State of Virginia

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | FTAF-0016 | A. BUILDING ______ B. WING ______ | 03/27/2013 |

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| ALEXANDRIA WOMEN'S HEALTH CLINIC | 101 S. WHITING ST, SUITE #215<br>ALEXANDRIA, VA 22304 |

| (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 |
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| T 000 | 12 VAC 5- 412 Initial comments<br><br>On March 27, 2013 two Medical Facilities Inspectors from the Office of Licensure and Certification, Virginia Department of Health conducted an unannounced Licensure Revisit survey to the survey performed July 18, 2012 through July 19, 2012.<br>The following are citations from the initial survey of July 18, 2012 through July 19, 2012, which were not corrected and therefore repeat citations:<br>12 VAC 5-412-160 (A) (C) [Administrator]<br>12 VAC 5-412-170 (E) (H 2, 5) [Personnel]<br>12 VAC 5-412-180 (B) [Clinical staff]<br>12 VAC 5-412-210 (C) [Patient rights]<br>12 VAC 5-412-220 (B) (2, 3, 10), (C) (7) [Infection prevention]<br>12 VAC 5-412-260 (C) [Administration, storage and dispensing of drugs]<br>12 VAC 5-412-2-270 [Equipment and supplies]<br>12 VAC 5-412-300 (A) (B) (C) (D) (E) [Quality assurance]<br>12 VAC 5-412-350 (A) [Disaster preparedness]<br>12 VAC 5-412-370 (A) [Fire-fighting equipment].<br>The following citations are new finding:<br>12 VAC 5-412-140 (A) [Organization and management]<br>12 VAC 5-412-170 (E) (H) (3) [Personnel]<br>12 VAC 5-412-180 (A) [Clinical staff]<br>12 VAC 5-412-220 (B) (7) [Infection prevention]<br>12 VAC 5-412-2-350 (B) [Disaster preparedness]<br>The agency was not in compliance with 12 VAC-412 Regulations for the Licensure of Abortion Clinics. (Effective 12/29/2011) | T 000 | | |
| T 010 | 12 VAC 5-412-140 A Organization and management<br><br>A. Each abortion facility shall have a governing body responsible for the management and control of the operation of the facility. | T 010 | | |

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

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| T 010 | Continued From Page 1 | T 010 | | |

This RULE: is not met as evidenced by:
Based on observations, document review and interview the governing body failed to manage and ensure the facility operated in compliance with state regulations. The governing body failed to:

(1) Document in writing the appointment of the Administrator and Alternate Administrator;

(2) Ensure policies and procedures were implemented for personnel training, a process for verifying professional license, annual evaluation of employees and a process for reporting licensure or certification violations to the appropriate board.

(3) Ensure the facility had established a complaint process and designated a staff responsible for complaint resolution.

(4) Ensure staff were trained and had annual in proper infection prevention measures, correct hand washing technique, practiced safe injection practices by not having expired medications available for administration to patients, replace the facility's equipment (chairs, procedure tables), which had non-intact surfaces.

(5) Maintain oversight of the quality assurance program.

(6) Ensure the facility's staff was knowledgeable and trained in disaster preparedness, fire safety and designated a fire-safety staff member had been appointed.

The findings included:

1. The governing body failed to appoint in writing the Administrator and the Administrator's

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| T 010 | Continued From Page 2<br><br>alternate. Review of documents provided to the surveyors on March 27, 2013 did not indicate in writing the appointment of the Administrator and Alternate Administrator. The governing body minutes did not reflect the appointment of the Administrator or the Administrator's alternate.<br><br>An interview conducted on March 27, 2013 at 10:48 a.m., Staff #2 reported the governing body had not incorporated the appointment of the Administrator or the designated alternative in writing.<br><br>2. The governing body failed to ensure staff received training and evaluation of their skills. Review of personnel files on March 27, 2013 did not include documented personnel training related to job duties, infection control training, and annual evaluation of employees.<br><br>An interview was conducted on March 27, 2013 at 12:40 p.m., with Staff #1 and Staff #2. Staff #2 reported the training had not occurred.<br><br>The governing body failed to provide oversight and ensure the facility had the required policies and procedures. Review of the facility's policy and procedure manual did not include a process for reporting licensure or certification violations to the appropriate board. Staff #2 verified the governing body had not made the necessary changes to the policy and procedure manual.<br><br>3. The governing body failed to ensure the facility developed a complaint process and designate a staff to be responsible for complaint resolution. Review of the documents provided on March 27, 2013 did not include an established a complaint process. The document provided did not designate a staff responsible for complaint | T 010 | | |

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| T 010 | Continued From Page 3<br><br>resolution.<br><br>An interview was conducted on March 27, 2013 at approximately 11:30 a.m., with Staff #1. Staff #1 reported he/she was not aware the agency had to designate a person to handle the complaints. Staff #1 reported the facility did not have a procedure to handle complaints in accord with the licensure regulations.<br><br>4. Observations on March 27, 2013 from 9:45 to 11:52 a.m. revealed the governing body had failed to provide oversight of infection prevention practices. Observations conducted with Staff #2 on March 27, 2013 revealed expired medications available for administration to patients. The observations revealed the governing body had failed to replace chairs, a gurney and make changes to ensure reusable items were able to be disinfected between patients.<br><br>Observations conducted on March 27, 2013 at 9:45 a.m., with Staff #2 revealed the cloth chairs remained in patient care areas. The governing body had failed to replace the cloth chairs, with chairs that could be disinfected between patients. Staff #2 reported awareness of the inability to disinfect the cloth chairs between patients.<br><br>Observations conducted on March 27, 2013 at 10:40 a.m., with Staff #2 revealed the procedure table and a gurney in the "Immediate Recovery" area had rust and tape residue, which prevented disinfection between patients.<br><br>Review of employee files on March 27, 2013 did not provide documentation of staffs' infection prevention training. The employee files did not contain documentation of annual infection prevention training and correct hand washing technique and the situations, which require hand | T 010 | | |

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| T 010 | Continued From Page 4<br><br>hygiene.<br><br>An interview was conducted on March 27, 2013 at 12:40 p.m., with Staff #1 and Staff #2. Staff #2 reported the training had not occurred.<br><br>5. The governing body failed to ensure the development of an integrated on-going quality assurance program. A second request was made on March 27, 2012 at 12:43 p.m. for the facility's quality assurance documents. Staff #2 stated, "I have not completed the quality policies, I've been busy and have not gotten to it yet." Staff #2 reported no action had been taken on developing the required components of the facility's quality assure program.<br><br>6. Review of employee files on March 27, 2013 did not reveal staff training regarding fire safety and disaster preparedness. A request was made on March 27, 2013 for the facility's documentation of staffs' training related to disaster preparedness, fire safety training and documentation of the designated fire-safety staff member.<br><br>An interview was conducted on March 27, 2013 at 12:40 p.m., with Staff #1 and Staff #2. Staff #2 reported the training had not occurred. Staff #2 reported the governing body had not established a designated fire safety staff. | T 010 | | |
| T 045 | 12 VAC 5-412-160 A Administrator<br><br>A. The governing body shall select an administrator whose qualifications, authority and duties shall be defined in a written statement adopted by the governing body. | T 045 | | |

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| T 045 | Continued From Page 5<br><br>This RULE: is not met as evidenced by:<br>Based on document review and interview the governing body failed to document in writing the appointment of the administrator.<br><br>The findings included<br><br>Review of documents provided to the surveyors on March 27, 2013 did not indicate in writing the appointment of the Administrator. The governing body minutes did not reflect the appointment of the Administrator.<br><br>An interview conducted on March 27, 2013 at 10:48 a.m., Staff #2 reported the governing body had not incorporated the appointment of the Administrator or the designated alternative in writing. Staff #2 stated, "I had a piece of paper somewhere that listed me as the administrator." Staff #2 reported he/she was not able to locate the paper that listed him/her as administrator. | T 045 | | |
| T 055 | 12 VAC 5-412-160 C Administrator<br><br>C. A qualified individual shall be appointed in writing to act in the absence of the administrator.<br><br>This RULE: is not met as evidenced by:<br>Based on document review and interview the governing body failed to designate a staff member to function as the alternate administrator in the administrator's absence.<br><br>The findings included:<br><br>On arrival, an interview was conducted on March 27, 2013 at 9:25 a.m., with Staff #5. Staff #5 reported the administrator had not arrived. A request was made to speak to the alternate administrator. Staff #5 did not initially answer the | T 055 | | |

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| T 055 | Continued From Page 6<br><br>request. Staff #5 reported the surveyors could speak to one of the nurses, while he/she contacted the administrator. At 9:28 a.m., Staff #1 assisted the surveyors to an area to set up for the survey. Staff #1 introduced himself/herself as the assistant to the administrator.<br><br>Review of documents provided to the surveyors on March 27, 2013 did not indicate in writing the appointment of an Alternate Administrator. The governing body minutes did not reflect the appointment of an alternate Administrator.<br><br>An interview conducted on March 27, 2013 at 10:48 a.m., Staff #2 reported the governing body had not incorporated the appointment of or the designated alternative to the administrator in writing. | T 055 | | |
| T 080 | 12 VAC 5-412-170 E Personnel<br><br>E. The facility shall develop, implement and maintain policies and procedures to document that its staff participates in initial and ongoing training and education that is directly related to staff duties, and appropriate to the level, intensity and scope of services provided. This shall include documentation of annual participation in fire safety and infection prevention in-service training.<br><br>This RULE: is not met as evidenced by:<br>Based on staff interview and staff record review, the agency staff failed to implement policies and procedures for staff training and participation in fire safety and infection control.<br><br>The findings included: | T 080 | | |

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| T 080 | Continued From Page 7<br><br>On 3/27/13 at 12:40 p.m., the survey team requested evidence of training and participation for staff for fire and safety, including fire drills, and infection control. Staff # 2 stated, "I did some training on handwashing and infection control, but I didn't write it down...we have not had any fire drills and I did not do any fire safety training for our staff..." Staff #1 stated, "I called for training but they never came..."<br><br>During review of staff records on 3/27/13 at 11:00 a.m., there was no evidence of current infection control training related to handwashing/infection control practices, or fire/safety/disaster preparedness training included in 5 (five) of 5 (five) employee records reviewed.<br><br>No further information was provided by the end of the survey. | T 080 | | |
| T 095 | 12 VAC 5-412-170 H Personnel<br><br>H. Personnel policies and procedures shall include, but not be limited to:<br>1. Written job descriptions that specify authority, responsibility, and qualifications for each job classification;<br>2. Process for verifying current professional licensing or certification and training of employees or independent contractors;<br>3. Process for annually evaluating employee performance and competency;<br>4. Process for verifying that contractors and their employees meet the personnel qualifications of the facility; and<br>5. Process for reporting licensed and certified health care practitioners for violations of their licensing or certification standards to the appropriate board within the Department of Health Professions. | T 095 | | |

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| T 095 | Continued From Page 8<br><br>This RULE: is not met as evidenced by:<br>Based on document review and interview the facility failed to verify the licensure for one of three nursing staff (Staff #4), failed to have policies and procedures for verification of licensure, and reporting licensure /certification violations to the appropriate board. The facility failed to ensure employees had annual evaluations for seven (7) of seven (7) employees. (Employee records #1 - #7)<br><br>The findings included:<br><br>Review of the registered nurses' employee files revealed Staff #4's file did not have current licenses and certifications. The licenses in Staff #4's file expired on "02/28/2013." Staff #4's certification related to his/her provision of anesthesia had also expired as of "10/01/12."<br><br>An interview was conducted on March 27, 2013 at 11:58 a.m., with Staff #2. Staff #2 was informed of the findings and reviewed Staff #4's employee file and offered the photocopy of Staff #4's licenses and certification. Staff #2 was encouraged to notice the expiration date and stated, "I'm sure [Staff #4's name] has a current license and certification. We just don't have them in [his/her] file." Staff #2 acknowledged the facility had not verified Staff #4's license with the Department of Health Professionals. Staff #2 reported the facility had not created policies and procedures for verification of professional license and certifications. Staff #2 reported the facility had failed to correct previous deficient practice related to the development of a policy and procedure for reporting licensed and certified health care practitioners for violations of their licensing or certification standards to the appropriate board. | T 095 | | |

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| T 095 | Continued From Page 9<br><br>An interview was conducted on March 27, 2013 at approximately 12:05 p.m., with Staff #4. Staff #4 stated, "I turned in a copy of my current licenses. I don't know why they are not in my file."<br><br>2. A review of seven employee files was conducted on March 27, 2013. The employee files did not include annual evaluation of the staff's performance or skills.<br><br>An interview was conducted on March 27, 2013 at 12:01 p.m., with Staff #2. Staff #2 reported the annual evaluations had not been performed. Staff #2 reported the facility had not followed its policy and procedures for annual evaluations. | T 095 | | |
| T 110 | 12 VAC 5-412-180 B Clinical staff<br><br>B. Abortions shall be performed by physicians who are licensed to practice medicine in Virginia and who are qualified by training and experience to perform abortions. The facility shall develop, implement and maintain policies and procedures to ensure and document that abortions that occur in the facility are only performed by physicians who are qualified by training and experience.<br><br>This RULE: is not met as evidenced by:<br>Based on document review and interview the facility failed to implement policies and procedures to ensure the verification of physicians' national data, he provision of appointment to clinical staff and the physician's delineation of privileged for three of three physicians (Physicians #1 -#3)<br><br>The findings included:<br><br>During the entrance conference on March 27, | T 110 | | |

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| T 110 | Continued From Page 10<br><br>2013 at approximately 10:28 a.m., with Staff #2 a request was made for the credentialing files for the facility's three physicians. Staff #3 provided the surveyor a file folder at 11:44 a.m. on March 27, 2013. Staff #3 stated, "All I have is in this folder. I have not been able to make the corrections from the last survey."<br><br>Review of the documents in the file folder did not reveal the facility had performed a national databank inquiry for the three physicians. The file folder did not contain documentation that the governing body had granted the three physicians appointment to the clinical staff. The file folder did not contain documentation of the physician's delineation of privileges. The file folder did not include the three physicians' board certification, medical education, or other qualifications related to their ability to perform of abortions.<br><br>An interview was conducted on March 27, 2013 at approximately 11:59 a.m., with Staff #3. Staff #3 stated, "I just didn't get to make the needed corrections or pull their data." Staff #3 verbalized understanding the national databank inquiry and delineation of privileges were essential components to ensure the physicians were qualified. Staff #3 verbalized understanding the governing body's appointment of the physicians to the clinical staff verified the type of procedures the physicians' were allowed to perform. | T 110 | | |
| T 145 | 12 VAC 5-412-210 C Patients' rights<br><br>C. The facility shall designate staff responsible for complaint resolution, including:<br>1. Complaint intake, including acknowledgement of complaints;<br>2. Investigation of the complaint;<br>3. Review of the investigation findings and | T 145 | | |

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| T 145 | Continued From Page 11<br><br>resolution for the complaint; and<br>4. Notification to the complainant of the proposed resolution within 30 days from the date of receipt of the complaint.<br><br>This RULE: is not met as evidenced by:<br>Based on staff interview and agency document review, the agency staff failed to designate a staff member responsible for complaint resolution and develop a procedure to acknowledge, investigate, review complaints/grievances, and notify the complainant of a resolution within 30 days.<br><br>The findings included:<br><br>On 3/26/13 at approximately 11:30 a.m., the survey team requested the agency complaint/grievance log and policy/procedure. The survey team was presented a log but no policy and procedure. Staff #1 stated he/she was not aware the agency had to designate a person to handle the complaints and there was no written procedure for how it would be done.<br><br>On 3/26/13 at 4:00 p.m., the survey team again discussed with agency staff #1 and #2 the need for a procedure to handle complaints including the designation of a person responsible for ensuring the complaint procedure was followed. | T 145 | | |
| T 170 | 12 VAC 5-412-220 B Infection prevention<br><br>B. Written infection prevention policies and procedures shall include, but not be limited to:<br>1. Procedures for screening incoming patients and visitors for acute infectious illnesses and applying appropriate measures to prevent transmission of community acquired infection within the facility;<br>2. Training of all personnel in proper infection | T 170 | | |

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| T 170 | Continued From Page 12<br><br>prevention techniques;<br>3. Correct hand-washing technique, including indications for use of soap and water and use of alcohol-based hand rubs;<br>4. Use of standard precautions;<br>5. Compliance with blood-bourne pathogen requirements of the U.S. Occupational Safety & Health Administration.<br>6. Use of personal protective equipment;<br>7. Use of safe injection practices;<br>8. Plans for annual retraining of all personnel in infection prevention methods;<br>9. Procedures for monitoring staff adherence to recommended infection prevention practices; and<br>10. Procedures for documenting annual retraining of all staff in recommended infection prevention practices.<br><br>This RULE: is not met as evidenced by:<br>Based on observation, staff interview and agency document review, the agency staff failed to ensure all staff were trained in infection prevention techniques, including proper handwashing, safe injection practices, and annual retraining of staff with documentation of the training for seven (7) of seven employees (Employee records #1- #7).<br><br>The findings included:<br><br>1. During the tour of the agency on 3/27/13 at 10:00 a.m., the survey team observed in the "Crash Cart" the following medications were expired : *Amonophylline 250 mg (milligram) 10 ml (milliliter) vial 25 mg/ml (milligram per milliliter) expiration date September 1, 2012, Epinephrine injection 1:10,00 (one to ten-thousand solution) 1 mg (0.1 mg/ml) expiration date March 1, 2013, and in the medication refrigerator in the "procedure room" were 2 (two) vials of succinylcholine 200 mg (20 mg/ml) vials expiration | T 170 | | |

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date December 1, 2012. Staff #1 stated the medications should have been removed when expired.

During an observation of a procedure on 3/27/13 at 11:20 a.m., Staff #1 was observed to don gloves without washing hands prior to the procedure. Staff #1 then completed the procedure for Patient # 6, removed the gloves, spoke to the patient, providing some education and information, and left the room without washing his/her hands.

On 3/27/13 at 12:40 p.m., the survey team requested the agency evidence of training and participation for infection control. Staff # 2 stated, "I did some training on handwashing and infection control, but I didn't write it down.."

During review of staff records on 3/27/13 at 11:00 a.m., there was no evidence of current infection control training related to handwashing/infection control practices, or fire/safety/disaster preparedness training included in 5 (five) of 5 (five) employee records reviewed. There was no evidence of annual re-training for staff on infection control. At 12:40 p.m. on 3/26/13, Staff #2 stated, "It has not been done..."

On 3/27/13 at 4:00 p.m. Staff #1 acknowledged that he/she had not washed his/her hands prior to or after the procedure observed by the surveyor.

*Aminophylline- a bronchodilator used to relax the muscles in the lungs to allow more ventilation. Epinephrine- used to treat anaphylactic reactions and cardiac arrest (adrenaline). Succinylcholine- a neuromuscular blocker, paralytic agent. Used for rapid sequence endotracheal intubation and relax skeletal muscles during surgery. Drug

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| T 170 | Continued From Page 14<br><br>Information Handbook for Nursing 2011 Lexi-Comp Corporation pages 1048, 427, and 1149.<br>2. Observations conducted on March 27, 2013 at 10:10 a.m., with Staff #1 in the laboratory area revealed three vials of blood used to verify Rh factor. The vials had expired on "3/21/13", "3/22/13", and "2/22/13."<br><br>A review of seven employee files was conducted on March 27, 2013. The employee files did not include infection control/prevention training or annual re-training.<br><br>An interview was conducted on March 27, 2013 at 12:01 p.m., with Staff #2. Staff #2 reported the infection control/prevention training had not been documented. Staff #2 stated, "I know if its not documented it hasn't been done." Staff #2 verified the employee files did not have proof of annual infection prevention re-training.<br>[According to Merriam Webster online Medical dictionary- Rh Factor "a genetically determined protein on the red blood cells of some people that is one of the substances used to classify human blood as to compatibility for transfusion and that when present in a fetus but not in the mother causes a serious immunogenic reaction in which the mother produces antibodies that cross the placenta and attack the red blood cells of the fetus -- called also rhesus factor." ] | T 170 | | |
| T 275 | 12 VAC 5-412-260 C Administration, storage and dispensing of dru<br><br>C. Drugs maintained in the facility for daily administration shall not be expired and shall be properly stored in enclosures of sufficient size with restricted access to authorized personnel only. Drugs shall be maintained at appropriate | T 275 | | |

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| T 275 | Continued From Page 15 | T 275 | | |

temperatures in accordance with definitions in 18 VAC 110-20-10

This RULE: is not met as evidenced by:
Based on observation and staff interview, the agency staff failed to ensure drugs maintained at the facility were not expired and that staff were educated on the medications that were available for use.

The findings included:

During the tour of the agency on 3/27/13 at 10:00 a.m., the survey team observed in the "Crash Cart" the following medications were expired :
*Aminophylline 250mg (milligram) 10 ml (milliliter) vial 25mg/ml (milligram per milliliter) expiration date September 1, 2012, Epinephrine injection 1:10,00 (one to ten-thousand solution) 1mg (0.1mg/ml) expiration date March 1, 2013. Staff #1 stated the medications should have been removed when expired.
*Aminophylline- a bronchodilator used to relax the muscles in the lungs and allow better ventilation. Epinephrine- used to treat anaphylactic reactions and cardiac arrest (adrenaline) Drug Information Handbook for Nursing 2011 Lexi-Comp Corporation pages 1048 and 427.

In the medication refrigerator in the "procedure room" the surveyor observed 2 (two) vials of the drug **succinylcholine 200mg (20mg/ml) vials expiration date December 1, 2012. The surveyor interviewed Staff #2 as to the use of the medication. Staff #2 stated, "It is on our list of drugs for the cart and it is used for convulsions..." The surveyor inquired as to when the medication was last administered to a patient. Staff #2 stated, "I can't remember ever using this." When asked if the medication was going to be re-ordered, Staff #2 stated, "Absolutely, if the

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| T 275 | Continued From Page 16<br><br>doctor wants it to be." The surveyor inquired as to whether Staff #2 was familiar with the side effects of the succinylcholine and the potential for malignant hyperthermia (MH). Staff #2 stated he/she was not familiar with MH. The surveyor then asked Staff #2 if the medication Dantrolene was available at the agency. Staff #2 stated "No I do not know what that is for..." The medication (succinycholine) was immediately removed by Staff #2.<br><br>On 3/27/13 at 1:15 p.m., Staff # 3 (physician) was interviewed regarding the succinylcholine. Staff #3 stated, "I do not know why that medication would even be here. We do not use that. We do not have ventilators and we do not intubate...we would never use that medication and it will not be reordered. I don't know why it is here in the first place. I think (Staff #2) thought it was needed for the cart, but it is not and will be removed from that list. That medication has never been used here..."<br><br>** Succinylchonine- a neuromuscular blocking agent used to facilitate rapid sequence intubation during surgery. Malignant Hyperthermia a life threatening condition associated with the use of Succinylcholine. [According to www.drugs.com "Possibly fatal Malignant Hyperthermia;Malignant manifested by a rapid, profound elevation in body temperature and sometimes extreme muscular rigidity. Risk increases with concomitant administration of inhalation anesthetics. If Malignant Hyperthermia occurs, discontinue all anesthetic agents and initiate IV dantrolene therapy in conjunction with supportive measures (e.g., administering oxygen, treating metabolic acidosis, instituting cooling procedures); maintain urinary output and monitor serum electrolytes."] [According to www.askhealth.com "DANTROLENE (DAN troe leen) helps to relieve spasms and stiffness of muscles in conditions | T 275 | | |

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| T 275 | Continued From Page 17<br><br>such as multiple sclerosis, cerebral palsy, stroke, or injury to the spine. This medicine can also help prevent and treat a condition called Malignant Hyperthermia, which may occur after surgery or anesthesia.<br><br>The findings were again discussed with Staff #1 and #2 on 3/27/13 at 4:00 p.m. | T 275 | | |
| T 290 | 12 VAC 5-412-270 Equipment and supplies<br><br>An abortion facility shall maintain medical equipment and supplies appropriate and adequate to care for patients based on the level, scope and intensity of services provided, to include:<br>1. A bed or recliner suitable for recovery;<br>2. Oxygen with flow meters and masks or equivalent;<br>3. Mechanical suction;<br>4. Resuscitation equipment to include; as a minimum, resuscitation bags and oral airways;<br>5. Emergency medications, intravenous fluids, and related supplies and equipment;<br>6. Sterile suturing equipment and supplies;<br>7. Adjustable examination light;<br>8. Containers for soiled linen and waste materials with covers; and<br>9. Refrigerator.<br><br>This RULE: is not met as evidenced by:<br>Based on observations and interviews the facility failed to ensure suitable equipment was available in patient care areas. The facility utilized cloth chairs in patient care areas, which could not be disinfected between patients. The facility's recovery area gurney and procedure table had non-intact surfaces, which could not be disinfected between patients. The facility failed to ensure that supplies utilized in patient care were not expired. | T 290 | | |

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| T 290 | Continued From Page 18<br><br>The findings included:<br><br>Observations conducted on March 27, 2013 at 9:45 a.m., with Staff #2 revealed the cloth chairs remained in patient care areas. The facility had six (6) cloth chairs in its sonogram area, two (2) cloth chairs, for patients in the counseling areas, seven (7) chairs in their front waiting area, and four (4) cloth chairs in the waiting area on the procedure side of the facility.<br><br>An interview was conducted on March 27, 2013 at 10:20 a.m., with Staff #1. Staff #1 stated, "We have not changed the chairs since the last survey. We have just not replaced them. We just don't have the money to replace them." Staff #1 reported the facility had "hoped to replace them two at a time, but had not been able to do it." Staff #2 joined the interview and reported awareness that cloth chairs should not be available in patient care related to the inability to disinfect the chairs between patients. Staff #2 could not provide documentation of purchase orders or a planned/schedule by the facility related to the replacement of the cloth chairs with chairs that could be disinfected between patients.<br><br>Observations conducted on March 27, 2013 at 10:40 a.m., with Staff #2 revealed the procedure table and a gurney in the "Immediate Recovery" area had rust and tape residue, which prevented disinfection between patients. Staff #2 verified the findings. Staff #1 reported the facility had not addressed the rust or non-intact surfaces on the procedure table or the "Immediate Recovery" area's gurney. Staff #2 reported, "After we covered the table cushion, nothing else has been done, really."<br><br>An observation conducted on March 27, 2013 at | T 290 | | |

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| T 290 | Continued From Page 19<br><br>10:45 a.m., in the procedure room with Staff #2 revealed two (2) yankauer suction devices, which had expired "2010-09." Staff #2 verified the yankauer suction devices were available for use in case of an emergency or if a patient needed to be suctioned.<br><br>[According to www.online free medical dictionary.com a "Yankauer suction device" is a "rigid hollow tube made of metal or disposable plastic with a curve at the distal end to facilitate the removal of thick pharyngeal secretions during oral pharyngeal suctioning."<br>2. On 3/27/13 at 10:40 a.m., the surveyor observed a gurney (stretcher) in the "immediate recovery area" which had chipped metal and rust visible along the metal frame and handrails. This was also observed by Staff #2. Staff #2 acknowledged the condition of the stretcher at that time. There were also 2 (two) "Uterine Explora Model II curettes with vacu loc syringe" which expired on 7/2012 and 1/2013. These were removed by staff #1. | T 290 | | |
| T 315 | 12 VAC 5-412-300 A Quality assurance<br><br>A. The abortion facility shall implement an ongoing, comprehensive, integrated, self-assessment program of the quality and appropriateness of care or services provided, including services provided under contract or agreement. The program shall include process, design, data collection/analysis, assessment and improvement, and evaluation. The findings shall be used to correct identified problems and revise policies and practices, as necessary.<br><br>This RULE: is not met as evidenced by:<br>Based on interview the facility failed to develop an ongoing, comprehensive, and integrated quality | T 315 | | |

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| T 315 | Continued From Page 20<br><br>assurance/self-assessment program. The facility failed to implement a program to assure that identified problems were corrected.<br><br>The finding included:<br><br>During the entrance conference on March 27, 2013 at approximately 10:28 a.m., with Staff #2 a request was made for the facility's quality assurance data and any documentation relate to the implementation of correction for identified deficient practice.<br><br>A second request was made on March 27, 2012 at 12:43 p.m. for the facility's quality assurance documents. Staff #2 stated, "I have not completed the quality policies, I've been busy and have not gotten to it yet." Staff #2 reported no action had been taken on developing the required components of the facility's quality assure program. | T 315 | | |
| T 320 | 12 VAC 5-412-300 B Quality assurance<br><br>B. The following shall be evaluated to assure adequacy and appropriateness of services, and to identify unacceptable or unexpected trends or occurrences:<br>1. Staffing patterns and performance;<br>2. Supervision appropriate to the level of service;<br>3. Patient records;<br>4. Patient satisfaction;<br>5. Complaint resolution;<br>6. Infections, complications and other adverse events; and<br>7. Staff concerns regarding patient care.<br><br>This RULE: is not met as evidenced by:<br>Based on interview the facility failed to develop a | T 320 | | |

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| T 320 | Continued From Page 21<br><br>quality assurance program, which included the required elements.<br><br>The findings included:<br><br>During the entrance conference on March 27, 2013 at approximately 10:28 a.m., with Staff #2 a request was made for the facility's quality assurance plan.<br><br>A second request was made on March 27, 2012 at 12:43 p.m. for the facility's quality assurance documents. Staff #2 stated, "I have not completed the quality policies, I've been busy and have not gotten to it yet." Staff #2 reported no action had been taken on developing the required components of the facility's quality assure program. | T 320 | | |
| T 325 | 12 VAC 5-412-300 C Quality assurance<br><br>C. A quality improvement committee responsible for the oversight and supervision of the program shall be established and at a minimum shall consist of:<br>1. A physician<br>2. A non-physician health care practitioner;<br>3. A member of the administrative staff; and<br>4. An individual with demonstrated ability to represent the rights and concerns of patients. The individual may be a member of the facility's staff. In selecting members of this committee, consideration shall be given to the candidate's abilities and sensitivity to issues relating to quality of care and services provided to patients.<br><br>This RULE: is not met as evidenced by:<br>Based on interview the facility failed to develop a quality assurance committee. | T 325 | | |

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| T 325 | Continued From Page 22 | T 325 | | |

The findings included:

During the entrance conference on March 27, 2013 at approximately 10:28 a.m., with Staff #2 a request was made for the facility's quality assurance plan and members of the quality assurance committee.

A second request was made on March 27, 2012 at 12:43 p.m. for the facility's quality assurance documents. Staff #2 stated, "I have not completed the quality policies, I've been busy and have not gotten to it yet." Staff #2 reported no action had been taken towards developing the quality assurance committee membership.

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| T 330 | 12 VAC 5-412-300 D Quality assurance | T 330 | | |

D. Measures shall be implemented to resolve problems or concerns that have been identified.

This RULE: is not met as evidenced by:
Based on interview the facility failed to identify and implement corrective action.

The findings included:

During the entrance conference on March 27, 2013 at approximately 10:28 a.m., with Staff #2 a request was made for the facility's quality assurance data and actions implemented to correct identified deficient practices.

A second request was made on March 27, 2012 at 12:43 p.m. for the facility's quality assurance documents. Staff #2 stated, "I have not completed the quality policies, I've been busy and have not gotten to it yet." Staff #2 reported no action had been taken towards developing the

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| T 330 | Continued From Page 23<br><br>quality assurance program. Staff #2 reported the facility had not implemented necessary actions to correct identified deficient practices. | T 330 | | |
| T 335 | 2 VAC 5-412-300 E Quality assurance<br><br>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 by the governing body and the facility. All corrective actions shall be documented. Identified deficiencies that jeopardize patient safety shall be reported immediately in writing to the licensee by the quality improvement committee.<br><br>This RULE: is not met as evidenced by:<br>Based on interview the facility failed to identify and implement corrective action. The facility failed to submit annual data to the governing body.<br><br>The findings included:<br><br>During the entrance conference on March 27, 2013 at approximately 10:28 a.m., with Staff #2 a request was made for the facility's analysis of quality assurance data and the corrective actions forwarded to the governing body.<br><br>A second request was made on March 27, 2012 at 12:43 p.m. for the facility's quality assurance documents. Staff #2 stated, "I have not completed the quality policies, I've been busy and have not gotten to it yet." Staff #2 reported no action had been taken towards developing the quality assurance program. Staff #2 reported the facility had not implemented necessary actions to | T 335 | | |

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| **ALEXANDRIA WOMEN'S HEALTH CLINIC** | **101 S. WHITING ST, SUITE #215 ALEXANDRIA, VA 22304** |

| (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 |
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| T 335 | Continued From Page 24<br><br>correct identified deficient practices or forwarded information to the governing body. | T 335 | | |
| T 365 | 12 VAC 5-412-350 A Disaster preparedness<br><br>A. Each abortion facility shall develop, implement and maintain policies and procedures to ensure reasonable precautions are taken to protect all occupants from hazards of fire and other disasters. The polices and procedures shall include provisions for evacuation of all occupants in the event of a fire or other disaster.<br><br>This RULE: is not met as evidenced by:<br>Based on staff interview and agency document review, the agency staff failed to develop and maintained policies and procedures related to fire safety and disaster preparedness.<br><br>The findings included:<br><br>On 3/27/13 at 12:40 p.m., the survey team requested evidence of training and participation for staff for fire and safety, including fire drills, disaster preparedness and infection control. Staff # 2 stated, "We have not had any fire drills and I did not do any fire safety training for our staff..." Staff #1 stated, "I called for training but they never came..."<br><br>During review of staff records on 3/27/13 at 11:00 a.m., there was no evidence of fire/safety/disaster preparedness training included in 5 (five) of 5 (five) employee records reviewed. There was no policy/procedure specific to the agency for fire safety/disaster preparedness available. | T 365 | | |
| T 370 | 12 VAC 5-412-350 B Disaster preparedness<br><br>B. A facility that participates in a community | T 370 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FTAF-0016 | A. BUILDING ___ B. WING ___ | 03/27/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| T 370 | Continued From Page 25<br><br>disaster plan shall establish plans, based on its capabilities, to meet its responsibilities for providing emergency care.<br><br>This RULE: is not met as evidenced by:<br>Based on staff interview and agency document review, the agency failed to ensure participation in a community disaster plan.<br><br>The findings included:<br><br>On 3/27/13 at 12:40 p.m., the survey team requested evidence of training and participation for staff for fire and safety, including fire drills, disaster preparedness and infection control. Staff # 2 stated, "We have not had any fire drills and I did not do any fire safety training for our staff..." Staff #1 stated, "I called for training but they never came..." Staff #1 stated the agency did not plan to participate in community disasters. | T 370 | | |
| T 385 | 12 VAC 5-412-370 A Fire-fighting equipment and systems<br><br>A. Each abortion facility shall establish a monitoring program for the internal enforcement of all applicable fire and safety laws and regulations and shall designate a responsible employee for the monitoring program.<br><br>This RULE: is not met as evidenced by:<br>Based on staff interview and agency document review, the agency staff failed to ensure a monitoring program for internal enforcement of all applicable fire and safety laws and regulations.<br><br>The findings included:<br><br>On 3/27/13 at 12:40 p.m., the survey team requested evidence of training and participation | T 385 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FTAF-0016 | A. BUILDING ____<br>B. WING ____ | 03/27/2013 |

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| T 385 | Continued From Page 26<br><br>for staff for fire and safety, including fire drills, disaster preparedness and infection control. Staff # 2 stated, "We have not had any fire drills and I did not do any fire safety training for our staff..." Staff #1 stated, "I called for training but they never came..." Staff #2 stated there was not a program for fire safety and no person was designated responsible at the time of the survey. | T 385 | | |