hours sequence and ets to OLC will amentation. oved by OLC ne corrective of deficiency. B will report uested even if ed. GB will to see any eview for changed | 01/01/15                      |  |

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| AND PLAN OF CORRECTION IDENTIFICATION N |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |   | (X2) MULTIF             | PLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---|-------------------------|--|-------------------------------|--|
|   |  | AF-0017  | 7   | B. WING                 | ***  | 10/2                          | 29/2014  |
|   |  | STREET ADD   | RESS, CITY, S   | TATE, ZIP CODE          |  |                               |  |
| FALLS C                                 | HURCH HEALTHCAR  | E CENTER   | 900 SOUT  | H WASHING<br>URCH, VA 2 | TON ST SUITE 300<br>22046  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORMA  | FULL  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETE<br>DATE   |
| T 355                                   | Continued From Pa  | nge 24   |   | T 355                   |  |                               |  |
|   | (D). Compliance w relieve the abortion any other applicable requirements, such enforcement or profession (E). Records that a state law shall be made the OLC and shall no OLC except as requirements to the OLC. Not aware of a requirement to the OLC with the OLC with the old of the surveyor inquirements regulations for the Effective June 20, 2 | the abortion facility fety and to prevent resith 12VAC5-412-320 facility from complying reporting or notification as those relating to fessional regulatory are confidential understaintained as confidential understained or permitted by and understaintained as confidential understaintained as confi | does not not with attion law agencies.  federal or ntial by ed by the law.  14 at request reporting /she was porting the currence. iewed the n Facilities ed they ulations ed Staff #1 and out s in the rmed Staff or updated he facility is, the new |                         | RECE<br>DEC 15<br>VDH/C  | EIVED<br>2014                 |  |
|   | reporting requiremen   | nts to comply with the   |   |                         | VDH/C  | 2014<br>PLC                   | The state of the s |

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If continuation sheet 25 of 25

