Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	C5103	A. BUILDING _____ B. WING _____	05/01/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REPRODUCTIVE HEALTH SERVICES	811 SOUTH PERRY STREET MONTGOMERY, AL 36104

(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
L 100	ALABAMA LICENSURE DEFICIENCIES THE FOLLOWING ARE LICENSURE DEFICIENCIES AND REQUIRE A PLAN OF CORRECTION. This Rule is not met as evidenced by: 420-5-1-.03(7)(b) Pharmaceutical Services (b) Administering, Dispensing, and Prescribing Drugs and Medicines. Only physicians and properly credentialed nurse practitioners and physician assistants may prescribe or order medications. Nurse practitioners and physician assistants may prescribe only those medications described in their individual collaborative agreements. Except for standing orders as permitted below, medications shall be prescribed for patients of the facility by patient name after an appropriate medical evaluation. Oral and telephone orders shall be received only by a physician, nurse practitioner, physician assistant, registered professional nurse, licensed practical nurse, or a pharmacist. Oral and telephone orders shall be immediately documented in writing by the individual receiving the order. Prescribing, dispensing, and administration of medications shall meet all standards required by law and by regulations of the State Board of Medical Examiners and the State Board of Pharmacy. Abortifacient medications shall be prescribed only by a physician. Abortifacient medications shall be administered only by a physician or by a nurse practitioner, physician assistant, registered professional nurse or licensed practical nurse, under the direct supervision of a physician. For the	L 100		

Health Care Facilities

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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L 100	Continued From page 1 purposes of this subsection, a physician is directly supervising the administration of an abortifacient medication when he [or she] is in the building and the administration is performed within the physician's sight or pursuant to the physician's written instructions concerning a specific patient given after the examination of the patient. Based on a review of medical records and interview it was determined the facility failed to have an order for medications administered, a policy for the use of abortifacient medications, and documentation of instruction to a patient regarding medications dispensed by the facility in 1 of 1 patient who received abortifacient medications. This had the potential to affect all patients served. Findings include: 1. Medical Record # 09-121 had a therapeutic suction curettage abortion performed 2/13/09. The following information was found on plain paper hand written by different staff and the physician. The patient returned for her follow-up visit 3/03/09 and had an ultrasound which was reviewed by the physician 3/04/09. The patient was advised she needed to have a re-suction procedure due to "debris in the uterus." The re-suction procedure was performed 3/04/09. The patient returned 3/18/09 for her follow-up appointment at which time she had another ultrasound. This ultrasound showed a,"small space in uterus." The patient was,"given 8 tablets of Ergotrate 0.2 mg (milligrams) sublingual an instructed to take 1 every 8 hours and return to office for recheck 3/20/09. Pt. (patient) was also advised to call me back at 9:00 AM this AM to	L 100		

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L 100	Continued From page 2	L 100		

see what Dr.... wants her to do. Verbalized understanding."
On 3/18/09 at 9:50 AM, "Chart reviewed recommend that pt. RTC (return to clinic) on 3/20/09 for repeat sono (sonogram), exam, and pregnancy test- may need another suction." This entry was signed by the physician. There was no order for the Ergotrate in the medical record from the physician.

On 3/20/09 at 7:55 AM, "Pt RTO (return to office) as instructed, ultrasound done an appears to be retained tissue in uterus. Pt. was advised she needed to see the Dr. this AM..." Patient also stated, "I can't go thru that again, I just can't" referring to re-suction. The next entry on the paper in the medical record documented, "Since pt. unwilling to allow repeat suction, will try Cytotec 800 mg buccally." This sentence was signed by the physician.

The next entry was from a registered nurse working in the facility, "Cytotec 200 mg phoned into pharmacist... at 9:40 AM. Pharmacist instructed to dispense Cytotec 200 mg x 4 & patient is to take as directed. Pharmacist stated that meds will be delivered to clinic before twelve noon."

There was no documentation of the following:

1. When the medication was given to the patient.

2. Who actually dispensed the medication to the patient.

3. If the physician was present in the building when the Abortifacient medication was given to the patient.

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L 100	Continued From page 3 4. What if any instruction was given to the patient regarding action and side effects of the medication. 5. An actual order from the physician for the medication. An interview with the LPN (licensed practical nurse) 4/29/09 at 1:30 PM regarding the use of the Cytotec confirmed that they did not have a policy for the use of Cytotec. An interview on 4/30/09 at 9:45 with Administrator, LPN, and the Registered Nurse who called the prescription to the drug store confirmed that they did not document the time the medication was given to the patient or any instructions. The Administrator stated that they did not usually give this medication. It was not even on the formulary and that was why they had to order it from the drug store. 420-5-1-.03 Patient Care. 3. The physician who is to perform the abortion or the referring physician is required to perform an ultrasound before the abortion. The woman has right to view the ultrasound before an abortion. The woman shall complete a required form to acknowledge that she either saw the ultrasound image or that she was offered the opportunity and rejected it. Based on review of records it was determined the facility failed to assure 2 of 18 patients acknowledged they saw the ultrasound image or were offered the opportunity and rejected to view the ultrasound image. This had the potential to affect all patients served.	L 100		

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L 100	Continued From page 4 Findings include: 1. Medical Record # 08-837 had a procedure on 11/05/08. The certification of opportunity to view ultrasound form in the record did not document if the patient reviewed or rejected to review the ultrasound before the abortion was performed. 2. Medical Record # 08-930 had a procedure on 12/17/08. The certification of opportunity to view ultrasound form in the record did not document if the patient reviewed or rejected to review the ultrasound before the abortion was performed. 420-5-1-.02 Administration. (3) There shall be a facility-wide quality improvement program to evaluate patient care and facility services. The program shall be ongoing, have statistical summaries and a written plan of implementation. Based on review of the quality improvement documentation the facility failed to assure there was a written plan in place to correct problem areas for patient care and facility services. This had the potential to affect all patients served. Findings include: On 4/28/09 at 2:35 PM the surveyors requested to review the Quality Improvement (QI) documentation from the Administrator. Upon review of the documentation there were only statistical summaries listed on forms that were signed by the Medical Director and Administrator. The statistical summaries identified areas of	L 100		

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L 100	Continued From page 5 concern (Patients calling in with cramps, heavy post procedure bleeding) but there were no action plans to address these areas. In an interview with the Administrator on 4/30/09 at 10:35 AM it was confirmed the facility did not have QI plans to address concerns found on the QI reviews. 420-5-1-.03 Patient Care. (8) Infection Control. 1. Reports of infections observed during any follow-up or return visit of the patient shall be made and kept as a part of the patient's medical record. Each facility shall maintain a surveillance logbook recording all follow-up visits and telephone inquiries in which infections or other complaints are reported or observed. This logbook shall be reviewed at least quarterly by the facility's medical director. The facility's medical director may specify certain patient complaints, such as mild cramps, which, in his professional opinion and judgment, do not warrant being recorded in the logbook. The logbook shall in all events contain documentation of the following: (i) Any report by a patient of severe cramps; (ii) Any report by a patient of passage of a blood clot as large or larger than three centimeters, or one and one fourth inches, in diameter (the approximate size of a fifty cent piece); (iii) Any report by a patient that she has passed tissue; (iv) Any report by a patient of foul-smelling discharge;	L 100		

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L 100	Continued From page 6 (v) Any report by a patient that she has soaked two or more sanitary pads in one hour; (vi) Any report by a patient of a body temperature of 100 degrees Fahrenheit or more; (vii) Any diagnosis of perforation of the uterus; and (viii) Any hospitalization of a patient for adverse conditions resulting from a procedure performed at the facility. Based on review of the infection control meeting minutes the facility failed to assure the Medical Director reviewed the surveillance log book at least quarterly. This had the potential to affect all patients served. Findings include: A review of the facility meeting minutes for 4/02/09 revealed there was no documentation the Medical Director had reviewed the surveillance logs for the first quarter of 2009. On 4/30/09, while the survey team was on-site, a staff member took the surveillance logs for the first quarter to the Medical Director's office for his signature.	L 100		