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L 000	INITIAL COMMENTS An onsite licensure survey was conducted 5/10/16 deficiencies were cited and a plan of correction is required.	L 000		
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-.02 Administration. (2) Policies and Procedures. Policies and procedures for operation of the facility shall be formulated and reviewed annually by the governing authority. They shall include at least the following: (e) Provision for annual review and evaluation of the facility's policies, procedures, management and operation; This rule is not met as evidenced by: Based on review of the policy and procedure binder and sign in log the clinic failed to assure all currently employed staff completed the annual review of the clinic policies. This had the potential to affect all patients served. Findings include: On 5/10/16 at 9:20 AM, the surveyor reviewed with Employee Identifier (EI) # 1, Health Center Manager, the policy and procedure binder sign in log to show staff had completed the annual policy review. A review of the sign in log revealed no policy and procedure review had been completed for calendar year 2016.	L 100		

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L 100	Continued From page 1 The last documented review of the policy and procedure by clinic staff was as follows: Physician - last review 3/01/14 Nurse - last review 5/16/14 Health Center Manager - 11/2014 Health Center Assistant - 2/05/15 There was no documentation to show clinic staff had completed the annual policy review. *** 420-5-1-.02(5)(d)(2)Physician Qualifications. 2. Before a physician performs any procedure at the facility, the Medical Director shall credential each physician on the basis of his or her qualifications, and a file shall be kept at the facility detailing the qualifications and experience of each physician. This file must, at a minimum, include: (i) Proof of licensure in Alabama and all other states in which the physician is or has ever been licensed, (ii) A record of any adverse actions ever taken against the physician's license in Alabama or any other state, (iii) A current resume, (iv) A record of staff privileges at any accredited hospital in the United States, (v) A report from the National Practitioner Databank, and (vi) Proof of the nature of the physician's training and experience. This file shall be kept current. The medical director shall review the physician's qualifications at the time the physician is hired and at least yearly thereafter. This review shall include direct	L 100		

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L 100	Continued From page 2	L 100		

observation of the physician's clinical skills, and the results of this review shall be placed in the physician's file.

This rule is not met as evidenced by:

Based on review of personnel records to include physician credentialing files it was determined that 1 of 1 physician's file reviewed failed to have a yearly review documented by the medical director in the file. This had the potential to affect all patients served in this clinic.

Findings include:

A review of Employee Identifier (EI) # 3, Physician's credentialing file and personnel information revealed documentation of a Clinician Skills Checklist dated 7/2014 or 08/2014, the date was written over and difficult to decipher, which included documentation of Abortion Services to include:
Surgical Abortion, Medical Abortion, Post-abortion check- up, Recovery Room and Management of Complications. The form was signed by EI # 2, Medical Director 10/24/14.

The clinic Medical Director failed to document an annual review for EI # 3 for 2015.

In an interview 5/10/16 at 4:50 PM with EI # 1, Health Center Manager confirmed there was no documentation of a review for 2015 on EI # 3.

***

420-5-1-.03(6) Post Operative Procedures.
(a) Post Operative Observation. After an abortion procedure, patients shall be observed until a determination can be made whether any

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L 100	Continued From page 3	L 100		

immediate post operative complications are present. Patients shall either be discharged within twelve hours of admission in an ambulatory condition without need for further observation or acute care, or shall be offered transportation to a local hospital for further treatment. During and after an abortion procedure performed at an abortion or reproductive health center, a physician shall remain on the premises until all patients are discharged. The discharge order must be signed by the physician. Prior to discharge from the facility, the patient shall be provided with the name and telephone number of the physician who will provide care in the event of complications, and the name of the medications given at the abortion clinic.

This rule is not met as evidenced by:

Based on review of medical records and interview it was determined in 12 of 17 records reviewed that the facility failed to provide each patient with the name and telephone number of the physician who would provide care in an event of an emergency call and the name of all medications the patient received in the facility. This had the potential to affect all patients served.

Findings included:

The surveyors reviewed 12 medical records of patients who completed an abortion procedure and failed to receive the name of the physician who would respond to an emergency complication and the name of the medications received at the clinic on their discharge paperwork.

In an interview 5/10/16 at 4:45 PM Employee Identifier # (EI) 1, Health Center Manager stated

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L 100	Continued From page 4 that when they were copying forms they failed to copy the back of the form which included ,"Medications you took at the office today". EI # 1 stated they did not realize it and confirmed the information had not been provided to the patients. Prior to the survey exit the clinic staff had corrected the form. *** 420-5-1-.03 (8) Infection Control. 2. There shall be procedures to govern the use of sterile and aseptic techniques in all areas of the facility. This rule is not met as evidenced by: Based on observations of staff and standard of practice CDC (Center for Disease Control) Guidelines, the clinic failed to assure all staff completed hand washing appropriately. This had the potential to affect all patients served. Findings include: Guideline for Hand Hygiene in Health-Care Settings Recommendations of the Healthcare Infection Control Practices Advisory Committee and the Hand Hygiene Task Force Centers for Disease Control and Prevention: BOX 2." Elements of health-care worker educational and motivational programs Rationale for hand hygiene · Potential risks of transmission of	L 100		

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L 100	Continued From page 5	L 100		

microorganisms to patients
· Potential risks of health-care worker colonization or infection caused by organisms acquired from the patient
· Morbidity, mortality, and costs associated with health-care-associated infections

Indications for hand hygiene
· Contact with a patient's intact skin (e.g., taking a pulse or blood pressure, performing physical examinations, lifting the patient in bed)
· Contact with environmental surfaces in the immediate vicinity of patients
· After glove removal "

During observations on 5/10/16 at 3:45 PM the surveyor observed Employee Identifier (EI) # 1, Health Center Manager, setting up the procedure room for the first surgical procedure patient.

EI # 1 used sanitizing hand gel and then applied a pair of sterile gloves to open the sterile tray. She opened the tray and proceeded to lay out the instruments, removed the sterile gloves, placed a new pair of clean gloves on and continued to open syringe, needle, sterile bowl and speculum. EI # 1 changed gloves again, placed sterile gloves back on and then sorted the tray items and had the technician in the room pour Betadine in the small bowl and then covered the tray with a sterile towel.

EI # 1 changed gloves multiple times without performing hand hygiene or using hand sanitizer.

In an interview 5/10/16 at 5:00 PM, EI # 1 confirmed she washed her hands but not after each glove change.

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L 200	Continued From page 6	L 200		
L 200	ALABAMA LICENSURE DEFICIENCIES This Rule is not met as evidenced by: 420-5-1-.04(3)(d) Physical Environment (d) Fire Extinguisher. An all-purpose fire extinguisher shall be provided at each exit, special hazard areas and located so that a person will not have to travel more than 75 feet from any point to reach the nearest extinguisher. Fire extinguishers shall be of a type approved by the local fire department or State Fire Marshal and shall be inspected in accordance with the manufacturer's specifications, but not less than monthly. An attached tag shall bear the initials or name of the inspector and date inspected. Maintenance on each extinguisher shall be performed by trained personnel at least annually. Maintenance tags showing the year, month, and name of the individual performing maintenance shall be attached to the extinguisher. This rule is not met as evidenced by: Based on observation and interview it was determined that four of four fire extinguishers in the facility failed to have documented monthly inspections. This had the potential to affect all patients served. Findings Include: During a tour of the facility on 5/9/16 at 10:30 AM, the surveyor observed fire extinguishers without a documented monthly check as follows: a. In the patient care area there were two fire extinguishers. The last monthly check	L 200		

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L 200	Continued From page 7 documented on the tags were 2/26/16 and 3/18/16. b. In the clerical area the last monthly check documented on the tag was 3/18/16. c. In the front lobby waiting room the last monthly check documented was in 2015. In an interview on 5/10/16 at 4:45 PM with Employee Identifier # 1, Health Center Manager, it was confirmed the tags had not been updated monthly. *** 420-5-1-.04 Physical Environment. (6) Equipment and Supplies. (b) Preventive Maintenance. There shall be a schedule of preventive maintenance developed for all equipment in the facility integral to patient care to assure satisfactory operation thereof. This rule is not met as evidenced by: Based on observation of the blood glucose meter and x-ray illuminator light box, the clinic failed to assure preventive maintenance (PM) was completed for all patient used equipment. This had the potential to affect all patients served. Findings include: During a tour of the clinic on 5/09/16 at 10:00 AM, the surveyor observed the x-ray illuminator light box with a PM sticker showing the due date of the next PM check was to be completed 3/2015. During this same tour the surveyor observed in the laboratory an Assure Platinum blood glucose meter with no PM sticker.	L 200		

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L 200	Continued From page 8 *** 420-5-1-.04 Physical Environment. (6) Equipment and Supplies. (d) Medications and supplies which have deteriorated or reached their expiration dates shall not be used for any reason. All expired or deteriorated items shall be disposed of promptly and properly. Each facility shall examine all stored medications and supplies no less frequently than once each month and shall remove from its inventory all deteriorated items and all items for which the expiration date has been reached. The facility shall maintain a log recording each such examination with its date, time, the person conducting the examination, and a description of each item or group of items removed from inventory and the reason for such removal. This rule is not met as evidenced by: Based on observation the clinic staff failed to remove from use ultrasound test strips that had an expiration date of 4/14/16 and failed to remove from use expired medications from the Emergency Medications. This had the potential to affect all patients served. Findings include: During a tour of the facility on 5/09/16 at 10:00 AM, the surveyor observed in one of the two clinic exam rooms a bottle of Revital - Ox Solution test strips with an expiration date of 4/14/16. According to the Steris website the Test Strip is a chemical indicator designed exclusively to determine whether hydrogen peroxide, the active	L 200		

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L 200	Continued From page 9 ingredient in RESERT High Level Disinfectant Solutions, is above the minimum recommended concentration of 1.5%. On 5/9/16 during a tour of the facility at 10:45 AM the surveyors inspected the Emergency Kit drugs and observed Epinephrine 2 prepared syringes of 1:1000 boxes had expired 4/1/16. In an interview with Employee Identifier # 4, Registered Nurse, confirmed 5/9/16 at 10:45 AM the drugs were expired. Prior to the survey exit the clinic staff replaced the expired medication. *** 420-5-1-.04 Physical Environment. (3) General. (c) Structural Soundness. The building shall be structurally sound, free from leaks and excessive moisture, in good repair, and painted at intervals to be reasonably attractive inside and out. This rule is not met as evidenced by: Based on observation the clinic failed to assure ceiling tiles in the employee break room and the wall in the hallway across from the sterilization room was properly maintained. This had the potential to affect all staff at the clinic. Findings include: During a tour of the clinic on 5/09/16 at 10:35 AM, the surveyor observed in the employee break room a ceiling tile hanging down with the insulation inside the tile exposed. This ceiling tile	L 200		

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L 200	Continued From page 10 was located at one of the two entry room doors to the employee break room. During observations of care on 5/10/16 at 3:30 PM, the surveyor observed in the hallway across from the sterilization room above the wall mounted fire extinguisher a hole in the sheetrock. Next to the hole in the wall was a white broken faceplate.	L 200		