Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: C5103	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 08/03/2011

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 Patient Care (8) Infection Control 2. There shall be procedures to govern the use of sterile and aseptic techniques in all areas of the facility. Based on review of policies, observations and interview with administrative staff the facility failed to ensure sterile technique was utilized for the preparation of injectable medications. This had the potential to affect all patients served by this facility. Findings include: The policy titled Instruments and Sterilization included, "D. Lidocaine 1. Syringes will be drawn up using the sterile technique." On 8/02/11 at 1:35 PM Employee Identifier # 4, Licensed Practical Nurse, was observed preparing syringes with Lidocaine 1% from a 50 milliliter vial. The Lidocaine vial was open and dated 7/22/11. EI # 4 drew up two 10 ml syringes of Lidocaine without cleaning the septum of the vial with alcohol or other cleaning agent. An interview on 8/02/11 at 2:20 PM with EI # 1, Facility Administrator, confirmed sterile technique for the preparation of Lidocaine syringes had not been followed.	L 100		

Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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L 100	Continued From page 1 ************************ Based on observations and interview with administrative staff the facility failed to ensure disinfecting items are maintained in a safe and sanitary manner. This had the potential to affect all patients served by this facility. Findings include: During the initial tour of the facility on 8/02/11 at 8:15 AM two procedure rooms were observed to be set up for use. The suction machines in both rooms were observed with a covered container of 4 x 4 gauze in an alcohol solution and a covered container of betadine soaked cotton balls. None of the containers were labeled with the contents or date when prepared. An interview on 8/02/11 at 3:15 PM with Employee Identifier # 1, Facility Administrator, revealed betadine had not been used by a physician for two months. EI # 1 stated the containers should be labeled with the contents and when they were prepared. ********************* Based on observations and interview with Employee Identifier (EI) # 1, Facility Administrator, it was determined the facility staff failed to change gloves and wash/clean hands or clean examination tables between patients after procedures had been performed. This had the potential to affect all patients served by this facility. Findings include:	L 100		

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L 100	Continued From page 2 Observations of patient care were conducted on 8/3/11. On 8/3/11 at 9:05 AM, after a patient procedure was performed in treatment room # 1, EI # 2, Procedure Room Assistant #1, assisted the patient to the recovery room. EI # 2 returned from the recovery room and cleaned the lower 3/4 portion for the exam table, suction machine, the surgical table and surgical light with Clorox wipe. EI # 2 then prepared the room for the next patient, including placing a new surgical tray on the surgical table and opening the surgical package tape. EI #2 failed to change his/her gloves or wash/clean hands after the patient procedure and prior to cleaning the above mentioned items. On 8/3/11 at 9:40 AM the surveyor observed EI # 3, Procedure Room Assistant # 2 clean treatment room # 2 after a patient procedure was performed. EI # 3 removed the paper covering from the examination table and placed clean paper over the table. EI # 3 cleaned the exposed edges of the examination table, the stool and surgical table with a Clorox wipe. EI # 3 then placed an open surgical pack on the cleaned surgical table. EI # 3 failed to clean the entire lower 3/4 of the examination table prior to placing clean paper on the table. An interview was conducted on 8/3/11 at 12:40 PM with EI # 1, who verified neither Procedure Room Assistants cleaned the procedure rooms in between patients properly.	L 100		