NOV 24 2015

PRINTED: 10/01/2015
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ab0015	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 08/27/2015

NAME OF PROVIDER OR SUPPLIER: **A WOMAN'S CHOICE OF GREENSBORO**

STREET ADDRESS, CITY, STATE, ZIP CODE: **2425 RANDLEMAN RD, GREENSBORO, NC 27406**

(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
E 132	.0303 POLICIES AND PROCEDURES 10A-14E .0303 The governing authority shall prepare a manual of clinic policies and procedures for use by employees, medical staff, and contractual physicians to assist them in understanding their responsibilities within the organizational framework of the clinic. These shall include: (1) Patient selection and exclusion criteria, and clinical discharge criteria. (2) Policy and procedure for each type of abortion procedure performed at the clinic. (3) Protocol for determining fetal age. (4) Protocol for referral of patients for whom services have been declined. (5) Protocol for discharge instructions that informs patients who to contact for post-procedural emergencies. This Rule is not met as evidenced by: Based on policy and procedure reviews and staff interviews, the facility staff failed to prepare a policy for selection and exclusion criteria, for each type of abortion completed at the center, and for the protocol for determining fetal age. The findings included: Review of policies and procedures on 08/26/2015 did not reveal policies for selection and exclusion criteria, for each type of abortion performed at the clinic or the protocol for determining fetal age. Interview with Administrative Staff (AS) # 1 on	E 132	The Regional Manager and Director of Patient Services implemented polices for selection and exclusion criteria for each type of abortion peformed at the clinic and a protocol for determining fetal age.	9/4/15

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda M. Spence

TITLE: regional manager

(X6) DATE: 10/30/15

11/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ab0015	A. BUILDING: ______ B. WING ______	08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A WOMAN'S CHOICE OF GREENSBORO	2425 RANDLEMAN RD GREENSBORO, NC 27406

(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
E 132	Continued From page 1 08/26/2015 revealed there was no available policy documentation for selection and exclusion criteria, for each type of abortion performed at the clinic or the protocol for determining fetal age. Interview revealed the types of abortions performed were on the facility website.	E 132		
E 137	.0305(A) MEDICAL RECORDS 10A-14E .0305 (a) A complete and permanent record shall be maintained for all patients including the date and time of admission and discharge; the full and true name; address; date of birth; nearest of kin; diagnoses; duration of pregnancy; condition on admission and discharge; referring and attending physician; a witnessed, voluntarily-signed consent for each surgery or procedure and signature of the physician performing the procedure; and the physician's authenticated history and physical examination including identification of pre- existing or current illnesses, drug sensitivities or other idiosyncrasies having a bearing on the operative procedure or anesthetic to be administered. This Rule is not met as evidenced by: Based on closed medical record reviews and staff and physician interviews, the clinic staff failed to maintain a complete permanent record including a signed consent for each surgical abortion with signature of the physician performing the procedure in 7 of 10 procedures performed (#1, 3, 5, 6, 7, 9, 10); and the physician's authenticated history and physical examination	E 137	A Womans Choice of Greensboro updated the medical records for the surgical and medical procedures The updated charts provide a section where the physicans can sign consent for each surgical or medical abortion. There is a section on the chart for the physcian to sign off on the history and physcial examination The Director of Patient Services will go over medical records daily to make sure information on the chart is filled out throughly and accurately. cont.	9/3/15

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ab0015	A. BUILDING: ____ B. WING ____	08/27/2015

NAME OF PROVIDER OR SUPPLIER: A WOMAN'S CHOICE OF GREENSBORO

STREET ADDRESS, CITY, STATE, ZIP CODE: 2425 RANDLEMAN RD, GREENSBORO, NC 27406

(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
E 137	Continued From page 2 (H&P) in 8 of 10 surgical or medical abortion procedures (# 2, 4, 5, 6, 7, 8, 9, 10). The findings included: 1. Review of medical record #1 revealed the patient had a SAB (Surgical Abortion) on 08/24/2015. Record review revealed documentation of a signed consent for the surgical procedure, but did not include the signature of the physician performing the procedure. Interview with Administrative Staff (AS) # 1 on 08/27/2015 revealed there was no documentation available of a signed consent for the surgical procedure with signature of the physician performing the procedure. Interview revealed clinic staff/ counselors have been signing/witnessing the consents. Interview with MD # 1 on 08/27/2015 revealed the physician has not been signing the surgical consents. 2. Review of medical record #2 revealed the patient had a MAB (Medical Abortion) completed on 08/22/2015. Record review did not reveal documentation of the physician's authenticated H&P. Interview with the AS # 1 on 08/27/2015 revealed H&P's have not been consistently done. Interview revealed if an H&P was done, documentation would include a note "PE (Physical Exam) done." Interview with MD # 1 on 08/27/2015 revealed the physician had been reviewing the history obtained by the clinic staff but had not been consistently completing a H&P on all patients.	E 137	The Director of Patient Service will audit medical records once a month, picking five charts randomly to ensure quality assurance. The doctor was educated about the change of medical records. 9/4/15	9/4/15

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ab0015	A. BUILDING: ______ B. WING ______	08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A WOMAN'S CHOICE OF GREENSBORO	2425 RANDLEMAN RD GREENSBORO, NC 27406

(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
E 137	Continued From page 3 3. Review of medical record # 3 revealed the patient had a SAB on 08/20/2015. Record review revealed documentation of a signed consent for the surgical procedure, but did not include the signature of the physician performing the procedure. Interview with the AS # 1 on 08/27/2015 revealed there was no documentation available of a signed consent for the surgical procedure with signature of the physician performing the procedure. Interview revealed clinic staff/ counselors have been signing/witnessing the consents. Interview with MD # 1 on 08/27/2015 revealed the physician has not been signing the surgical consents. 4. Review of medical record #4 revealed the patient had a MAB on 08/14/2015. Record review did not reveal documentation of the physician's authenticated H&P. Interview with the AS # 1 on 08/27/2015 revealed H&P's have not been consistently done. Interview revealed if an H&P was done, documentation would include a note "PE (Physical Exam) done." Interview with MD # 1 on 08/27/2015 revealed the physician had been reviewing the history obtained by the clinic staff but had not been consistently completing a H&P on all patients. 5. Review of medical record #5 revealed the patient had a SAB on 08/11/2015. Record review revealed documentation of a signed consent for the surgical procedure, but did not include the signature of the physician performing the procedure. Further review did not reveal	E 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ab0015	A. BUILDING: ______ B. WING ______	08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A WOMAN'S CHOICE OF GREENSBORO	2425 RANDLEMAN RD GREENSBORO, NC 27406

(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
E 137	Continued From page 4	E 137		

documentation of the physician's authenticated H&P.

Interview with Administrative Staff (AS) # 1 on 08/27/2015 revealed there was no documentation available of a signed consent for the surgical procedure with signature of the physician performing the procedure. Interview revealed clinic staff/ counselors have been signing/witnessing the consents. Interview revealed H&P's have not been consistently done and if a H&P was done, documentation would include a note "PE (Physical Exam) done".

Interview with MD # 1 on 08/27/2015 revealed the MD has not been signing the surgical consents. Interview revealed the MD had been reviewing the history obtained by the clinic staff, but had not been consistently completing a H&P on all patients.

6. Review of medical record #6 revealed the patient had a SAB on 08/04/2015. Record review revealed documentation of a signed consent for the surgical procedure, but did not include the signature of the physician performing the procedure. Record review did not reveal documentation of a physician's authenticated H&P.

Interview with AS # 1 on 08/27/2015 revealed there was no documentation available of a signed consent for the surgical procedure with signature of the physician performing the procedure. Interview revealed clinic staff/ counselors have been signing/witnessing the consents. Interview revealed H&P's have not been consistently done and if a H&P was done, documentation would include a note "PE (Physical Exam) done".

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ab0015	A. BUILDING: ______ B. WING ______	08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A WOMAN'S CHOICE OF GREENSBORO	2425 RANDLEMAN RD GREENSBORO, NC 27406

(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
E 137	Continued From page 5	E 137		

Interview with MD # 1 on 08/27/2015 revealed the MD had not been signing the surgical consents. Interview revealed the MD had been reviewing the history obtained by the clinic staff, but had not been consistently completing a H&P on all patients.

7. Review of medical record #7 revealed the patient had a SAB completed on 07/22/2015. Record review revealed documentation of a signed consent for the surgical procedure, but did not include the signature of the physician performing the procedure. Record review did not reveal documentation of a physician's authenticated H&P.

Interview with AS # 1 on 08/27/2015 revealed there was no documentation available of a signed consent for the surgical procedure with signature of the physician performing the procedure. Interview revealed clinic staff/counselors have been signing the consents. Interview revealed H&P's have not been consistently done and if a H&P was done, documentation would include a note "PE (Physical Exam) done".

Interview with MD # 1 on 08/27/2015 revealed the MD had not been signing the surgical consents. Interview revealed the MD had been reviewing the history obtained by the clinic staff, but had not been consistently completing a H&P on all patients.

8. Review of medical record #8 revealed the patient had a MAB on 07/08/2015. Record review did not reveal documentation of the physician's authenticated H&P.

Interview with the AS # 1 on 08/27/2015 revealed H&P's have not been consistently done. Interview

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ab0015	A. BUILDING: ______ B. WING ______	08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A WOMAN'S CHOICE OF GREENSBORO	2425 RANDLEMAN RD GREENSBORO, NC 27406

(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
E 137	Continued From page 6 revealed if an H&P was done, documentation would include a note "PE (Physical Exam) done." Interview with MD # 1 on 08/27/2015 revealed the physician had been reviewing the history obtained by the clinic staff, but had not been consistently completing a H&P on all patients. 9. Review of medical record #9 revealed the patient had a SAB on 07/21/2015. Record review revealed documentation of a signed consent for the surgical procedure, but did not include the signature of the physician performing the procedure. Record review did not reveal documentation of a physician's authenticated H&P. Interview with AS # 1 on 08/27/2015 revealed there was no documentation available of a signed consent for the surgical procedure with signature of the physician performing the procedure. Interview revealed clinic staff/ counselors have been signing the consents. Interview revealed H&P's have not been consistently done and if a H&P was done, documentation would include a note "PE (Physical Exam) done". Interview with MD # 1 on 08/27/2015 revealed the MD had not been signing the surgical consents. Interview revealed the MD had been reviewing the history obtained by the clinic staff, but had not been consistently completing a H&P on all patients. 10. Review of medical record #10 revealed the patient had a SAB on 03/25/2015. Record review revealed documentation of a signed consent for the surgical procedure, but did not include the signature of the physician performing the procedure. Record review did not reveal	E 137		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ab0015	A. BUILDING: ______ B. WING ______	08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A WOMAN'S CHOICE OF GREENSBORO	2425 RANDLEMAN RD GREENSBORO, NC 27406

(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
E 137	Continued From page 7 documentation of a physician's authenticated H&P. Interview with AS # 1 on 08/27/2015 revealed there was no documentation available of a signed consent for the surgical procedure with signature of the physician performing the procedure. Interview revealed clinic staff/ counselors have been signing the consents. Interview revealed H&P's have not been consistently done and if a H&P was done, documentation would include a note "PE (Physical Exam) done". Interview with MD # 1 on 08/27/2015 revealed the MD had not been signing the surgical consents. Interview revealed the MD had been reviewing the history obtained by the clinic staff, but had not been consistently completing a H&P on all patients.	E 137		
E 147	.0306(B) PERSONNEL RECORDS 10A-14E .0306 (b) Job Descriptions: (1) The facility shall have a written description which describes the duties of every position. (2) Each job description shall include position title, authority, specific responsibilities and minimum qualifications. Qualifications shall include education, training, experience, special abilities and license or certification required. (3) The facility shall review annually and update all job descriptions, and shall provide a current copy to each employee or contractual employee assigned to the position.	E 147	The Director of Patient Services created a detailed job description for the Registered Nurse The Staff at AWCG have a detailed job description where they will signoff understanding their job description. When their is a change in a job description the Director of Patient Services will make sure each employee understand and sign off on the job.	9/3/15 [illegible]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ab0015	A. BUILDING: ____ B. WING ____	08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A WOMAN'S CHOICE OF GREENSBORO	2425 RANDLEMAN RD GREENSBORO, NC 27406

(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
E 147	Continued From page 8 This Rule is not met as evidenced by: Based on personnel file review and administrative staff interview, the clinic failed to have evidence of employee job description available in 1 of 2 Registered Nurse (RN) employee files (RN#1). The findings include: Personnel file review of RN # 1 revealed a signed first page of a Nurse Aide Job Description. File review did not reveal a signed job description for a Registered Nurse. Interview on 08/27/2015 at 1600 with AS #1 (Administrative staff) revealed RN #1 personnel file did not include a job description for a RN. Further interview revealed AS # 1 could not locate an available copy of a RN job description in the facility.	E 147		
E 156	.0310 EMERGENCY BACK-UP SERVICES 10A-14E .0310 The facility shall provide intervention for emergency situations. These provisions shall include but are not limited to: (1) Basic cardio-pulmonary life support; (2) Emergency protocols for: (a) Venous access supplies, (b) Air-way support and oxygen, (c) Bag-valve mask unit with oxygen reservoir, and (d) Suction machine; (3) Emergency lighting available in the operating room; and (4) Ultrasound equipment. This Rule is not met as evidenced by:	E 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ab0015	A. BUILDING: ______ B. WING ______	08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A WOMAN'S CHOICE OF GREENSBORO	2425 RANDLEMAN RD GREENSBORO, NC 27406

(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
E 156	Continued From page 9 Based on policy and procedure review, observation during tours and staff interviews facility staff failed to provide for emergency situations by failing to have a functioning backup light in Operating Room (OR) # 1. The findings included: Policy and procedure review revealed a policy, no date, "EMERGENCY BACK-UP SERVICES ....Additional emergency equipment is available in each operating room including emergency lighting. ..." Observation during tour on 08/26/2015 at 1300 revealed the back up lighting in OR # 1 did not work. Interview with AS # 1 on 08/27/2015 at 1600 revealed the back up lighting in OR # 1 was not still functioning.	E 156	A Womans Choice of Greensboro had Dye Barker Emergency Light Service come out to replace faulty equipment. They will come out 3-5 years to check lights unless needed before then. The Director of Patient Services implented an Emergency Light log that will be signed off monthly to ensure quality assurance.	9/3/15 9/3/15
E 165	.0314 CLEANING OF MATERIALS AND EQUIPMENT 10A-14E .0314 (a) All supplies and equipment used in patient care shall be properly cleaned or sterilized between use for different patients. (b) Methods of cleaning, handling, and storing all supplies and equipment shall be such as to prevent the transmission of infection through their use. This Rule is not met as evidenced by: Based on policy and procedure review, review of disinfectant solution manufacturer's guidelines, observation and staff interviews, the clinic failed	E 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ab0015	A. BUILDING: ______ B. WING ______	08/27/2015

NAME OF PROVIDER OR SUPPLIER: **A WOMAN'S CHOICE OF GREENSBORO**

STREET ADDRESS, CITY, STATE, ZIP CODE: **2425 RANDLEMAN RD, GREENSBORO, NC 27406**

(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
E 165	Continued From page 10 to prevent the transmission of infection by: A. failing to have policies for the cleaning of surgical instruments that specified the concentrations of chemicals to be used for instrument cleaning, and B. failing to perform biological testing according to manufacturers' recommendation for steam sterilization of the surgical instruments. The findings included: A. Interview of AS (Administrative Staff) #1 on 08/27/2015 at 1430 revealed no policy for cleaning of surgical instruments. Review of manufacturer's guidelines of Glutaraldehyde 28 day package insert revealed "Immerse medical equipment/device completely in Pro Advantage 28-Day solution for a minimum of 90 minutes at 25 degrees C (Celsius) to destroy...pathogenic microorganisms (germs)....Remove devices and equipment from the solution and rinse thoroughly following the rinsing instructions below. C) Rinsing Instructions: Following immersion in Pro Advantage 28-Day solution, thoroughly rinse the equipment or medical device by immersing it completely in three separate copious volumes of water. Each rinse should be a minimum of one minute in duration unless otherwise noted by the device or equipment manufacturer. Use fresh portions of water for each rinse. Discard the water following each rinse. Do not reuse the water for rinsing or any other purpose, as it will be contaminated with glutaraldehyde." Observation on 08/27/2015 at 1500 revealed instruments were rinsed with tap water then soaked in sink with 1/2 amount of water and 1/2 amount of Glutaraldehyde. Observation revealed surgical instruments were rinsed once with tap	E 165	A) The Regional Manager and Director of Patient Services implemented a policy on how to clean surgical instrument. Staff are trained and educated on how to properly clean surgical instruments by the Director of Patient Services. Staff will sign and date the policy to ensure each employee has been trained.	9/21/15

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ab0015	A. BUILDING: ______ B. WING ______	08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A WOMAN'S CHOICE OF GREENSBORO	2425 RANDLEMAN RD GREENSBORO, NC 27406

(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
E 165	Continued From page 11 water after soaking. Observation revealed amounts of water and solution were made by visualization not measurements. Surgical instruments were then placed on towel on shelf awaiting autoclave for sterilization. Observation of bottle of Glutaraldehyde revealed no opened date on bottle. Further observation revealed no timer or thermometer used for soaking of instruments. Further observation revealed a plastic container sitting on the counter with a blue lid. Other surgical instruments were observed sitting in clear liquid in the container. Interview of Certified Nursing Assistant (CNA) #1 on 08/27/2015 at 1500 revealed no policy for amount of solution added to sink. "I fill the sink up with 1/2 water and 1/2 Glutaraldehyde. That is what I was taught on orientation." Interview revealed instruments are left soaking until the next case, then rinsed and placed on towel for autoclave. Further interview revealed no specific amount of time is used to soak instruments. Interview of AS #1 on 08/27/2015 at 1430 revealed there is a policy for cleaning tubing but no policy for cleaning surgical instruments. B. Policy and procedure review did not reveal a policy/ procedure on the autoclave for frequency of biological/ spore testing (testing to ensure items are sterile after processing). Direct observation during tour revealed an autoclave (heat/ steam sterilizer) for sterilizing instruments. Interview during tour with AS # 1 on 08/26/2015 around 1330 revealed the clinic was using "a 3 strip biological monitoring service that provides increased testing accuracy." Interview revealed it is a mail in service.	E 165	A Womans Choice of Greensboro use Crosstex as their biological monitoring service. Crosstex mail them a maxi test to use quarterly to ensure auto clave is working efficiently The Director of Patient service will make sure this is done quarterly to ensure quality assurance. The results are emailed or fax to the clinic. If there is a failure the report is fax or emailed immediately with a follow up phone call to verify receipt of report	9/4/15

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ab0015	A. BUILDING: ______ B. WING ______	08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A WOMAN'S CHOICE OF GREENSBORO	2425 RANDLEMAN RD GREENSBORO, NC 27406

(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
E 165	Continued From page 12 Observation of the back of a testing package on 08/27/2015 revealed "...RECOMMENDED USE The Centers for Disease Control and Prevention (CDC)....recommend weekly spore testing of all heat sterilizers. ..." Interview on 08/27/2015 with AS # 1 revealed the clinic sent their first one "last Thursday" (6 weeks after the clinic opened) and had not received results back yet. AS # 1 stated the company had told AS # 2 they should do this quarterly. Follow-up interview around 1530 revealed AS # 1 had not located documentation confirming acceptability of quarterly spore (biologic) testing.	E 165	Revised 11/23/15 A Womans Choice of Greensboro used Biological monitoring test from Henry Schein. The maxi test will be done weekly to ensure the auto clave is working efficiently. The staff will be educated about the maxi test and how to use it by the Director of Patient Services on 11/24/15. They will sign and date the updated protocol sheet to ensure they were provided with the updated information and understand how to use the maxi test. The Director of Patient Services will monitor the staff for month to make sure they are doing the maxi test properly	11/23/15

Brenda M. Spence regional manager 11/23/15