A Capital Women's Health Clinic
1511 Starling Drive • Richmond, Virginia 23229
Telephone (804) 754-1928
1-800-254-4479

June 26, 2012

Karen Remley, MD, MBA, FAAP
State Health Commissioner
P O Box 2448
Richmond, Virginia 23218

Dear Ms. Remley:

Enclosed please find the Plan of Corrections for A Capital Womens Health Clinic in response to the deficiencies noted on the Licensure Inspection Report dated June 11, 2012.

I hope you will find these responses satisfactory.

If you have any questions, please feel free to contact me.

Sincerely,

Shelley Abrams
Administrator

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State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-011	A. BUILDING _____ B. WING _____	05/21/2012

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T 000	12 VAC 5-412 Initial comments An announced Initial Licensure Abortion Facility Inspection was conducted at the above referenced facility on May 21, 2012 by two (2) Medical Facilities Inspectors from the Virginia Department of Health's, Office of Licensure and Certification. The facility was out of compliance with the State Board of Health 12 VAC 5-412, Regulations for Abortion Facility's effective December 29, 2011. Deficiencies were identified, cited, and will follow in this report.	T 000		
T 070	12 VAC 5-412-170 C Personnel C. Each abortion facility shall obtain a criminal history record check pursuant to 32.1-126.02 of the Code of Virginia on any compensated employee not licensed by the Board of Pharmacy, whose job duties provide access to controlled substances within the abortion facility. This RULE is not met as evidenced by: Based on personnel file review, select document review and interview, it was determined that the facility failed to ensure a criminal record report was obtained on all compensated personnel not licensed by the Board of Pharmacy and whose job duties may provide the employee access to controlled substances within the abortion facility. Specifically, one (1) of three (3) personnel who have access to controlled substances failed to have a criminal record report from the Virginia State Police in their personnel file, (employee #8). The findings were: Personnel files were reviewed in the facility on May 21, 2012 beginning at 3 PM in the Administrator's office. Nine personnel files were	T 070	12 VAC 5-412-170 C Personnel Although ACWHC had obtained a criminal background check on Employee #8, it was not acquired through the Virginia State Police. As of June 19, Employee #8's background check had been applied for and received from the Virginia State Police. Furthermore, our facility has created a new protocol for acquiring criminal background checks which specifically states all future necessary background checks must be applied for directly through the Virginia State Police. The Administrator is responsible for obtaining all criminal background checks and has been made aware of the specific requirement that these checks be obtained through the Virginia State Police.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shelley Abrams — TITLE: Administrator — (X6) DATE

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T 070	Continued From Page 1 reviewed. The Administrator stated during the review of files that three of the nine employees files reviewed were for employees who have access to controlled substances and are not licensed by the Board of Pharmacy, those employees were #1, 8 & 9. Employee #8's file failed to contain evidence that a criminal record report through the Virginia State Police had been obtained and this employee has been employed with the company for more than 30 days. The Administrator was asked if the file contained a criminal record report from the Virginia State Police and he/she replied, "No." Review of the facility's Policy and Procedure manual on May 21, 2012 beginning at or about 12 noon revealed that the facility did have a policy regarding criminal record reports. During the exit conference in the facility at 4:30 PM on May 21, 2012 the Administrator acknowledged the above finding.	T 070		
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 &	T 170	12 VAC 5-412-220 B Infection Prevention The facility has purchased disposable lab coats for usage by employee #8. On June 15, a meeting was held with Employee #8 and the Facility's Designated Infection Control Person and the employee was reminded of the importance of PPE for the protection of both the employee and patients. Also on June 15, specific PPE protocol was created for the exact tasks performed by Employee #8 and a meeting was held on this date with Employee #8 outlining this protocol. Employee #8 has demonstrated understanding of and compliance with the new protocol. The facility's Designated Infection Control Person will monitor Employee #8 to ensure that the protocol is executed correctly.	

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T 170	Continued From Page 2 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 observations and interviews it was determined the facility's staff failed to wear personal protective equipment (PPE) related to the risk of exposure to blood and body fluids for one (1) employee as observed in the dirty scrub room and a procedure room (employee #8). The findings were: 1. During the initial tour of the facility beginning at approximately 12 noon on May 21, 2012 employee #8 was observed in a hallway with 2 wet spots on the chest of his/her scrub shirt, each wet area was approximately 1 - 2 inches round. Employee #8 entered a procedure room and began working with a patient. After the procedure, employee #8 carried a tray with used instruments and a glass jar containing the products of conception back to the dirty scrub room. Employee #8 proceeded to put the used instruments in one side of a double sink that had water and a small amount of bubbles in it. Standing in front of the empty side of the double sink employee #8 then proceeded to examine the contents of the glass jar after pouring the contents of the jar into a strainer and placing the strainer under running water. Once rinsed, the contents of the strainer were poured into a square glass dish and placed next to a bright light for	T 170	Disposable lab coats have also been purchased for usage by Employee #7 in the clean scrub room. On June 15, a meeting was held with Employee #7 and the Facility's Designated Infection Control Person and the employee was reminded of the importance of PPE for the protection of both the employee and patients. Employee #7 was also informed that under no circumstances should the same PPE be worn between the clean and dirty scrub rooms. Furthermore, Employee #7 was retrained on appropriate hand hygiene technique. Also on June 15, specific PPE protocol was created for the exact tasks performed by Employee #7 and a meeting was held on this date with Employee #7 outlining this protocol. Employee #7 has demonstrated understanding of and compliance with the new protocol. The facility's Designated Infection Control Person will monitor Employee #7 to ensure that the protocol is executed correctly.	

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T 170	Continued From Page 3 further examination. Employee #8 then poured the contents of the glass dish into a plastic bag and walked back to a procedure room and entered. At no time was employee #8 observed wearing personal protective equipment/clothing on or change out of the wet scrub shirt that he/she was wearing. A few minutes later employee #8 was observed leaving the procedure room with the same 2 wet areas on his/her scrub shirt and walked back into the dirty scrub room to repeat the same process as described above. 2. Interviews with employee #9 on May 21, 2012 at about 3 PM revealed that employee #9 had also observed the same incident as described above. 3. After employee #8 left the dirty scrub room, employee #7 was noted to be working in the clean scrub room. Employee #7 had a large full body apron on that covered the chest, abdominal and upper leg area's of their body. Employee #7 walked across the hall from the clean scrub room to the dirty scrub room, put on 2 pair of disposable gloves, picked up a yellow sponge and proceeded to turn on the water and direct the faucet into the empty side of the sink where employee #8 had previously rinsed the strainer that had the products of conception in it. Employee #7 then began picking up the dirty instruments one at a time out of the side of the sink with the standing water with bubbles in it and cleaned them with the sponge under the running water. At no time was employee #7 observed donning protective clothing between the clean and dirt scrub rooms. The same clothes (scrubs) were worn to work in the clean and then the dirty scrub room. After cleaning the used instruments, employee #7 pulled off both pair of gloves and picked up the	T 170		

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T 170	Continued From Page 4 cleaned instruments and walked them across the hall into the clean scrub room where they were deposited on top of a large stack of blue paper. Blue paper is used to wrap the instruments in before they are placed in the autoclave (sterilizing device). Before wrapping the instruments recently cleaned, employee #7 picked up one pack of gloves and 4 x 4's and placed them on top of the instruments, wrapped them and applied a special type of masking tape. After completing this task, employee #7 walked across the hall and began the previous procedure of cleaning instruments. 4. During the exit conference on May 21, 2012 beginning at 4:30 PM employee #9 was informed of this writers observations made during time spent with employee #7 in the clean and dirty scrub rooms. Employee #9 acknowledged that employees working in the clean and dirty scrub rooms do not change their clothes or add personal protective equipment when traveling between areas.	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); 4. Procedures for handling, storing and	T 175	12 VAC 5-412-220 C Infection Prevention On May 22, 2012, a meeting was held with appropriate staff informing them that after the regular daily preparation of clorox 1:10 solution, a label with the date of preparation must also be affixed to the container. Random spot checks since May 22 by the Administrator have confirmed that staff is labeling clorox solutions daily after preparation.	

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T 175	Continued From Page 5 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 observation, interview and record review the facility failed to have infection control procedures to prevent cross-contamination as evidenced by: 1. Proper procedure for the cleaning and	T 175	The facility has purchased disposable lab coats for usage by employee #8. On June 15, a meeting was held with Employee #8 and the Facility's Designated Infection Control Person and the employee was reminded of the importance of PPE for the protection of both the employee and patients. Also on June 15, specific PPE protocol was created for the exact tasks performed by Employee #8 and a meeting was held on this date with Employee #8 outlining this protocol. Employee #8 has demonstrated understanding of and compliance with the new protocol. The facility's Designated Infection Control Person will monitor Employee #8 to ensure that the protocol is executed correctly. Disposable lab coats have also been purchased for usage by Employee #7 in the clean scrub room. On June 15, a meeting was held with Employee #7 and the Facility's Designated Infection Control Person and the employee was reminded of the importance of PPE for the protection of both the employee and patients. Employee #7 was also informed that under no circumstances should the same PPE be worn between the clean and dirty scrub rooms. Furthermore, Employee #7 was retrained on appropriate hand hygiene technique. Also on June 15, specific PPE protocol was created for the exact tasks performed by Employee #7 and a meeting was held on this date with Employee #7 outlining this protocol. Employee #7 has demonstrated understanding of and compliance with the new protocol. The facility's Designated Infection Control Person will monitor Employee #7 to ensure that the protocol is executed correctly.	

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T 175	Continued From Page 6 disinfection of dirty/used instruments, as evidenced by the staff's handling of clean and dirty equipment between patients and staff's knowledge of manufacturer's recommendations for cleaning re-useable equipment between patients. Staff re-used sponges for cleaning dirty equipment, counter-tops and sinks. 2. The shelf life of mixed disinfection solutions as evidenced by the cleaning of environmental surfaces in procedure and ultrasound room's with appropriately dated mixed cleaning agents, 3. The facility was not able to determine that linens laundered on-site were processed at the correct water temperature of 160 degrees Fahrenheit, 4. The placement/location of soiled linen and biohazard waste receptacles, 5. Lack of PPE use. 6, Appropriate storage location of clean supplies, sterile instruments, and environmental cleaning supplies. 7. Staff failing to perform hand hygiene between glove changes. The findings were: During the initial tour of the facility's two (2) procedure and one (1) ultrasound rooms with the Administrator on May 21, 2012 each room was noted to have sitting next to the sink, a spray bottle with writing on it. Written in black magic marker on the bottles was, "Bleach 1:10." The Administrator was asked when were the bottles mixed, the Administrator replied, we mix them every morning. No dates were found on any of the bottles observed. Also during the initial tour of the facility beginning at approximately 12 noon on May 21, 2012 employee #8 was observed in a hallway with 2 wet	T 175	On May 22, 2012 an in-service was held with Employee #7 and the facility's Designated Infection Control Employee on the appropriate use of the instrument cleanser. A measuring cup was placed in the dirty scrub room for precise measurements of instrument cleanser. Spot checks since May 22 have shown that Employee #7 is adhering to the manufacturer's directions for use of Metriwash. Effective June 19, 2012 use of sponges in the dirty scrub room was discontinued, and instruments are now being cleaned with a plastic cleaning brush. A new specific protocol was developed for this cleaning tool and explained to Employee #7. Effective June 19, 2012 the facility has discontinued the use of cloth linens, and has replaced them with disposable drapes. Laundry is no longer being done on site. Because laundry is no longer done on site, the dirty linen receptacle has been removed entirely from the property. Effective June 19, 2012 the freezer in the clean scrub room is no longer located in the facility.	

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T 175	Continued From Page 7 spots on the chest of his/her scrub shirt. Employee #8 entered a procedure room and began working with a patient. Employee #8 was observed in the procedure room and during that time the only PPE worn was a pair of gloves and glasses. After the procedure, employee #8 carried a tray with used instruments and a glass jar containing the products of conception back to the dirty scrub room. Employee #8 proceeded to put the used instruments in one side of a double sink that had water with a small amount of bubbles in it. Standing in front of the empty side of the double sink employee #8 then proceeded to examine the contents of the glass jar after pouring the contents of the jar into a strainer and placing the strainer under running water. Once rinsed, the contents of the strainer were poured into a square glass dish and placed next to a bright light for further examination. Employee #8 then poured the contents of the glass dish into a plastic bag and walked back to a procedure room and entered. At no time was employee #8 observed after leaving the first procedure room wearing personal protective equipment/clothing or changing out of the wet scrub shirt that he/she was wearing. A few minutes later employee #8 was observed leaving the procedure room with the same 2 wet areas on his/her scrub shirt and walked back into the dirty scrub room to repeat the same process as described above. After employee #8 left the dirty scrub room, employee #7 was noted to be working in the clean scrub room. Employee #7 had a large full body apron on that covered the chest, abdominal and upper leg area's of their body. Employee #7 walked across the hall from the clean scrub room to the dirty scrub room, put on 2 pair of disposable gloves, picked up a yellow sponge and proceeded to turn on the water and direct the faucet into the empty side of the sink where employee #8 had	T 175	Disposable lab coats have been purchased for usage by Employee #7 in the clean scrub room. On June 15, a meeting was held with Employee #7 and the Facility's Designated Infection Control Person and the employee was reminded of the importance of PPE for the protection of both the employee and patients. Employee #7 was also informed that under no circumstances should the same PPE be worn between the clean and dirty scrub rooms. Furthermore, Employee #7 was retrained on appropriate hand hygiene technique. Also on June 15, specific PPE protocol was created for the exact tasks performed by Employee #7 and a meeting was held on this date with Employee #7 outlining this protocol. Employee #7 has demonstrated understanding of and compliance with the new protocol. The facility's Designated Infection Control Person will monitor Employee #7 to ensure that the protocol is executed correctly. On May 22, 2012 Staff were reminded about the importance of maintaining the integrity of the clean room. Staff was instructed that at no time should dirty mops, buckets, cleaning supplies, etc be placed in the clean scrub room. Furthermore the staff was made aware that VDH does not want table paper or clean mop heads stored in the clean scrub room. Periodic spot checks by the Administrator since have demonstrated staff compliance. On June 19, 2012 the telecommunications panel was dusted thoroughly and a protective barrier was installed. On May 22, 2012 the biohazard waste container previously located in the hallway was placed permanently in the dirty scrub room.	

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T 175	Continued From Page 8 previously rinsed the strainer that had the products of conception in it. Employee #7 then began picking up the dirty instruments one at a time out of the side of the sink with the standing water with bubbles in it and cleaned them with the sponge under the running water. Employee #7 was asked what the solution was on the side of the sink with the standing water in it. Employee #7 replied "That's MetriWash, it's something to soak these in." Employee #7 was asked how the solution is mixed up and replied, I put a little bit of this (MetriWash) in the sink and then add hot water. When asked if anything (MetriWash or water) was measured he/she replied, "No, I pour the MetriWash up to about here pointing to an area on the sink and then I just add hot water to about here, again pointing to an area on the sink. Employee #7 was asked do you change the solution in the sink everytime dirty instruments are brought in and he/she replied, "No." A white plastic gallon jug of MetriWash was sitting in the dirty scrub room. Instructions on the container read as follows, MetriWash (Instrument detergent concentrate)... Dilute MetriWash 1/4 oz (ounce) to 2 oz. per gallon of tap water. Discard diluted MetriWash after each use. Employee #7 was also asked how often do you change the sponge that you use to clean the equipment, wipe down the counters and sinks with and he/she replied, "Once a week, on Thursdays." According to the USDA Agriculture Research Service (ARS) newsletter dated February 2008 "...Sponges were soaked in 10% bleach solution for 3 minutes, lemon juice for 1 minute, or pure water for 1 minute, placed in a microwave oven for 1 minute at full power, or placed in a dishwasher for a full wash-dry cycle, or left untreated (control). Microwaving and dishwashing treatments significantly lowered bacterial counts compared to	T 175		

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T 175	Continued From Page 9 any of the immersion chemical treatments or the control. Counts of yeasts and molds recovered from sponges receiving microwave or dishwashing treatments were significantly lower than those recovered from sponges immersed in chemical treatments." According to ARS website Best Ways to Clean Kitchen Sponges - April 23, 2007 - News from the USDA Agricultural Research Service.mht read: "...treated each sponge in one of five ways: soaked for three minutes in a 10 percent chlorine bleach solution, soaked in lemon juice or deionized water for one minute, heated in a microwave for one minute, placed in a dishwasher operating with a drying cycle-or left untreated...They found that between 37 and 87 percent of bacteria were killed on sponges soaked in the 10 percent bleach solution, lemon juice or deionized water-and those left untreated. That still left enough bacteria to potentially cause disease. Microwaving sponges killed 99.99999 percent of bacteria present on them, while dishwashing killed 99.9998 percent of bacteria..." After cleaning the used instruments, employee #7 pulled off both pair of gloves and picked up the cleaned instruments and walked them across the hall into the clean scrub room where they were deposited on top of a large stack of blue paper. Blue paper is used to wrap the instruments in before they are placed in the autoclave (sterilizing device). Next to the blue paper on the counter were at least 10 piles of gloves and 4 x 4's'. Before wrapping the recently cleaned instruments, employee #7 picked up one pack of gloves and 4 x 4's and placed them on top of the instruments, wrapped them and applied a special type of masking tape. After completing this task, employee #7 walked across the hall and began the previous procedure of cleaning instruments.	T 175		

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T 175	Continued From Page 10 At no time was employee #7 observed donning protective clothing or washing hands between the clean and dirt scrub rooms. The same clothes (scrubs) were worn to work in the clean and then the dirty scrub room. While this writer was observing in the clean scrub room it was noted that a mop and bucket used for cleaning the floors was sitting in a back corner, a clean mop head (previously used and washed) was stored on top of boxes immediately below the autoclave and rolls of paper used to cover the exam tables were also stored in the clean scrub room. Behind the door was a large telecommunication panel on the wall. The panel and all it's wires were open to the room. There did not appear to be any means of placing a cover over the panel thus leaving it open with no means of keeping it free of dust or debris. Outside the scrub rooms in the hallway were two (2) receptacles, one for dirty or used linen and one was a cardboard box with a red bag in it for contaminated or bio-hazard waste. There was no separate area designated for the bio-hazard waste or the receptacle with the used dirty linens. During the initial tour of the facility observations were also made in the facility's laundry room. The room contained a standard washer and dryer. Employee #9 reported that linens are washed in hot water with one cup of bleach added to each load. Employee #9 was not able to confirm that linens were washed at the correct water temperature of 160 degrees Fahrenheit. There was no thermometer to measure the temperature of the hot water and the washer did not have a water temperature booster or a separate water heating unit attached to the water line.	T 175		

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	FTAF-011	A. BUILDING _____ B. WING _____	05/21/2012

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T 290	Continued From Page 11	T 290		
T 290	12 VAC 5-412-270 Equipment and supplies 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: 1. A bed or recliner suitable for recovery; 2. Oxygen with flow meters and masks or equivalent; 3. Mechanical suction; 4. Resuscitation equipment to include; as a minimum, resuscitation bags and oral airways; 5. Emergency medications, intravenous fluids, and related supplies and equipment; 6. Sterile suturing equipment and supplies; 7. Adjustable examination light; 8. Containers for soiled linen and waste materials with covers; and 9. Refrigerator. This RULE: is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain adequate medical equipment. Specifically, the facility failed to have a suction machine on the premises for emergent medical care. Also, the facility maintained a box of supplies for emergent medical situations; the box had two laryngoscope blades but failed to have the base unit which is needed to make the laryngoscope work. The findings were: During the initial tour of the facility (May 21, 2012) the Administrator opened the "Emergency Box." An Emergency Box contains medications used during life threatening situations and various other medical equipment that may be used during a life threatening emergency, some of those items were, intravenous fluids, needles, airways and two	T 290	12 VAC 5-412-270 Equipment and Supplies On May 23, 2012 the facility purchased a suction machine. Also purchased were two new laryngoscope blades and two new base units with two new coordinating base units. Furthermore, the Medical Director inspected the Medical Box for any further oversights and confirmed the adequacy of the box, its equipment, and medications. The Nursing Supervisor will monitor this adequacy and currency on a monthly basis.	

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T 290	Continued From Page 12 (2) laryngoscope blades. A Laryngoscope is device used by a trained medical professional to open a patient's airway and insert a special tube (endotracheal tube) to assist a patient's breathing. The box contained the laryngoscope blades but failed to contain the base unit which is needed to use the blades. A suction machine is also needed at the time a medical professional is attempting to insert an airway. There was no suction machine on the counter with the Emergency Box. The Administrator was asked where the base unit and suction machine might be located. The Administrator explained that he/she was not a medical professional and was not aware of any additional equipment. No other equipment was noted on or near the counter where the Emergency Box was stored. No medical professionals were in the facility during this portion of the tour.	T 290		
T 375	12 VAC 5-412-360 A Maintenance A. The facility's structure, its component parts, and all equipment such as elevators, heating, cooling, ventilation and emergency lighting, shall be all be kept in good repair and operating condition. Areas used by patients shall be maintained in good repair and kept free of hazards. All wooden surfaces shall be sealed with non-lead-based paint, lacquer, varnish, or shellac that will allow sanitization. This RULE is not met as evidenced by: Based on observations made during the initial tour of the facility (May 21, 2012), it was determined that the facility failed to ensure that equipment was kept in good repair, free of hazards or maintain infection control precautions for the cleaning and disinfection of all surfaces. More specifically, one (1) of two (2) suction machines	T 375	On June 19, 2012 all rust was removed from the suction machine in room #2, and the surface of the machine was painted. Staff was made aware of the importance of reporting rust spots and other deficits to the integrity of equipment surfaces. As of May 31, 2012 all metal paper towel dispensers have been replaced with plastic dispensers. As of June 20, 2012 the Mechanical room floor has been completely re-tiled with new linoleum.	

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T 375	Continued From Page 13 used in the procedures rooms could not be completely cleaned or sanitized due to multiple rusted areas that were located on the front metal panels of the machine. Rust was also apparent on one (1) of at least ten (10) paper towels holders in the facility. Additionally, the floor in the Mechanical room was missing approximately 20% of the linoleum like tile and had dirt and debris scattered throughout the room on the floor. The findings were: During the initial tour of the facility on May 21, 2012 beginning at 10 AM procedure room #2 was examined. The suction machine used during procedures, had multiple areas of what appeared to be rust on the front panels. The Administrator who accompanied this writer on the tour was asked to look at the front of the suction machine and describe what he/she saw. The Administrator remarked that he/she saw rust on the panels of the machine. In the bathroom across the hall from procedure room #2 was a metal paper towel dispenser mounted on the wall. The front of the dispenser had multiple areas of rust on it. The Administrator acknowledged the rust on the dispenser and stated, "We've replaced most of these with plastic one's, that does look like rust." The Mechanical room where the main heating and air conditioning units are located had a large area, approximately 20% of the floor that was missing tile. Debris and dirt were noted all over the floor.	T 375		
T 400	12 VAC 5-412-380 Local and state codes and standards Abortion facilities shall comply with state and	T 400		

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T 400	Continued From Page 14 local codes, zoning and building ordinances, and the Uniform Statewide Building Code. In addition, abortion facilities shall comply with Part 1 and sections 3.1-1 through 3.1-8 and section 3.7 of Part 3 of the 2010 Guidelines for Design and Construction of Health Care Facilities of the Facilities Guidelines Institute, which shall take precedence over Uniform Statewide Building Code pursuant to Virginia Code 32.1-127.001. Entities operating as of the effective date of these regulations as identified by the department through submission of Reports of Induced Termination of Pregnancy pursuant to 12 VAC 5-550-120 or other means and that are now subject to licensure may be licensed in their current buildings if such entities submit a plan with the application for licensure that will bring them into full compliance with this provision within two years from the date of licensure. Refer to Abortion Regulation Facility Requirements Survey workbook for detailed facility requirements. This RULE is not met as evidenced by: Based on observations and interview during a tour of the facility and interview, it was determined the facility failed to have an architect's attestation and failed to meet FGI (AIA) Guidelines for Chapters 3.1 and 3.7. The findings were: On May 21, 2012 a tour of the facility was conducted with the Administrator from approximately 12 noon to 3:30 PM. During the tour, there was no evidence that the facility was in compliance with state and local codes and building ordinances as evidenced by: - No hand washing sink in the Recovery area, - Both procedure rooms had less than 3 feet of space between the procedure tables and the wall,	T 400	12 VAC 5-412-380 Local and State Codes and Standards The finding of deficiency for noncompliance with 12VAC5-412-380 is inappropriate because ACWHC submitted a plan for coming into compliance with this regulation along with its application, as the regulations clearly allowed. If the Department refuses to remove the finding, it should grant ACWHC a variance. The plan that ACWHC submitted with its application for licensure continues to be the most accurate statement of its plans to comply with this regulation within two years of licensure. Furthermore, on June 15, 2012 The Board of Health of Virginia passed permanent regulations exempting existing facilities from having to comply with these architectural requirements. In an effort to provide the Department with an update on our implementation of our plan, following is a timeline for our work over the next several months: March 13, 2012 - Brought in an architect to do an assessment of ACWHC's facility for compliance with 12VAC5-412-380. June 1, 2012- Received written report of architect's assessment. Reviewed. July-Oct. 2012 - Gather information about: compliance with any section of buidling code that may be applicable based on the date of the building's construction, contact the local building department to schedule an inspection; compliance with the fire code, contact fire marshal to schedule an inspection; HVAC system and inspections, schedule inspections or evaluation visits as appropriate; insulation rating, follow up with architect to get referrals for a contractor who can provide that information. Nov. 2012 - Assess information gathered and create a timeline for gathering any outstanding information by end of 2012.	

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T 400	Continued From Page 15 - No evidence of a separate room or closet for clean or clinical supplies, - no verification of ventilation, humidity or temperature control in the area where sterile supplies are stored, - No designated room for soiled linen receptacles, which are presently stored in the hall, - The freezer used to store the products of conception is stored in the clean scrub room, there is no separate designated area for it, - Red bag bio-hazard waste has no designated area to be stored and secured in. Presently left in the hallway, - No environmental room, - No equipment room for telecommunication panel, presently in clean scrub room, - An area rug (approximately 5' x 8' in size) is in a counseling room and is not secured or glued to the floor, - Air flow/exchanges for rooms is unknown, - No documentation on type of insulation, - No documentation regarding HVAC ductwork, filtering efficiency or filter frame, and - no labeling for plumbing or piping system. The Administrator stated that an architect had been onsite late March and was in the process of documenting those findings. The Administrator called the architect's office and spoke with the architect. The Administrator was told by the architect, "I don't know what an attestation is..."	T 400	Dec. 2012-Complete information gathering process. Jan.-April 2013 - In consultation with an architect, evaluate whether renovations are necessary and/or feasible. Assess availability and affordability of loans that would be necessary to complete such renovations. Evaluate whether seeking any variances from discrete requirements would allow ACWHC to comply with 12VAC5-412-380 and consult the Department for information about the process of seeking any such variances and the documentation required. Submit any requests with appropriate documentation. Contingent on the feasibility, cost, and variances possible, if renovations can be done, establish a timeline for developing a plan for construction, submitting for bids, evaluating bids and hiring a contractor. Consult with the Department of Health concerning timeline. If renovations cannot be done, evaluate whether to move to a new location. Establish a timeline for talking to a broker, assessing the available commercial real estate stock, availability and affordability of loans that would be necessary to accomplish a move, and for deciding whether the costs of such a move would be affordable by ACWHC in the long run. Consult with the Department of Health concerning timeline. May-Nov. 2013 - If renovations are possible, begin moving forward on the items in the timeline for renovations. If renovations are not possible, begin moving forward on the items in the timeline for evaluating whether to move. Dec. 2013-July 2014 - If renovations are possible, attempt to complete all necessary work during this period. If renovations are not possible, attempt to complete the process of moving during this period. Evaluate and seek any variances necessary, depending on the rapidity of either process, in consultation with the Department.	