

M/L/EGW

State of Virginia


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AF-0002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/16/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>VIRGINIA LEAGUE FOR PLANNED PARENTHOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 N. HAMILTON STREET RICHMOND, VA 23221</b>
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(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  An unannounced Licensure Biennial survey for a First Trimester Abortion Facility was conducted 10/15/2014 through 10/16/2014. 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		
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T 125	12 VAC 5-412-190 Consent of the patient  A physician shall not perform an abortion without first obtaining the informed written consent of the patient pursuant of 18.2-76 of the Code of Virginia.  This RULE: is not met as evidenced by: Based on document review and interview the facility failed to obtain a signed written consent for an abortion for one (1) of twenty (20) patients included in the sample. (Patient #3)  The findings included:  Review of Patient #3's medical record revealed the patient was admitted to the facility on 11/15/2013 for a medical abortion. Review of Patient #3's medical record indicated the patient elected to have an in-center suction abortion. Patient #3's medical record contained an informed consent form titled "In-Center Suction Abortion", which had not been signed by the patient or staff. Patient #3 had an in-center suction abortion on 12/04/2013.  An interview was conducted on 10/15/2014 at approximately 4:45 p.m. with Staff #1 and Staff #7. Staff #1 reviewed Patient #3's medical record.	T 125	T125  VLPP abortion patients generally sign at least four consent documents as part of their service: - 24 Hour Informed Consent Record - Client Information for Informed Consent (specific to abortion type: surgical or medication) - Request for Surgery or Special Procedure (specific to abortion type: surgical or medication) - Request for Medical Services (general consent to receive services at the facility)  The first document includes all of the information required by Virginia state law for purposes of informed consent and was completed and signed by the patient. Therefore, the facility did not perform a surgical/suction abortion without a signed written informed consent. The second document was inadvertently missed in the process of the patient changing her mind about the type of abortion she would select. All other documents were properly signed and witnessed.	12/12/14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrative and Security Manager</i>	(X6) DATE <i>11/14/2014</i>
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T 125	Continued From Page 1  Staff #1 stated, "The consent is not signed, it was missed." Staff #1 acknowledged the facility performed a surgical/suction abortion without Patient #3 signing the informed consent.	T 125	T125 con'd  To prevent any such omissions in the future, VLPP has implemented a QA review step to confirm all signature lines are completed prior to scanning documents into the electronic health record . In addition, a staff review will be conducted on or before 12/12/14 to reinforce the importance of thorough completion of all consent documents.		
T 170	12 VAC 5-412-220 B Infection prevention  B. Written infection prevention policies and procedures shall include, but not be limited to: 1. Procedures for screening incoming patients and visitors for acute infectious illnesses and applying appropriate measures to prevent transmission of community acquired infection within the facility; 2. Training of all personnel in proper infection prevention techniques; 3. Correct hand-washing technique, including indications for use of soap and water and use of alcohol-based hand rubs; 4. Use of standard precautions; 5. Compliance with blood-bourne pathogen requirements of the U.S. Occupational Safety & Health Administration. 6. Use of personal protective equipment; 7. Use of safe injection practices; 8. Plans for annual retraining of all personnel in infection prevention methods; 9. Procedures for monitoring staff adherence to recommended infection prevention practices; and 10. Procedures for documenting annual retraining of all staff in recommended infection prevention practices.  This RULE: is not met as evidenced by: Based on observation, interview and document review the facility staff failed to perform hand hygiene after removing gloves and prior to donning new gloves for three of three observations.	T 170	T170  VLPP management is working with our infection control consultant to review and revise our infection control policies specific to glove use and hand hygiene. With her guidance/assistance we will identify and contract with an infection control specialist to complete a hands-on training with abortion staff members by 12/12/14.  In addition, periodic targeted observational audits will be incorporated into the 2015 QA work plan to ensure consistent implementation of these policies and procedures.	12/12/14	

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T 170	<p>Continued From Page 2</p> <p>The findings included:</p> <p>Observations conducted on 10/15/2014 at 9:30 a.m., with Staff #3 during quality check for equipment. Staff #3 obtained a vial of blood, removed the top from the vial and used a pipette to place blood on a slide for Rh factor testing. Staff #3 removed his/her contaminated gloves potentially contaminating his/her hands. Staff #3 without performing hand hygiene retrieved a new set of gloves from the box of gloves potentially contaminating the other gloves in the box and the new gloves. Staff #3 handled other equipment in the laboratory area with the potentially contaminated gloves.</p> <p>Observations were conducted on 10/16/2014 at approximately 12:09 p.m. in Procedure Room #1 as Staff #2 and Staff #4 cleaned the room post a procedure. Staff #2 handled the contaminated equipment from the previous procedure. Staff #2 changed gloves six times without performing hand hygiene between glove changes during the process of removing dirty items and setting up clean areas. Staff #2 failed to utilize the hand sanitizer located next to the box of gloves.</p> <p>Review of the facility's policy titled "VIII. Hand Hygiene Instructions: ... A. When to Wash Hands: 1. After touching blood, body fluids, secretions, excretions or items that touch these substances. 2. After removing gloves. 3. Before donning gloves. 4. Between each patient even if gloves are used. B. Where to Wash Hands: 1. ... exam room ...lab ... D. When to Use Alcohol-Based Waterless Hand cleaner ... 2. Soap and water are not immediately available..."</p> <p>An interview was conducted on 10/16/2014 at 2:15 p.m., with Staff #8 related to the findings and the</p>	T 170	

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T 170	Continued From Page 3  review of the facility's policy. Staff #8 reviewed the facility's policy and stated "I think that it is just your interpretation of the policy." The surveyor informed Staff #8 regarding the potential cross-contamination of not having cleaned hands prior to reaching into the box of gloves and then spreading infectious agents.  "CDC (Center for Disease Control and Prevention) Protocol for hand hygiene and glove use" in part read: "Glove use: 1. In general, gloves should be worn prior to contact with patients at the treatment station and potentially contaminated surfaces (e.g. ... environmental surfaces) ... Gloves should always be changed between patients and between clean and contaminated sites on the same patient. Holding a glove in one's hand instead of wearing it is not considered acceptable. Glove use does not preclude the need for hand hygiene after removing gloves. 2. Examples of situations when gloves should be changed: 1. After contact with blood or body fluids ... 2. After contacting a potentially contaminated site before moving to a clean site"	T 170			
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);	T 175	T175  The tape residue was immediately removed from the exam table. Nursing staff will no longer apply tape to the exam table.  Staff #4 was misquoted. The recliners are in fact disinfected between patients: they are thoroughly wiped down with germicidal disposable wipes, air dried and re-covered with disposable cloth liners. The food particles (from patient snacking) that were discovered in the lower crevices of the	12/12/14	

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T 175	Continued From Page 4  4. Procedures for handling, storing and transporting clean linens, clean/sterile supplies and equipment; 5. Procedures for handling/temporary storage/transport of soiled linens; 6. Procedures for handling, storing, processing and transporting regulated medical waste in accordance with applicable regulations; 7. Procedures for the processing of each type of reusable medical equipment between uses on different patients. The procedure shall address: (i) the level of cleaning/disinfection/sterilization to be used for each type of equipment, (ii) the process (e.g., cleaning, chemical disinfection, heat sterilization); and (iii) the method for verifying that the recommended level of disinfection/sterilization has been achieved. The procedure shall reference the manufacturer's recommendations and any applicable state or national infection control guidelines; 8. Procedures for appropriate disposal of non-reusable equipment; 9. Policies and procedures for maintenance/repair of equipment in accordance with manufacturer recommendations; 10. Procedures for cleaning of environmental surfaces with appropriate cleaning products; 11. An effective pest control program, managed in accordance with local health and environmental regulations; and 12. Other infection prevention procedures necessary to prevent/control transmission of an infectious agent in the facility as recommended or required by the department.  This RULE: is not met as evidenced by: Based on observations and document review the facility failed to ensure:  1. Environmental surfaces were disinfected	T 175	T175 Con'd  recliners were removed with a small vacuum. The recovery room nurse now applies additional liners to the recliner seat to prevent crumbs from falling between the cushion and sides. In addition, the janitorial service has been notified to incorporate this additional cleaning step into the daily routine.  A review of room cleaning/disinfecting procedures, with opportunities for hands-on practice, will be incorporated into the planned training with the infection control specialist (see T170).	

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T 175	<p>Continued From Page 5</p> <p>between patients; 2. Staff maintained procedures which prevented cross-contamination and the transmission of infectious agents.</p> <p>The findings included:</p> <p>1. An observation and interview was conducted in "Procedure Room #1" on 10/15/2014 at 10:45 a.m., with Staff #1 and Staff #4. The facility staff verified the procedure room was ready for use. The observation revealed a sticky residue on the left side of the exam table. The finding was verified by Staff #4. Staff #4 reported the nurse applied tape to the table during the process of anchoring the patient's intravenous (IV) site. Staff #1 agreed the "tape residue" provided a surface for the potential spread of infectious agents and prevented the exam table from being disinfected between patients.</p> <p>An observation and interview was conducted in "Procedure Room #2" on 10/15/2014 at 10:56 a.m., with Staff #1 and Staff #4. The facility staff verified the procedure room was ready for use. The observation revealed a sticky residue on the exam table. The finding was verified by Staff #4. Staff #1 acknowledged the "stick residue" should have been removed during the cleaning process. Staff #1 agreed the substance prevented the exam table from being disinfected between patients.</p> <p>Observations were conducted in the "Recovery area" on 10/15/2014 at 11:05 a.m., with Staff #1, Staff #3, and Staff #4. The facility staff verified the "Recovery area" was ready to receive patients. The observation revealed four (4) of the seven (7) recliners had food particles between the seat cushion and the bilateral sides. Staff #3 reported the recliners were cleaned between each patient.</p>	T 175	

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T 175	Continued From Page 6  Staff #3 reported the patients were given cracker-like snacks during the recovery process. Staff #3 and Staff #4 verified the four recliners had food particles between the seat cushion and the bilateral sides. Staff #4 verified the recliners had not been disinfected between patients.  2. Observations were conducted on 10/16/2014 at approximately 12:09 p.m. in Procedure Room #1 as Staff #2 and Staff #4 cleaned the room after a procedure. Staff #2 picked up a container of disinfecting cloths from a cart containing supplies located in the procedure room. Staff #2 removed several disinfectant cloths from the container and sat the container on the top of the biohazard (red) box. Staff #2 determined the exam table had air dried and informed Staff #4 to prepare the exam table. Staff #2 picked up the container of disinfecting cloths from the bio-hazard box and placed the container on the exam table. Staff #4 began to set up the exam table. The surveyor stopped the process and asked Staff #2 if he/she had picked up the container of disinfecting cloths from the bio-hazard box? Staff #2 replied "Yes." Staff #2 was able to determine he/she had moved an item from a "dirty/contaminated area" to a "clean area." Staff #2 obtained several disinfectant cloths and wiped the exam table again. Staff #2 explained while the exam table was air drying, he/she would set-up the physician's equipment for the next procedure. The observation revealed a cart with a disposable absorbent padding covering the top shelf. Staff #2 reported the absorbent padding was not changed between cases. The top shelf of the cart had six emesis basins stacked inside of each other, a pump bottle of hand sanitizer, a partially used box of gloves, and a container of antiseptic skin cleanser. Staff #2 obtained four large cotton tip applicator and gauzes and placed them on the absorbent pad, which had been used during the	T 175	

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T 175	Continued From Page 7  previous case. Staff #2 picked up the container of disinfecting cloths from the bio-hazard box and placed it on the cart along with the clean supplies on the absorbent pad. The surveyor attempted to stop Staff #2 prior to his/her reaching into a drawer, retrieving a sterile pack, and placing it next to the clean supplies with the contaminated container of disinfecting cloths. The surveyor asked Staff #2 to process the potential contamination by moving the container of disinfecting cloths from the bio-hazard box to an area with "clean supplies." Staff #2 was able to process that he/she had contaminated the field and introduced potential infectious agents to the clean supplies.  An interview was conducted on 10/16/2014 at approximately 2:15 p.m., with Staff #1 and Staff #8. The surveyor informed Staff #1 and Staff #8 regarding the above findings. Staff #1 acknowledged the staff involved in the cleaning process had failed to perform the task in the proper manner.	T 175	

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