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
	C5101	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON WOMEN'S CENTER	**1011 MONTICELLO COURT MONTGOMERY, AL 36117**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 (4) Operative Procedures (c) Before a physician performs an abortion, the physician shall examine the fetus by use of ultrasound and by such other techniques as to produce a reasonably accurate method of determining the gestational age and viability of the fetus. After such examination, the physician shall enter into the patient's medical record the test or examinations performed, and his findings regarding viability. This regulation is not met as evidenced by: Based on a review of medical records, it was determined that although the facility was performing ultrasounds and determining gestational age, the physician failed to enter into the patient's medical record his findings regarding viability in 18 of 18 charts reviewed. ********** 420-5-1-.03(7)(d) Investigation of Infections 1. Reports of infections observed during any follow-up or return visits of the patient shall be made and kept as 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	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 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 judgement, 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; (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. The regulation is not met as evidenced by: Based on a review of medical records, answering service call logs, and interview, it was determined the facility failed to keep a surveillance log book recording complaints of	L 100		

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L 100	Continued From page 2 pain, infection, and patients requiring hospital admission related to a complication from an abortion. Findings include: The examples listed below should have been included in a facility surveillance logbook. None of them were. 1. The answering service call log records for the month of April 2006 was 10 pages long, had 36 calls, 28 of which were for directions, to schedule an appointment, or non-medical from information recorded by the call service. The remaining calls are broken down as follows: (i) Severe cramps; 2 patients called with this complaint. (ii) Passing large clots; 2 patients called with this complaint. (iv) Any report by a patient of foul smelling discharge; 3 patients called with this complaint. (viii) Any hospitalization for adverse conditions resulting from a procedure performed at the facility; 1 patient was hospitalized. The examples listed below should have been included in a facility surveillance logbook. None of them were. 2. The answering service call log records for the month of May 2006 was 16 pages long, had 56 calls 37 of which were for directions, to schedule an appointment, or non-medical from information recorded by the call service. The remaining calls are broken down as follows:	L 100		

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L 100	Continued From page 3 (i) Severe cramps; 9 patients called with this complaint and 2 patients with just a complaint of severe pain. (ii) Passing large clots; 1 patient called with this complaint. (iv) Any report by a patient of foul smelling discharge; 2 patients called with this complaint. (viii) Any hospitalization for adverse conditions resulting from a procedure performed at the facility. 1 patient was hospitalized. The examples listed below should have been included in a facility surveillance logbook. None of them were. 3. The answering service call log records for the month of June 2006 was 15 pages long, had 45 calls 34 of which were for directions, to schedule an appointment, or non-medical from information recorded by the call service. The remaining calls are broken down as follows: (i) Severe cramps; 3 patients called with this complaint. (ii) Passing large clots; 2 patients called with this complaint and 4 others called regarding severe or heavy bleeding and one called complaining of feeling weak. (iv) Any report by a patient of foul smelling discharge; 1 patient called with this complaint. (vi) Any report by a patient of a body temperature of 100 degrees Fahrenheit or more; 2 patients called with this complaint.	L 100		

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L 100	Continued From page 4 The examples listed below should have been included in a facility surveillance logbook. None of them were. 4. The answering service call log records for the month of July 2006 was 11 pages long, had 37 calls 28 of which were for directions, to schedule an appointment, or non-medical from information recorded by the call service. The remaining calls are broken down as follows: (i) Severe cramps; 2 patients called with this complaint. (ii) Passing large clots; 1 patient called with this complaint and 4 others called with issues regarding bleeding. ********** 420-5-1-.03(7)(a) State Board of Health requires there shall be an infection control committee composed of a physician and registered professional nurse who shall be responsible for investigating, controlling, and preventing infections in the facility. The regulation is not met as evidenced by: Based on interview, it was determined that the facility failed to have an infection control committee, and procedures to govern the use of sterile and aseptic techniques. Findings include: An interview conducted with the Administrator on August 03, 2006 at 2:30 P.M., confirmed that she did not have an infection control committee. She	L 100		

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L 100	Continued From page 5 stated," Isn't that the same thing as QA (quality assurance)?" She was unable to provide the requested information. ********** 420-5-1-.03(2)(a) Patient Rights The facility shall have written policies and procedures to ensure the rights to dignity, privacy, and safety. The regulation is not met as evidenced by: Based on a review of medical records, review of policies and interview it was determined in 6 of 18 patients the facility did not follow their policy on safety in prescribing birth control pills. Findings include: Protocol: Standing Orders for BCP's and Depo Injections Birth Control Pills/ Prescriptions and Depo-Provera Injections are not to be given to the following patients: 1. Patients who are over 35 years of age or older. 2. Patients who have an elevated blood pressure of 140/90 or more. 3. Patients who smoke. These standing orders are signed by the Medical Director with the following dates on the bottom of the form: 01-30-01 2-9-02 1/16/03	L 100		

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L 100	Continued From page 6 1-10-04 1-6-05 1/5/06. The following were patients who received BCP & are over 35 or have an elevated blood pressure of 140/90 or more: 1. Patient # 11 was seen in the facility for a procedure on May 11, 2006. Documentation on discharge revealed the patient was given Loestrin Fe 24. The patient's age was listed as 39 years. 2. Patient # 5 was seen in the facility for a procedure on June 8, 2006. Documentation on discharge revealed the patient was given Ortho Lo. The patient's age was listed as 36 years. 3. Patient # 7 was seen in the facility for a procedure on June 29, 2006. Documentation on discharge revealed the patient was given Loestrin 24 Fe. The patient's age was listed as 36 years. 4. Patient # 13 was seen in the facility for a procedure on March 23, 2006. Documentation on discharge revealed the patient was given Estro-Stef. The patients blood pressure in the recovery was 138/105 at 4:07 P.M. 5. Patient # 4 was seen in the facility for a procedure July 7, 2006. Documentation on discharge revealed the patient was given Loestrin 24 Fe. The patient's age was listed as 42 years .The patients blood pressure in the recovery room was 113/92 at 4:40 P.M. 6. Patient # 15 was seen in the facility for a procedure June 22, 2006. Documentation on discharge revealed the patient was given Loestrin 24 Fe. The patients blood	L 100		

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L 100	Continued From page 7 pressure in the recovery room on discharge was 137/94 at 3:58 P. M. The Administrator was advised during the exit on August 3, 2006 of the policy not being followed. A fax transmittal received August 4,2006 had # 4 added to the protocol for BCP's. 4. The physician may review each individual case and make exceptions as needed. The physician did not sign the additional order. A note was written on the fax cover sheet which stated," Dr..... every patient need 1 pack for bleeding as needed." Again no physician signature was observed. ********** 420-5-1-.03(1) Patient Care Patient Care Policies and Procedures shall be developed, reviewed yearly, and revised as necessary. Patient Care Policies and Procedures shall be consistent with professionally recognized standards of practice and shall be in accordance with the Alabama Nurse Practice Act. This regulation is not met as evidenced by: Based on observation, the facility failed to follow standards of practice by having pre-filled, unlabeled and undated syringes of a clear liquid substance in the double locked cabinet. The Alabama Board of Nursing adopted the Council Recommendations, "Recommendations to Enhance Accuracy of Administration of Medications" Revised June 02, 2005, from the National Coordinating Council for Medication	L 100		

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L 100	Continued From page 8 Error Reporting and Prevention. Recommendations: 8. .... health care professional administer only medications that are properly labeled ..... Findings: The facility also failed to follow standards of practice by having pre-filled and unlabeled syringes of Nubain in a tray in the double locked cabinet. The surveyor observed 7 syringes in the cabinet with a clear liquid solution in each. The registered nurse was questioned about the prefilled syringes? The nurse stated they were filled with Nubain which they no longer used and threw the syringes in the sharps container. ********** 420-5-1-.03(6)(b)Pharmaceutical Services Administering, Dispensing, and Prescribing Drugs and Medicines. All oral or telephone orders for medications shall be received by a physician, a registered professional nurse, licensed practical nurse, or a registered pharmacist and shall be reduced to writing on the physician's order reflecting the prescribing physician and the name and title of the person who wrote the order. Telephone or oral orders shall be signed by the prescribing physician within 48 hours. Standing orders shall be used only in accordance with a policy of the facility reduced to writing. Drugs and medications shall not be dispensed, except by or under the supervision of a physician or pharmacist. Any patient requiring medications	L 100		

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L 100	Continued From page 9 outside the facility shall be given a written prescription permitting her to obtain the medications from a licensed pharmacy. The regulation is not met as evidenced by: Based on observation, review of medical records, and interview, it was determined that the physician failed to follow standards of practice for prescription requirements. Findings include: Rules of the Alabama Board of Medical Examiners Chapter 540x4-.05(1)(e)," It is improper for a physician to pre-sign blank prescription pads or forms and make them available to non-physician employees or support personnel under any circumstances." On a tour of the facility on August 2, 2006, multiple tablets of prescription pads were found presigned by the medical director. The medication on the prescription was stamped in to say the following: 1. Ortho Evra 1 month sig. Apply 1 patch weekly x3 2. Estro-step sig. 1 tablet daily disp 1 pack of 28 3. Loestrin 24 FE sig. 1 tablet daily disp. 1 pack of 28 4. Naprosyn 250 mg/Methergine 0.2 mg 30 signed prescriptions were present with no patient name. The registered nurse disposed of the presigned prescriptions for Naprosyn and Methergine as	L 100		

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L 100	Continued From page 10 they no longer use Naprosyn. 420-5-1-.03(6)(b)Pharmaceutical Services The facility failed to assure all narcotic medications were properly secured at all times. Findings: On a tour of the recovery room on August 3, 2006 at 2:30 P.M., prefilled cups of medication were sitting beside each chair with 2 blue tablets and one white tablet, a box in the immediate area contained multiple cups stacked with blue tablets and other medications which were not labeled. Also noted on a small stand was a 100 count bottle of Valium unsecured. A second tray on the emergency cart contained vials of Versed. On August 3rd, 2006 at 2:45 P.M. the registered nurse was asked what this prefilled medication was. She replied," the cups by the chairs have Aleve and Methergine and the other cups some have just Aleve, some have Valium and Aleve." 420-5-1-.03(6)(b)Pharmaceutical Services The facility also failed to assure the medications given were accurately documented. Findings include: Standing Orders For Abortion Patients state: II. Pre-Op 1. Valium 5mg 10mg PO 2. Aleve 220mg or Ultram 50mg PO (ultram marked through) 3. IV sedation	L 100		

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L 100	Continued From page 11 4. Nitrous Oxide (marked through) III. Post-Op 2. Aleve 220mg tabs 2 or Ultram 50mg PO (ultram marked through) or Bextra 20mg 1 bid/Motrin 800mg 1 every 4-6 hours (Bextra and Motrin were handwritten in) 6. Naprosyn 50mg PO-Rx given for cramps or Bextra Rx Given (handwritten in) These standing orders are signed by the Medical Director with the following dates on the bottom of the form: 01-30-01 2-9-02 1/16/03 1-10-04 1-6-05 1/5/06. Facility Standing Orders:Medications for Twilight Sedation Patients 1. Twilight sedation patients (1st trimester and second trimester up to 16 weeks) will receive 5mg Versed IM, 30mg Talwin IV and 12.5mg Phenergan IV push. 5-22-04 Nubain 5mg will be used instead of Talwin. 1. Patient # 11 was seen in the facility for a procedure on May 11, 2006. A review of the facility procedure record revealed documentation by the nurse that the patient had been given Talwin pre-operatively. An interview with the nurse on August 2, 2006 at 2:00 P.M. revealed the facility standing orders had been changed effective May 22, 2004, and	L 100		

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L 100	Continued From page 12 no longer included orders for Talwin to be given. A review of the documented orders on discharge included a prescription had been given for Bextra 20 mgs. (milligrams). A review of information from the Food and Drug Administration revealed Bextra had been taken off the market in April 2005, and therefore not available. An interview with the nurse on August 2, 2006 at 2:00 P.M. revealed the form that was completed was an old form and should not have been used, but could not deny/confirm the medications had been given as documented. 420-5-1-.03(6)(b)Pharmaceutical Services The facility also failed to ensure when medication changes were to be effective. It was not possible to know which version of the protocol was put into effect on what date, as there were no dates written beside the handwritten changes. The handwritten strike through updates make it impossible to know what protocol was in effect for any given patient. On a page titled PROTOCOL Standing orders for medications, the following items had been marked through and a different medication name written in: 1. Naprosyn 250 mg or 500 mg every 4-6 hours for cramping # 12 no refills (Naprosyn is marked through and Aleve hand written in). 2. Motrin 600 mg every 6 hours for cramping # 12 no refills (Motrin is marked through and Ibuprofen 800 hand written in).	L 100		

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L 100	Continued From page 13 4. Tylenol extra strength two (2) every 4-6 hours for cramping (Tylenol extra strength is marked through and Darvocet hand written in). 5. Tylenol # 3 one (1) every 6 hours for cramping (Tylenol# 3 is marked through and Darvocet hand written in). These standing orders are signed by the Medical Director with the following dates on the bottom of the form: 01-30-01 2-9-02 1/16/03 1-10-04 1-6-05 1/5/06. An interview conducted with the registered nurse on August 02, 2006, at 3:00 P.M., stated that they no longer used Naprosyn, they only used Ibuprofen. 420-5-1-.03(6)(b)Pharmaceutical Services The facility failed to assure that when standing orders were used on a individual patient, that the order was reduced in writing in the individuals record, and that the physician co-signed the order. Patient # 11 had a procedure on May 11, 2006. Phone calls were received from the patient on May 15, 2006 at 10:06 P.M., May 16, 2006 at 12:13 A.M. and on May 17, 2006 (date should be May 16, 2006) at 10:00 A.M. with complaints of pain. On May 17, 2006, the facility nurse documented she called in Darvocet N-100 # 10 (as per the facility standing orders listed on the facility protocol sheet) to the patient's pharmacy.	L 100		

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L 100	Continued From page 14 No documentation could be found or provided that the physician had been notified of the use of Darvocet for this patient, and no written order was located in the patient's record. ********** 420-5-1-.03(6)(d) Records Records shall be kept of all stock controlled substance giving an account of all items received and administered. Records shall be kept in a manner which allows accurate reconciliation. The regulation is not met as evidenced by: Based on observation and interview, it was determined the facility failed to account for all medications and was unable to reconcile the stock of controlled drugs. Findings include: On August 2, 2006 during a tour of the facility the surveyor observed the double locked cabinet for controlled substances. The surveyor asked the registered nurse for the count sheet on Valium. The nurse returned several minutes later and said she had been updating her list and she had a count of 115 was that right? The surveyor in the presence of the registered nurse counted the pills in the two 100 count bottles and counted 122 tablets of Valium 10 mg. The nurse offered no explanation. ********** 420-1-.04(2)(d) Fire Extinguisher An all purpose fire extinguisher shall be provided	L 100		

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BEACON WOMEN'S CENTER	1011 MONTICELLO COURT MONTGOMERY, AL 36117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	Continued From page 15 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 Marshall and shall be inspected in accordance with the manufacturer's specifications, but not less than annually. The regulation is not met as evidenced by: Based on observation and interview it was determined the fire extinguisher in the laboratory had not been inspected since 2003. Findings include: 1. During a tour of the facility the surveyor observed the tag on the fire extinguisher in the laboratory was last inspected in 2003. An interview with the Administrator August 3, 2006 at 4:00 P.M., confirmed the last inspection was in 2003. ********** 420-5-1-.04(4)(h) Preventive Maintenance There shall be a schedule of preventive maintenance developed for all equipment in the facility to assure satisfactory operation. This equipment shall be checked and tested in accordance with manufacturer's specifications at periodic intervals, not less than annually, to insure proper operation and a state of good repair. After repairs or alterations are made to any equipment, the equipment shall be thoroughly tested for proper operation before returning it to service. Records shall be	L 100		

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L 100	Continued From page 16 maintained on each piece of equipment to indicate its history of testing and maintenance. This regulation is not met as evidenced by: Based on observation and interview it was determined the facility failed to assure all equipment in the facility was in satisfactory condition. The facility failed to have dates to verify the accurate date of the procedure in 9 of 18 records reviewed, due to a faulty ultrasound machine in procedure room # 2 that could not be calibrated for the correct date, nor to determine the gestational age. Findings include: 1. Patient # 1 procedure date was June 22, 2006. The date on the ultrasound attached to the post-op sonar form is May 29 no year. 2. Patient # 3 procedure date was July 27, 2006. The date on the ultrasound attached to the post-op sonar form was July 03 with no year listed. 3. Patient # 4 procedure date was July 19, 2006. The date on the ultrasound attached to the post-op sonar form was June 26 with no year listed. 4. Patient # 5 procedure date was June 8, 2006. The date on the ultrasound attached to the post-op sonar form was May 15 with no year listed. 5. Patient # 6 procedure date was June 10, 2006. The date on the ultrasound attached to the post-op sonar form was May 16 with no year listed.	L 100		

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L 100	Continued From page 17 6. Patient # 10 procedure date was July 13, 2006. The date on the ultrasound attached to the post-op sonar form was June 19 with no year listed. 7. Patient # 11 procedure date was May 11, 2006. The date on the ultrasound attached to the post-op sonar form was April 16 with no year listed. 8. Patient # 13 procedure date was March 23, 2006. The date on the ultrasound attached to the post-op sonar form was February 20 with no year listed. 9. Patient #14 procedure date was July 06, 2006. The date on the ultrasound attached to the post-op sonar form was June 19 with no year listed. On a tour of the procedure room on August 3, 2006, the medical assistant printed out a picture from the ultrasound machine in procedure room 2 on request from the surveyor, who was present as the picture printed out. The picture had a preprinted date of July 9. An interview with the facility administrator on August 3, 2006 at 1:15 P.M. verified the ultrasounds did not have the correct dates. ********** 420-5-1-.03(f)Informed Consent. Except in the case of a medical emergency, as defined in these rules, no abortion shall be performed or induced without the voluntary and informed consent of the woman whom the abortion is to be performed or induced. Except in	L 100		

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L 100	Continued From page 18 the case of a medical emergency, as defined in these rules, consent to an abortion is voluntary and informed if and only if: 3. The physician who is to perform the abortion or the referring physician is required to perform an ultrasound before the abortion. The regulation is not met as evidenced by: Based on record review , it was determined the facility failed to document whether a physician performed an ultrasound prior to a procedure in 3 of 18 records. Findings include: 1. Patient # 11 was seen in the facility for a procedure on May 11, 2006. There was an ultrasound in the record dated May 9, 2006, a Tuesday, when no physician is present in the facility. It was impossible to determine by this record whether the physician performed an ultrasound prior to the procedure. 2. Patient # 5 was seen in the facility for a procedure on June 8, 2006. There was an ultrasound in the record dated June 7, 2006, a Wednesday, when no physician is present in the facility. It was impossible to determine by this record whether the physician performed an ultrasound prior to the procedure. 3. Patient # 13 was seen in the facility for a procedure on March 23, 2006. There was an ultrasound in the record dated March 14, 2006, a Tuesday, when no physician is present in the facility. It was impossible to determine by this record whether the physician performed an ultrasound prior to the procedure.	L 100		

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L 100	Continued From page 19 ********** 420-5-1-.02(6)(b) State Board of Health Rule requires that fire drills shall be conducted at least semi-annually for the staff and written observations of the effectiveness of these rehearsals shall be filed and kept at least three years. The regulation is not met as evidenced by: Based on an interview with the facility staff member, it was determined the facility had not conducted semi-annual fire drills as required. Findings include: Fire drills for the past year were requested from the Administrator on August 2, 2006 at 2:00 P.M. The items were again requested from the Administrator on August 3, 2006. The requested items could not be located and provided. ********** 420-5-1-.02(1)(a) Administration State Board of Health requires that the governing authority is the person or persons responsible for the management, control, and operation of the facility, including the appointment of personnel to fill the minimum staffing requirements. The governing authority shall ensure that the facility is organized, equipped, staffed and administered in a manner to provide adequate care for each patient admitted. This regulation is not met as evidenced by:	L 100		

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L 100	Continued From page 20 The deficient practice cited above was of such a nature and demonstrated that the governing body does not ensure that the facility is operated in a manner to provide adequate care. Findings include: The governing body committee members or verification of meetings was requested from the Administrator on August 2, 2006 at 2:00 P.M. and on August 3, 2006 at 2:30 P.M. The information could not be provided as requested.	L 100		