State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-003	A. BUILDING _____ B. WING _____	05/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A TIDEWATER WOMEN'S HEALTH CLINIC	891 NORFOLK SQUARE NORFOLK, VA 23502

(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 175	Continued From Page 3 evidenced by 1. Staff moving between clean and dirty areas without having or changing personal protective outerwear and staff did not follow manufacturer's recommendation for enzymatic cleaner. 2. The design of the paper towel dispensers facilitated the spread of infection. 3. The cleaning supplies and mops were stored in a manner to promote cross contamination. 4. The freezer which is used to store the collected conception material, had blood and un-bagged conception material frozen to the inner bottom surface. The air vents in the clean utility room had a thick dust build up. A small portable fan with thick dust on the fan blades, front grill and back grill sat on the counter with opened clean supplies. Five of six recovery room recliners had torn surfaces, which could not be disinfected between patients. Six of six recovery room recliners had clear tape over the identification numbers and old adhesive on the wooden arms of the recliners, which prevented disinfection of the surface between patients. 5. A bucket that held water to rinse the suction pump lines after procedures was turbid with floating black particles. Supplies scheduled for the day's procedures were open and left uncovered on the treatment/procedure room counter exposed to contamination. 6. The suction pump and portable lamps utilized during procedures did not have proof of preventative maintenance according to manufacturer's recommendations. The findings included:	T 175	T175 #2 cont. ④ Pull paper towel dispensers are monitored daily by employees assigned to each area to ensure they are well stocked & functional. ⑤ Completion Date: Pull style paper towel holders installed 6/4/12 → Documentation attached with ID PreFix Tag T175(#2) T175 #3 ① We corrected this action by purchasing new mop head replacements and new mop bucket, as well as relocating mops, mop bucket and cleaning supplies, as of 5/11/12. ② It is important that all cleaning supplies and all other products are stored in their designated area to ensure NO cross contamination to the clean room. ③ Staff was properly trained on 5/12/12 on the difference between the clean & dirty room, so they are now knowledgeable where to store cleaning supplies and why the mop/bucket belongs in the dirty room. ④ The Soiled Room Attendant Job Description was updated 5/11/12 + Clean Room Attendant Job Description was updated 5/11/12 so reoccurence will not happened. ~~ERAC~~ SRA + CLA aware & trained on 5/12/12. ⑤ Completion Date: 5/11/12 Mops were removed from clean room to the dirty room on 5/11/12.	

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	FTAF-0014	A. BUILDING ______ B. WING ______	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE MEDICAL CENTER FOR WOMEN	1119 2ND STREET SW ROANOKE, VA 24016

(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 175	Continued From Page 9 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, interviews and record review the facility failed to develop and implement polices/procedures for the prevention and control of infections as evidenced by: 1. Failing to provide adequate hand washing equipment in the "Dirty" utility room. 2. Multiple use of a single-use product and failing to disinfect the single-use vacutainer needle holders between patient lab draws. Staff used of a sponge to clean the procedure jars and failed to disinfect procedure jars and stoppers between patients. 3. Failure to disinfect three (3) of three recovery room cots between patients and one (1) of one lab chair. 4. The policy for linens did not include the facilities current practice. The findings include: 1. An observation conducted on July 17, 2012 at 9:35 a.m., with Staff #1 during the initial tour of the facility revealed the "Dirty" utility room did not have paper towels, paper towel dispenser or other method for staff to dry their hands. Observations were conducted on July 18, 2012 from 11:00 a.m. to 1:18 p.m., in the "Dirty" utility room with Staff #5. Staff #5 washed his/her hands at the sink in	T 175 T175 (1)	(1) Failed to have adequate hand washing equipment in "dirty" room. This was corrected immediately by instructing maintenance / Construction personnel to install paper towel dispenser & alcohol dispenser. Also antibacterial soap was placed in the dirty room. (2). Once these items are installed, we will not be deficient again. Items will be replaced when they get low (3). The procedure will be that utility staff will inform administrator when items are low and those items will be replaced immediately. (4) Administrator will follow up with construction personnel to ensure items are installed in a timely manner. Administrator will then check supply of these items weekly and replenish as necessary (5). Items will be installed and functional by 8/17/12 ~~[illegible]~~	

of Virginia

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	FTAF-0014	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE MEDICAL CENTER FOR WOMEN	1119 2ND STREET SW ROANOKE, VA 24016

(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 175	Continued From Page 10 the "Dirty" utility room. Staff #5 did not have a method to dry his/her hands within the "Dirty" utility room. Staff #5 with wet hands left the "Dirty" utility room, walked approximately three (3) feet to obtain paper towel from the Scrub sink's paper towel dispenser. For each glove change thereafter, Staff #5 left the "Dirty" utility room to wash and dry his/her hands at the Scrub sink. [A "Dirty" scrub/utility room is a room designated to receive, clean and disinfect used instruments and or equipment following a procedure. After instruments are cleaned and disinfected in the "Dirty" scrub/utility room/designated area, they are taken to the "Clean" scrub/utility room/designated area where instruments are packaged and sterilized as appropriate for use again.] An interview was conducted on July 18, 2012 at 2:45 p.m. with Staff #1. Staff #1 acknowledged the need for the "Dirty" utility room to have adequate equipment for staff to dry their hands as part of hand hygiene and to prevent the spread of infection. 2. Observation and interview was conducted during the initial tour on July 17, 2012 at 9:28 a.m., with Staff #10. The observation revealed two (2) vacutainer plastic needle holders placed on a blood collection tube holder. Staff #10 reported to the surveyor the vacutainer needle holders were reused between patients. When asked about the process to distinguish "dirty" from "clean" vacutainer needle holders Staff #10 reported the vacutainer needle holders were used then placed back on the tube holder. Staff #10 reported there was no need to clean the vacutainer needle holders between patients. The observation revealed one of the vacutainer needle holders had visible dark red splatter within the hub, which attached to the needle to draw the patient's blood. Staff #10 was asked to observe	T 175	① Vacutainer needles were not disinfected between patients. This was corrected immediately by disinfected vacutainer needles between each patient. T175 ② Nurse practitioner will recognize that disinfecting vacutainer needles between each patient is the requirement and will adhere to this requirement. ③ The process for disinfecting is spraying vacutainer needle with calvicide spray, letting it set for 3 minutes and then rinsing. This is done after each use. ④ Nurse practitioner will practice this process after each use and is the only staff member who draws blood. ⑤ This process is now in place and has been as of 7/19/12 - following inspection. This procedure is included in the policy on "processing of reusable medical equipment."	

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	FTAF-0014	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE MEDICAL CENTER FOR WOMEN	1119 2ND STREET SW ROANOKE, VA 24016

(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 175	Continued From Page 11 the inner surface of the vacutainer needle holders hub, Staff #10 reported he/she did not have his/her glasses. Staff #1 was asked to observe the vacutainer needle holders; Staff #1 stated, "It says BD, I can't make out the rest." Staff #1 was asked to look inside the hub of the two vacutainer needle holders. Staff #1 stated, "That looks like blood in this one." A request was made for information that guided the facility's reuse without cleaning the vacutainer needle holders. An observation of the two vacutainer needle holders by a second surveyor was conducted on July 17, 2012 at 1:26 p.m. The second surveyor identified dark red splatter within the hub of one of the two vacutainer needle holders available for patient use. The facility did not have a policy or procedure for the reuse of vacutainer needle holders. The facility did not provide additional information or evidenced based information for the reuse with or without cleaning their vacutainer needle holders. Review of the manufacturer's information on line did not provide information that the product should be used more than one time (www.bd.com). The manufacturer's information read "The BD Vacutainer (Trademark) Single-use Needle/Tube Holder is a quality, low-cost single use holder..." Observations were conducted on July 18, 2012 from 11:00 a.m. to 1:18 p.m., in the "Dirty" utility room with Staff #5. Staff #5 processed instruments, which needed to be autoclaved. Staff #5 left a pink sponge in the bottom of the sink. Staff #5 identified the sponge as "just a regular sponge". Staff #5 received the first jar after a procedure. Staff #5 removed the stopper from the procedure jar and ran water through the ports, where the suction hoses attached, used a toothbrush to scrub around the base of the ports	T 175	7/19/2012 The process for reusing vacutainer needles has outlined in the "processing of reusable medical Equipment" policy. ~~Corrective~~ This policy is applies to all ~~the~~ reusable equipment including the glass bottle and rubber stopper used in procedure. Staff #5 understands this process and is in compliance with this procedure. It is also understood that sponges can spread bacteria and can not be used on reusable equipment.	

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	FTAF-0019	A. BUILDING _____ B. WING _____	08/02/2012

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

(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 175	Continued From Page 22	T 175		

observation revealed an uncovered plastic endotracheal tube with a metal guide inserted. Staff #8 verified the opening near the tip of the endotracheal tube had dust and other particulate matter on the inner surface. Staff #8 reported the cart was utilized by the anesthesiologist

An observation was conducted in Procedure room #1 at 11:16 a.m., with Staff #8. Staff #8 reported the room was ready for the procedures scheduled for the day. The observation revealed the procedure table had visible dried blood on the metal joints (Bilaterally) that connected the metal leg stirrup/supports. Staff #8 verified the blood observed on the base of the procedure table and on the front of the drawers between the two leg stirrup/supports.

Observations in the "Second Recovery" area revealed four of the five recovery recliners had an un-identifiable substance spilled on the lower inner rail. Staff #1 verified the findings.

An observation on August 2, 2012 at 9:48 a.m. revealed the facility's designated Dirty scrub room the "Wet Lab" had been set up with towels on the counter and on the ledge between the "Wet Lab" and designate Clean scrub room the "Dry Lab."

During an interview on August 2, 2012 at 9:30 a.m., Staff #1 informed the surveyor the staff designated to perform the "Wet Lab" task of cleaning and disinfecting the equipment were assigned to assist in the procedure room related to the number of cases. Staff #1 reported equipment would not be clean/disinfected until the three scheduled cases were completed.

Observations conducted in the "Wet Lab"/ Dirty scrub room on August 2, 2012 from 9:58 a.m. to

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	FATF-009	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND MEDICAL CENTER FOR WOMEN	116 N. BOULEVARD RICHMOND, VA 23220

(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 175	Continued From Page 10	T 175		

patient care
7. Snacks provided for patients were multiple unwrapped items in opened packages, which increased cross-contamination of the food products
8. The staff's handling of clean and dirty equipment between patients and staff's knowledge of manufacturer's recommendations for cleaning re-usable equipment between patients. Staff re-used sponges for cleaning blood and body fluid spills post procedures.
9. A failure to develop procedures for the processing of each type of reusable medical equipment between uses on different patients, procedures for appropriate disposal of non-reusable equipment, and procedures for cleaning of environmental surfaces with appropriate cleaning products.

The findings included:

1. An observation and interview was conducted with Staff #2 on May 15, 2012 at 10:50 a.m. in the Recovery room. Staff #2 reported the Recovery recliners were cleaned between each patient use. Staff #2 reported the Recovery recliners had not been utilized since the last procedure day (May 5, 2012) and were ready for patients. Staff #2 and the surveyor placed the Recovery recliners in a raised foot position. The observation revealed two (2) of the three (3) Recovery recliners had an area of five (5) inches or greater of dark reddish brown substance on the sling between the seat and the footrest. Staff #2 identified the dark reddish brown substance as dried blood. Staff #2 reported understanding the infection risk related to blood left on the Recovery recliners between patients.
2. An observation and interview was conducted on May 15, 2012 from 10:20 a.m. to 11:18 a.m. with Staff #2. Staff # 2 reported the procedure table was wiped down with a 1:10 bleach/water solution between patients. The observation in the procedure room revealed the procedure table's

T 175

Staff retrained regarding need to disinfect surfaces between each patient use. Job descriptions revised to include disinfecting as a job responsibility
Infection Control Survey to be conducted quarterly to monitor adherence to infection control practices. Results to be reported to Quality Assurance Committee.
Staff instructed to monitor condition of equipment and advise administrator in the event of a tear or other condition which would hinder disinfection. Job descriptions reflect that responsibility.
Administrator to be advised of any condition that requires repair/ replacement of equipment.
Completion date June 28, 2012

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-042	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	10758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(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 175	Continued From Page 16 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 the review of the facility's policies and interview there were no policies/procedures for the facility management of : hand hygiene; cleaning, disposal, storage and transport of equipment, linen and supplies; product specific instructions for use of cleaning agents; procedures for handling, storing and transporting of medical waste; policy/procedure for pest control; and other infection prevention procedures necessary to prevent/control transmission of an infectious agent in the facility The findings include: 1. On May 30, 2012 the facility policies were reviewed between 2:00 PM and 5:00 PM in the Administrator's office. There were no policies/procedures for the management of the facility, equipment and supplies for the following: a. Access to hand-washing equipment and adequate supplies (e.g., soap, alcohol-based hand rubs, disposable towels or hot air dryers); b. Availability of utility sinks, cleaning supplies and other materials for cleaning, disposal, storage and transport of equipment and supplies; c. 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,	T 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-002	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENINSULA MEDICAL CENTER FOR WOMEN	19758 A JEFFERSON AVENUE NEWPORT NEWS, VA 23601

(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 175	Continued From Page 17 management of accidental exposures); d. Procedures for handling, storing and transporting clean linens, clean/sterile supplies and equipment; e. Procedures for handling/temporary storage/transport of soiled linens; f. Procedures for handling, storing, processing and transporting regulated medical waste in accordance with applicable regulations; g. 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; h. Procedures for appropriate disposal of non-reusable equipment; i. Policies and procedures for maintenance/repair of equipment in accordance with manufacturer recommendations; j. Procedures for cleaning of environmental surfaces with appropriate cleaning products; k. An effective pest control program, managed in accordance with local health and environmental regulations; and l. Other infection prevention procedures necessary to prevent/control transmission of an infectious agent in the facility as recommended or required by the department. 2. On May 30, 2012 an interview was conducted with both the facility Administrator and the nurse consultant in the Administrator's office. Both acknowledged that there were no policies for the management of the facility, equipment and	T 175		