STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AF-0010	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 10/31/2014
NAME OF PROVIDER OR SUPPLIER: PL PARENTHOOD METRO WASHINGTON-FALLS C		STREET ADDRESS, CITY, STATE, ZIP CODE: 303 S. MAPLE AVE. SUITE 300 FALLS CHURCH, VA 22046	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	12 VAC 5- 412 Initial comments An unannounced Licensure Biennial survey was conducted 10/30/2014 through 10/31/2014. Two Medical Facilities Inspectors from the Office of Licensure and Certification, Virginia Department of Health conducted the survey. The agency was not in compliance with 12 VAC-412 Regulations for the Licensure of Abortion Clinics. (Effective 06/20/2013).	T 000		
T 130	12 VAC 5-412-200 Minors No person may perform an abortion upon an unemancipated minor unless informed written consent is obtained from the minor and the minor's parent, guardian or other authorized person. If the emancipated minor elects not to seek the informed written consent of an authorized person, a copy of the court order authorizing the abortion entered pursuant to 16.1-241 of the Code of Virginia shall be obtained prior to the performance of the abortion. This RULE: is not met as evidenced by: Based on interview and record review it was determined that the agency failed to provide evidence that a written consent was obtained from an authorized adult for a minor (Patient #5) in one (1) out of three (3) minors in a survey sample of three. (Patients #5) The findings included: Review of electronic patient records on 10/30/2014, revealed that a 17 year old patient (#5) was admitted on 4/28/2014, and underwent an abortion on 5/2/2014. Review of the informed consent revealed that there was no signature of the parent or legal guardian.	T 130	**Actions to correct the deficiency:** Patients are our top priority. PPMW insists on the highest professional standards of care, and we follow all laws. During the state inspection, we became aware of one instance where our high standard was not met regarding our routine procedure of charting a minor's consent form. We have taken swift corrective action, including conducting an internal review to ensure that we are complying with all laws, retraining all staff, and instituting additional safeguards in our administrative and quality assurance systems. **Actions to prevent a recurrence of the deficiency:** To ensure the highest quality care, PPMW-Falls Church immediately implemented an expanded policy and additional procedures related to minor consent charting. The actions require extra checkpoints throughout a minor's visit to verify age and needed consent, a paperwork color coding system for minor patients, and expanded signing protocols for parents. Specifically, the expanded policy and procedures require the following: (1) the age of each patient will be reviewed at multiple steps of the visit to determine if the patient is a minor, (2) when the patient is determined by the front desk staff to be a minor, a red folder will be used for that patient's records to indicate that the patient is a minor, and (3) the physician will document in the electronic health records that before beginning the procedure, he/she reviewed the age of the patient and determined that the necessary consents had been obtained. The initial retraining occurred in mid-November and all additional safeguards will be in place fully by January 7, 2015. **Actions to maintain compliance:** All staff will be required to review the final policy and procedures and acknowledge that review on record by January 7, 2015.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cmeyers 12/17/14 TITLE: CEO (X6) DATE: 12/17/14

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T 130	Continued From Page 1 An interview was conducted on 10/31/2014 at 10:15 AM with Staff #9. Staff #9 reviewed the electronic record for Patient #5 and acknowledged there was no signature of a parent or legal guardian on the informed consent. Staff #9 stated the agency had experienced "a problem with the system capturing electronic signatures."	T 130	PPMW-Falls Church's Quality Risk Management program will review the charts of all minors every 3 months to ensure that the required documentation is complete. The review will also include a check of the physician's documentation that prior to beginning the procedure, the patient's age and the consent documents were reviewed. This audit will be recorded on the PPMW Schedule of FY 2015 CQRM Audits beginning on January 7, 2015.	
T 135	12 VAC 5-412-210 A Patients' rights A. Each abortion facility shall establish a protocol relating to the rights and responsibilities of patients consistent with the current edition of the Joint Commission Standards of Ambulatory Care. The protocol shall include a process reasonably designed to inform patients of their rights and responsibilities, in a language or manner they understand. Patients shall be given a copy of their rights and responsibilities upon admission. This RULE: is not met as evidenced by: Based on document review and interviews the agency failed to provide documentation that patients received a copy of their rights and responsibilities upon admission for six (6) of six (6) patients included in the survey sample (Patient #1-#6). The findings included: Review of six (6) patient records (#1-#6) on 10/30/2014, at approximately 1:00 p.m., showed no evidence of patient signatures acknowledging receipt of a copy of their rights and responsibilities. A review of the facility's policy and procedure manual on 10/30/2014 revealed a policy containing a list of patient rights and	T 135	PPMW Falls Church's practice at the time of the inspection mandated that staff has a patient sign, in the electronic health record, to acknowledge that the patient has reviewed the laminated copy of the Patient's Bill of Rights & Responsibilities that is provided upon admission. There are additional framed copies of the Patient's Bill of Rights & Responsibilities available in every procedure and examination room for further review. When a patient asked for a copy to take home, they received one from the Reception Desk, where there were copies of this document for this purpose. **Actions to correct the deficiency and prevent a recurrence:** PPMW-Falls Church implemented a new policy on provision of the Patient's Bill of Rights & Responsibilities wherein all patients will receive a paper copy to take home, in English and Spanish, of the Patient's Bill of Rights and Responsibilities along with the other forms provided at the Registration Desk. This will be reflected in the Front Desk Registration protocols. Further, all patients will sign a newly created form, the Forms Received Acknowledgment, confirming the patient's receipt of this copy. Staff will be retrained to provide these copies and all of these measures will be in place by January 7, 2015. **Actions to maintain compliance:** PPMW-Falls Church will annually, as part of the Quality Risk Management program, randomly audit a certain number of medical records to ensure that the Forms Received Acknowledgment form has been fully completed in all cases. This inspection will be recorded on the PPMW Schedule of FY 2015 CQRM Audits.	

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T 135	Continued From Page 2 responsibilities and the Office of Licensure and Certification (OLC) Complaint Unit toll-free complaint hotline and mailing address. On 10/30/2014 at approximately 4:00 p.m., Staff #2 and Staff #5 were shown a patient rights and responsibilities documentation in the patient electronic record and policy and procedure manual. Staff were questioned about the process of providing the patients with a copy of this form on admission. Staff #2 acknowledged staff discuss with the patients their rights and responsibilities at admission, but the facility is not providing patients with a copy. During an interview on 10/31/2014 at approximately 1:30 p.m., Staff #2 acknowledged that the patient files did not have signatures on receiving a copy of patient rights and responsibilities on the admission dates. Staff #2 provided a copy of admission forms that are given to the patients on admission. This procedure could not be substantiated as the form did not designate an area for the patients signature to acknowledge receipt. Staff #2 acknowledged he/she did not know the facility needed to provide a copy until it was brought to his/her attention by the surveyor. During the exit interview on 10/31/2014, Staff #1, Staff #2, Staff #5 and Staff #7 acknowledged the agency failed to provide documentation showing patients received their rights and responsibilities during admission in the manner required by this regulation and their own approved and established procedure.	T 135		
T 150	12 VAC 5-412-210 D Patients' rights D. The patient shall be given a copy of the complaint procedures, in a language or manner	T 150	PPMW Falls Church's practice mandated at the time of the inspection that any time a patient informs any staff member of a complaint, the patient received the laminated Complaint Handling Procedures form with the OLC Complaint Unit contact information from the Reception Desk or the health center manager. When patients asked for a copy, they received one to take home.	

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T 150	Continued From Page 3 she understands, at the time of admission to service. This RULE: is not met as evidenced by: Based on document review and interviews the agency failed to provide documented evidence that patients received complaint procedure information during admission for six (6) of six (6) patients included in the survey sample (Patient #1-#6). The findings included: Review of six (6) patient records (#1-#6) on 10/30/2014, beginning at approximately 1:00 p.m., showed no evidence of patient signatures acknowledging receipt of the Office of Licensure and Complaint (OLC) complaint information and telephone number, dated on patient admission. The six records also did not have complaint process and OLC information documented as given. A review of the facility's policy and procedure manual on 10/30/2014 revealed a policy containing a list of patient rights and responsibilities and the OLC Complaint Unit toll-free complaint hotline and mailing address. On 10/30/2014 at approximately 4:00 p.m., Staff #2 and Staff #5 were shown a complaint form taken from the waiting area, in the patient electronic record and policy and procedure manual. Staff were questioned about the process of providing the patients with a copy of this form on admission. The form reviewed in the policy and procedure manual included the OLC complaint information including the telephone number; however the form from the waiting area and electronic record showed no evidence the complaint procedures were given to the patient at	T 150	In the waiting room, the patients had access to a prominent box, with a sign on it indicating, "Complaints and Compliments," where patients may fill out complaints to PPMW-Falls Church and deposit them in the box. **Actions to correct the deficiency and prevent a recurrence:** PPMW-Falls Church has expanded the complaint procedure protocol to ensure that patients receive a paper copy of the Complaint Handling Procedures form to take home, in English and Spanish, along with the other forms provided at the Registration Desk. This will be reflected in the Front Desk Registration protocols. Further, all patients will sign a newly created form, the Forms Received Acknowledgment, confirming the patient's receipt of this copy. Staff will be retrained to provide these copies and all of these measures will be in place by January 7, 2015. **Actions to maintain compliance:** PPMW-Falls Church will annually, as part of the Quality Risk Management program, randomly audit a certain number of medical records to ensure that the Forms Received Acknowledgment form has been fully completed in all cases. This inspection will be recorded on the PPMW Schedule of FY 2015 CQRM Audits.	

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T 150	Continued From Page 4 the time of admission. Staff #2 acknowledged patients are given information regarding how to file a complaint with the agency; however the OLC's information is not provided to the patients. During an interview on 10/31/2014 at approximately 1:30 p.m., Staff #2 acknowledged that the patient files did not have signatures on a complaint process dated on the admission dates. Staff #2 provided a copy of admission forms that are given to the patients on admission. This procedure could not be substantiated as the form did not designate an area for the patients signature to acknowledge receipt. Staff #2 acknowledged that the complaint procedure provided to six (6) patients, on the day of the procedure, did not have the information for contacting the OLC. During the exit interview on 10/31/2014, Staff #1, Staff #2, Staff #5 and Staff #7 acknowledged the agency failed to provide documentation that patients received the complaint procedure during admission in the manner required by this regulation and their own approved and established procedure.	T 150		
T 155	12 VAC 5-412-210 E Patients' rights E. The facility shall provide each patient or her designee with the name, mailing address, and telephone number of the: 1. Facility contact person; and 2. The OLC Complaint Unit, including the toll-free complaint hotline number. Patients may submit complaints anonymously to the OLC. The facility shall display a copy of this information in a conspicuous place.	T 155	PPMW Falls Church's practice mandated at the time of the inspection that any time a patient informs any staff member of a complaint, the patient received the laminated Complaint Handling Procedures form with the OLC Complaint Unit contact information from the Reception Desk or the health center manager. When patients asked for a copy, they received one to take home. In the waiting room, the patients had access to a prominent box, with a sign on it indicating, "Complaints and Compliments," where patients may fill out complaints to PPMW-Falls Church and deposit them in the box. In 2012, the complaint procedure was framed and mounted on the wall. After the walls were painted in May 2014, the complaint procedure was inexplicably not replaced along with the framed	

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T 155	Continued From Page 5 This RULE: is not met as evidenced by: Based on observation and document review it was determined that the facility failed to display, in a conspicuous place, information on how to lodge a complaint with the facility contact person and the Office of Licensure and Certification (OLC) Complaint Unit. The findings included: On 10/30/2014 at approximately 9:00 a.m., a tour of the facility revealed a complaint box in the patient waiting area, but no postings in the facility with information for making a complaint to the OLC Complaint Unit, including the toll-free complaint hotline number or the facility contact person. A review of the facility's policy and procedure manual on 10/30/2014 revealed a policy containing a list of patients rights and responsibilities and the OLC Complaint Unit toll-free complaint hotline and mailing address. On 10/31/2014 at approximately 10:30 a.m., an interview was conducted with a patient in the recovery room. The patient revealed to the surveyor that the facility did discuss patient rights but a copy was not given to them on admission. The patient acknowledged if he/she had a complaint they would contact the agency directly; however the patient reported he/she did not know that a complaint could be made to the OLC or the OLC's contact information. During the exit interview on 10/31/2014, Staff #1, Staff #2, Staff #5 and Staff #7 acknowledged the agency failed to display information on how to make a complaint with the facility contact person and the OLC Complaint Unit in the manner	T 155	Patient Bills of Rights & Responsibilities and the internal complaint box. **Actions to correct the deficiency and prevent a recurrence:** PPMW-Falls Church will create a new framed copy of the Complaint Handling Procedures form, in English and Spanish, which includes the OLC hotline information. This form will be posted on the wall by January 7. **Actions to maintain compliance:** PPMW-Falls Church will mandate that monthly, the health center manager will check to make sure that the mounted Complaint Handling Procedures form is still present and is fully readable, and this inspection will be recorded on the Family Planning and Surgical Services Monthly Operational/Facility Survey.	

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T 155	Continued From Page 6 required by this regulation and their own approved and established procedure.	T 155		
T 175	12 VAC 5-412-220 C Infection prevention C. Written policies and procedures for the management of the facility, equipment and supplies shall address the following: 1. Access to hand-washing equipment and adequate supplies (e.g., soap, alcohol-based hand rubs, disposable towels or hot air dryers); 2. Availability of utility sinks, cleaning supplies and other materials for cleaning, disposal, storage and transport of equipment and supplies; 3. Appropriate storage for cleaning agents (e.g., locked cabinets or rooms for chemicals used for cleaning) and product-specific instructions for use of cleaning agents (e.g., dilution, contact time, management of accidental exposures); 4. Procedures for handling, storing and transporting clean linens, clean/sterile supplies and equipment; 5. Procedures for handling/temporary storage/transport of soiled linens; 6. Procedures for handling, storing, processing and transporting regulated medical waste in accordance with applicable regulations; 7. Procedures for the processing of each type of reusable medical equipment between uses on different patients. The procedure shall address: (i) the level of cleaning/disinfection/sterilization to be used for each type of equipment, (ii) the process (e.g., cleaning, chemical disinfection, heat sterilization); and (iii) the method for verifying that the recommended level of disinfection/sterilization has been achieved. The procedure shall reference the manufacturer's recommendations and any applicable state or national infection control guidelines;	T 175	*Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care* (CDC, 2014), Key Recommendations for Safe Injection Practices in Ambulatory Care Settings, page 11, the first two indicators state: "1. Use aseptic technique when preparing and administering medications 2. Cleanse the access diaphragms of medication vials with 70% alcohol before inserting a device into the vial." At PPMW-Falls Church, HCAs (Health Care Assistants) do not provide injections. HCA's do assist the providers who are wearing sterile gloves to draw up the local anesthetic into a syringe by placing and holding the multi-dose vial for the provider to insert the needle. Prior to insertion of the needle into the vial, the HCA will use aseptic technique and cleansed the diaphragm with 70% alcohol. **Actions to correct the deficiency and prevent a recurrence:** To ensure the CDC's recommendations for safe injection practices in ambulatory care settings are followed: 1. The Abortion Coordinator (Nurse Practitioner) will review the 9 recommendations with all staff involved in the provision of abortion and practice the techniques pertinent to their tasks. 2. Abortion procedure training for HCAs will include the step of cleansing all medication vials with 70% alcohol. 3. The Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care (CDC, 2014), page 11, "Key Recommendations for Safe Injection Practices in Ambulatory Care Settings" will be included in the PPMW Health and Safety Manual, Blood Bourne Pathogens Exposure Control Plan – Section I. **Actions to maintain compliance:** PPMW's New Clinical Employee Orientation Checklist has been revised and under the "Infection Control" section a new indictor was added – Preparation of injection vials. In addition, annual observations will include aseptic technique which includes preparation of multi-dose vials.	

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T 175	Continued From Page 7 8. Procedures for appropriate disposal of non-reusable equipment; 9. Policies and procedures for maintenance/repair of equipment in accordance with manufacturer recommendations; 10. Procedures for cleaning of environmental surfaces with appropriate cleaning products; 11. An effective pest control program, managed in accordance with local health and environmental regulations; and 12. Other infection prevention procedures necessary to prevent/control transmission of an infectious agent in the facility as recommended or required by the department. This RULE: is not met as evidenced by: Based on observation, interview, and review of CDC recommendation for Infection Protection for Outpatient Settings, it was determined that the facility failed to ensure infection prevention procedures necessary to prevent/control transmission of an infectious agent were followed. Note: This deficiency was previously cited in the Summary Statement of Deficiencies dated 6/29/2012, related to staff failure to clean the tops of vials prior to a second puncture. The findings included: Observation of a procedure performed on 10/31/2014, revealed Staff #10 did not clean the top of a multi-use vile prior to the physician withdrawing medication for injection. According to the CDC Guide to Infection Prevention for Outpatient Settings dated September 2014: Key recommendations for safe injection practices in ambulatory care settings: 1) Use aseptic technique when preparing and administering medications; 2) Cleanse the access diaphragms of medication vials with 70% alcohol before inserting a device into the vial. An interview with Staff #10 and Staff #11 was conducted on 10/31/2014 at approximately 1:15	T 175		

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T 175	Continued From Page 8 PM. Staff #10 stated he/she only cleansed the vile after the top is originally removed, but not afterwards or between procedures. Staff #11 stated, "The vials need to be cleaned prior to each procedure."	T 175		
T 380	12 VAC 5-412-360 B Maintenance B. When patient monitoring equipment is utilized, a written preventative maintenance program shall be developed and implemented. This equipment shall be checked and/or tested in accordance with manufacturer's specifications at periodic intervals, no less than annually, to ensure proper operation and a state of good repair. After repairs and/or alterations are made to any equipment, the equipment shall be thoroughly tested for proper operation before it is returned to service. Records shall be maintained on each piece of equipment to indicate its history of testing and maintenance. This RULE: is not met as evidenced by: Based on observations, document review and interviews the agency failed to ensure that all electrical equipment had been inspected as documented by proof of preventative maintenance per the manufacturer's recommendations as required in Section as required in Section 12 VAC5-412-360. Note: This is a re-cite from 2012 related to staff's failure to ensure all electrical equipment had been inspected. The findings included: During the tour of the clinic conducted on 10/30/2014 at 9:25 a.m., the following was observed: Exam room #2 was designated as the	T 380 (T-350)	PPMW-Falls Church insists on the highest professional standards, including ensuring that an emergency generator is available for medical purposes when electricity is lost. PPMW-Falls Church and the medical maintenance company ensure that all electrical equipment is part of the annual preventative maintenance program. The Triplite backup generator is included on the routine medical maintenance inspection report and was properly inspected on August 15, 2013. The audit found that although no backup generator was needed in 2014, a maintenance check on that piece of equipment did not occur in that year. A check for equipment preventative maintenance stickers is included as an additional indicator on the monthly compliance form, the Health Center Compliance Log, which is signed by staff. While the Triplite backup generator's preventative maintenance sticker expired in February 2014, the Health Center Compliance Log for that room has been signed every month. **Actions to correct the deficiency and prevent a recurrence:** The medical maintenance company came to inspect the Triplite generator on December 4, and the generator was fully functional, even though the required maintenance check had not occurred. PPMW-Falls Church took swift action to address the staff non-compliance and to ensure that this high standard is met in the future. Staff will be retrained to reemphasize that the Health Center Compliance Log checks must include all electrical equipment, including the backup generator, and a check of the status of each preventative maintenance sticker, and the new list of equipment for the medical maintenance company will be consistently reviewed. All of these measures will be in place by January 7, 2015. **Actions to maintain compliance:** PPMW-Falls Church will mandate that monthly, staff will check to ensure equipment compliance. An indicator was added to the	

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T 380	Continued From Page 9 Procedure Room. A Triplite back up generator failed to have an updated preventive maintenance sticker indication it had been inspected for any potential electrical failures. The policy and procedure manual stated all equipment would be inspected annually. In an interview with Staff #3 during the tour of exam room #2, reported he/she was unable to answer the surveyor in regards to the expired maintenance sticker. Staff #3 stated the surveyor would need to verify with Staff #2, because he/she did not utilize exam room #2 because he/she did not perform abortion procedures. On 10/30/2014 at approximately 10:00 a.m., an interview was conducted with Staff #2. Staff #2 verified the generator's preventive sticker expired 02/2014 and would gather additional information. Staff #2 was asked to provide a list of annual equipment inspections for the surveyor to review. On 10/31/2014 at 9:00 a.m., Staff #2 presented the survey team the facility's medical equipment inspection reports. The review of the equipment inspection reports revealed a Triplite power supply on the report for 8/15/2013, but failed to be included on the inspection report dated 3/26/2014. Staff #2 confirmed the Triplite power supply was not inspected for 2014, but he/she was not able to provide evidence the reason it was left off the list. During the exit interview on 10/31/2014, Staff #1, Staff #2, Staff #5 and Staff #7 acknowledged that the facility failed to maintain the system in the manner required by this Virginia regulation.	T 380	Facility Inspection portion of the Family Planning and Surgical Services Monthly Operational/Facility Survey stating, "Medical Equipment including the power generator is compliant with inspection". Health center manager will do a random review every 6 months of all equipment to check for preventative maintenance stickers.	