Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SA000003	A. BUILDING: _____ B. WING _____	07/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLE WOMAN'S HEALTH OF BALTIMORE, LLC	7648 BELAIR ROAD BALTIMORE, MD 21236

(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
A 000	Initial Comments A licensure survey of Whole Woman's Health of Baltimore was conducted on July 10 and 11, 2018. An exit interview was conducted on July 11, 2018. The center performs surgical abortion procedures. The facility includes two procedure rooms. The survey included: an on-site visit; an observational tour of the physical environment; observation of the patient laboratory (blood draw) process; observation of patient ultrasound process; observation of patient education process; observation of patient discharge process; observation of hand hygiene; observation of instrument cleaning/sterilization process; interview of the facility's administrator, medical director, registered nurse, counselor's, medical assistants, patient advocates; review of the policy and procedure manual; review of clinical records; review of the personnel files; review of quality assurance and infection control program, and review of professional credentialing. A total of seven patient clinical records were reviewed. The procedures were performed between February 2017 and July 2018. Findings in this report are based on data present at the time of review. The agency's staff was kept informed of the survey findings as the survey progressed. The agency staff was given the opportunity to present information relative to the findings during the course of the survey. A key code for the patients was provided to the facility at exit.	A 000		

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A 600	Continued From page 1	A 600		
A 600	.05(C)(5) .05 Administration (5) Infection control for patients and staff; This Regulation is not met as evidenced by: Based on patient observations, review of infection control training policy, review of staff infection control training and interview of the staff, it was determined that the staff failed to implement infection control policies and failed to ensure that measures to prevent infection were practiced at the facility. These measures included failed to don gloves when cleaning patient equipment and failed to perform hand hygiene. The findings include. Patients: F, G, H, I 1. Observation of Patient F's ultrasound on July 11, 2018 at 8:35 AM revealed, the staff member did not perform hand hygiene before donning gloves. The staff member performed the ultrasound, removed the gloves and did not perform hand hygiene. The staff member left the room with the patient. Observation of patient F's blood draw on July 11, 2018 at 8:50 AM revealed, the staff member donned gloves without performing hand hygiene. The staff member wiped the patient's finger with an alcohol pledge, pricked the finger and collected the patient's blood on a slide. The staff member then repeated the same blood draw a second time. After the testing the patient's blood for two different tests the staff member disposed of the slides into the medical waste. The staff member documented in the patient's medical record, then cleansed the patient's finger and applied a band-aid. The staff member removed their gloves, did not perform hand hygiene and	A 600		8/16/18

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A 600	Continued From page 2 wiped their hands on their pants. 2. Observation of Patient's G's blood draw on July 11, 2018 at 9:30 AM revealed, the staff member donned gloves without performing hand hygiene. The staff member wiped the patient's finger with an alcohol pledge, pricked the finger and collected the patient's blood on a slide. The staff member then repeated the same blood draw a second time. After the testing the patient's blood for two different tests the staff member disposed of the slides into the medical waste. The staff member documented in the patient's medical record, then cleansed the patient's finger and applied a bandaid. The staff member removed their gloves, performed hand hygiene with hand gel. The staff member did not allow the gel to dry and the staff member wiped their hands dry on their pants. 3. Observation of the staff in the recovery room area on July 11, 2018 at 11:51 AM revealed the staff member donned gloves without performing hand hygiene. The staff member then discontinued Patient I's intravenous port. 4. Observation of the staff in the recovery room area on July 11, 2018 at 12:10 PM revealed the staff member placed a blood pressure cuff on Patient H's upper right arm. After removing the blood pressure cuff the staff member donned a glove on the right hand leaving the left hand ungloved and withdrew a germicidal disposable wipe. The staff kept the wipe in his/her right hand and cleaned the blood pressure cuff while holding the patient use items with the ungloved left hand. The staff transferred the patient used item to the ungloved hand re-contaminating the patient use item. The staff then disposed of the germicidal wipe. The staff failed to follow the manufactures	A 600		

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A 600	Continued From page 3 instructions and to wear gloves when handling germicidal wipes. The staff did not perform hand hygiene per manufacturers instructions after disposal of the wipe. Review of the manufacturers directions on the disinfection wipe label revealed, "When using this product wear disposable protective gloves, gowns, face mask or eye coverings. Wash hands thoroughly with soap and water after handling." Review of the policy manual and interview of the staff on July 11, 2018 at 12:30 PM reveals the center follows and trains the staff using the OSHA bloodborne pathogens procedure that includes hand hygiene annually. Review of staff training files on July 10, 2018 at 11:30 AM reveals the staff have been trained using OSHA bloodborne pathogens training that includes hand hygiene annually. Interview of staff on July 11, 2018 at 12:30 PM revealed the staff was not aware of the infection control breaches.	A 600		
A 790	.06(B)(9) .06 Personnel (9) Data provided by the National Practitioner Data Bank. This Regulation is not met as evidenced by: Based on review of professional credentialing files for physicians, review of policies and procedures and interview of the staff, it was determined that three of three physician credentialing files reviewed were incomplete did not contain National Practitioner Data Bank information.	A 790		9/7/18

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A 790	Continued From page 4 The findings include. Review of physician's credentialing files revealed, the files did not include information from the National Practitioner Data Bank regarding claims against physicians. Review of the policies for personnel revealed, "Credentialing and verification: All LIP's (Licensed Independent Practitioner) (as applicable) will be checked against the National Practitioner Data Bank and enrolled in continuous query." Interview of the staff on July 10, 2018 at 2:30 PM revealed, the staff was not aware the National Practitioner Data Bank are missing from the credentialing files.	A 790		
A 810	.06(D)(1) .06 Personnel D. The administrator shall establish a procedure for the biennial reappointment of a physician which includes: (1) An update of the information required in §B of this regulation; and This Regulation is not met as evidenced by: Based on review of the policies, physician credentialing file and interview of the staff, it was determined that the scope of procedures performed and medical staff privileges were not reappraised by the center staff for three of three files reviewed. The findings include. Review of the agency policy revealed, "The	A 810		7/10/18

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A 810	Continued From page 5 revision or renewal of a LIP's (Licensed Independent Practitioner) privileges will occur at least every 2 years and includes primary source verification (verification by the original source of a specific credential to determine the accuracy of a qualification report by an individual health care practitioner) of expiring or expired credentials, a synopsis peer review results for the 2 year period and/or any relevant performance improvement information. Similar to the original granting of privileges, approval of subsequent privileges is vested in the governing board based on recommendations from the Medical Department Director and the CEO." Review of medical staff credentialing files revealed medical staff privileges were last reappraised on the following years: November 11, 2012, September 28, 2014 and March 17, 2016. Interview of the staff on July 10, 2018 at 2:30 PM revealed the privileges have not been reappraised.	A 810		
A1490	.14 (A) .14 Patients' Rights and Responsibilities The administrator shall ensure that the facility develops and implements written policies and procedures concerning patients ' rights and responsibilities, including but not limited to: A. The opportunity to participate in planning their medical treatment; and This Regulation is not met as evidenced by: Based on review of the patient rights statement and interview of the staff it was determined that the staff failed to maintain a current patient rights	A1490		8/10/18

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A1490	Continued From page 6 statement. The findings include. Review of the patient rights statement on July 11, 2018 at 11 AM revealed the statement does not include the patient has the opportunity to participate in planning their medical treatment. Interview of staff on July 11, 2018 at 12 PM revealed that the staff was not aware that the rights statement was incomplete.	A1490		