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 _____	02/05/2021

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 000	INITIAL COMMENTS An on site licensure survey was conducted on 2/4/2021 to 2/5/2021 and licensure deficiencies were cited.	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: Chapter 420-6-1-.02 -Administration (5) Personnel. (a) Each abortion clinic shall utilize personnel to provide services who have appropriate training and qualifications for the services that they provide. (b) Personnel Files. There shall be a personnel file for each employee which shall include: ...3. Orientation. There shall be a written orientation program to familiarize each new staff member with the facility and its policies and procedures, to include at a minimum, ...medical emergencies... There shall be documentation of completion of this orientation maintained in the personnel file. (c) Medical Director. Each abortion facility shall have a medical director who shall be responsible for supervising all clinical functions and ensuring that the facility meets the requirements of these rules and all professional standards of care... The medical director shall ensure that all clinical staff... are competent as required by these rules	L 100 .3 (C)	An appropriate orientation will be written for new RN and reevaluation of scrub tech. It will be written by the Clinic Director and approved and signed by the Medical Director. An all new orientation checklist will be created so each area is documented to include medical emergencies and competency for each employee. These shall be signed by the Medical Director and retained in the employee file. Monitored by Clinic Director quarterly.	

Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature] Parker, MD, MPH	Medical Director	March 3, 2021

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L 100	Continued From page 1 and professional standards of care. (d) Physician Qualifications. 1. Only a physician may perform an abortion... All physicians performing abortions at the facility shall be qualified through training and experience in performing abortions and recognizing and managing complications. 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 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 observation of the physician's clinical skills, and the results of this review shall be placed in the physician's file... (g) Cardio-Pulmonary Resuscitation. A person designated to perform cardio-pulmonary resuscitation... shall remain on the facility premises from the moment the first patient is sedated until all patients have left the facility premises. Individuals designated to perform cardio-pulmonary resuscitation shall be properly certified and attend a training class in cardio-pulmonary resuscitation at least annually. Each facility shall maintain adequate staffing records to demonstrate that this requirement is met. The Rule is not met as evidenced by:	L 100 D1. 2. (G)	Medical Director will certify attending physicians skills through direct, in person observation initially. Annually thereafter, the Medical Director will re-certify by viewing a procedure performed in real time, as per policy which was established during Covid. To review skills in real time, Clinic Director will obtain consent from a patient and copies of the consent will be dated and placed in the patient's chart and the attending physician's personnel file by the Clinic Director. Policy change implemented on 03/01/2021 reflects that all initial certifications of physicians will be completed in person and signed off on by the physician being certified, the medial director, and at least two witnesses. Medical Director will be responsible for reviewing physician skills annually and for documentation. CPR Class was held in July of 2020 but the instructor left off names. Employee names added to each CPR card are certified by RCLS instructor proficient in American Heart Association standards of instruction and education. Copy of recertification to be provided to ADPH. Clinic Director will be responsible for scheduling the class annually.	3/5/21 3/5/21

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L 100	Continued From page 2 Based on review of the facility policies and procedures, employee list, personnel files, physician personnel files, and interviews, it was determined the facility failed to: 1) Document a complete orientation on all employees, that included medical emergencies. 2) Follow it's own policy for initial certification of physicians and ensure the Medical Director observed each physician's clinical skills upon hire and prior to the physician performing any procedure at the facility. 3) Ensure designated staff were certified in Cardio-Pulmonary Resuscitation (CPR). This affected 1 of 1 physician hired in 2020 and did affect Employee Identifier (EI) # 5, Physician # 1, 6 of 6 clinical employee personnel files including EI # 1, EI # 2, EI # 3, EI # 4, EI # 9, EI # 11, and had the potential to affect all persons served by the facility. Findings include: Policy and Procedure: Pursuant to Regulation 420-6.02.5(d)311 August 2019 Regulations require recertification of clinic physicians annually by the medical director by direct observation of physician skills performing abortions,.. Video of abortions for recertification will be real time video at the clinic during normally scheduled clinics...The initial certification of all physicians will be with both the Medical Director and the new attending in attendance at the same time and by direct observation in the clinic,.. The policy was signed by EI # 6, Medical Director,	L 100	1) All personnel orientations will have a review of medical emergencies completed and documented by RN review, signed by staff and RN, and dated. 2) Schedule direct review of skills with EI #5 documented and signed and dated in her personnel file. Monitored annually by the Medical Director. 3) CPR Class was done for staff but names were omitted from cards. Instructor will complete cards and this will be done annually by instructor and confirmed by the Clinic Director.	1) 3/5/21 2) 3/5/21 3) 3/5/21

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L 100	Continued From page 3 and no signature date was documented. Policy for Managing Abortion Complications and Emergencies Date: None Listed A. All complications, emergencies and patient concerns arising as a result of an abortion at this office will receive immediate attention and management by the appropriate staff. B. Reproductive Health (RHS) has several measures in place to reduce the risk of complications in its abortion service. These measures include: ...2. Well-trained personnel who are provided with on going education to enhance their knowledge and abilities to provide safe and knowledgeable care. C. If complications do occur, RHS will be prepared to manage them by having: ...2. To have qualified and trained staff that can handle complications and emergencies, to include knowledge of CPR, ER (Emergency) Cart... 1. Review of the employee list revealed EI # 5, Physician # 1, was hired August 2020 and EI # 6, Medical Director, was hired September 2020. Review of the personnel file for EI # 5 revealed a typed document which included the following: "... (EI # 6, Medical Director) has agreed to certify (EI # 5) on this date (there was no date on the form)... (EI # 6) has directly observed in real time video of (EI # 5) performing an abortion on a patient on this date...all parties will sign below..."	L 100 1) C2 1)	420-5-02 5:D:311 The date was 09/11/2020 and both female attending physicians were scheduled so that the new attending could be certified before she did any abortions in our office. All first time attending physicians will be directly certified as they complete their first abortion and this is documented and dated. This will be done in person and all successive certifications will be real time tele-medical with the attending physician, the Medical Director, and a consenting patient and the record placed in both the attending's file and in the patient's chart and dated. Retraining in emergencies annually monitored by RN. Rescheduled date pending for Medical Director to directly observe physician skills of new attending	3/5/21 3/25/21

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L 100	Continued From page 4	L 100		
	The form was signed by EI # 6, EI # 5, and EI # 1, Director. There were no signature dates documented. Below the signatures was a handwritten notation, "via real time face time 9/11/20 8 AM" with no signature or date when this notation was added. The facility policy and procedure for initial certification requires "both the Medical Director and new attending to be in attendance at the same time and by direct observation in the clinic." This process was not followed for EI # 5. An interview conducted on 2/4/2021 at 12:30 PM with EI # 5 confirmed the observation of skills was performed via zoom and not in person.	1	Recertifications will be signed and dated with appropriate date, and monitored by Medical Director annually. This will be rectified as rescheduled pairing of attending physician and Medical Director so observation will be direct review of skills. Monitored thereafter in real time annually by Medical Director	3/25/21 3/25/21
	2. Review of the personnel file for EI # 4, Instrument Technician, date of hire 4/10/18, revealed no documentation medical emergencies were included in orientation. Review of the personnel file for EI # 2, Practical Nurse, date of hire 2/16/17, revealed no documentation medical emergencies were included in orientation. Review of the personnel file for EI # 3, Procedure Technician and Laboratory, date of hire 5/1/2020, revealed no documentation medical emergencies were included in orientation. Review of the personnel file for EI # 9, Registered Nurse, date of hire 11/6/2020, revealed no documentation medical emergencies were included in orientation. An interview was conducted on 2/5/21 at 10:40 AM with EI # 1, Director, who confirmed the	2 2 2	Staff members EI#4 EI#2 EI #3 and EI#9 all will have documentation of medical emergencies training Monitored annually by the Medical Director. EI#1 will have medical emergency and competency in their training. Record will be placed in personnel file Retrained annually and documented by the Clinic Director and placed in file. EI#9 will have medical emergency competency in their training. Record will be placed in personnel file.	3/9/21 3/9/21 3/9/21

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L 100	Continued From page 5 above listed employees' orientation failed to include medical emergencies. 3. During the survey, a total of 6 personnel files were reviewed, which included EI # 1, EI # 2, EI # 3, EI # 4, EI # 9, and EI # 11, RN. There was no documentation any of the 6 had current CPR certification. During an interview on 2/5/21 at 9:30 AM with EI # 1, the surveyor was given a sheet of CPR cards, dated 7/17/2020. There were no names on any of the cards. EI # 1 confirmed there was no documentation of current CPR for the six employees. Chapter 420-5-1-.02 Administration (6) Fire Evacuation Plan. ...(b) Fire Drills. 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. Based on review of policy and procedure manual and interview with staff, it was determined the facility failed to conduct fire drills semi-annually according to rules and facility policy. This had the potential to affect all persons served by the clinic. Findings include: Facility Policy: Emergency Procedures Date: None Listed A. Fire/Evacuation of Patients	L 100 3 (b)	Only one member is required to have CPR on staff with each clinic. CPR cards will be updated to reflect names of staff members with training and will be noted in personnel record. Clinic Director will monitor annually. A fire drill was done in the first quarter of 2021 and signed by all staff. Copy will be provided to ADPH. Fire drills will be conducted quarterly - First and Third Quarter Drills are Staff Only. Second and Fourth Quarter drills are performed with patients present in the building. This is scheduled and monitored by the Clinic Director quarterly.	2/5/21

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L 100	Continued From page 6 ...8. Semi-annual fire drills will be conducted and recorded to assess staff preparedness and test emergency lighting. A record of these drills will be maintained in the clinic business office. Review of the policy and procedure manual revealed staff meeting minutes dated 10/25/19. The minutes included a summary of a fire drill conducted on that date. There was no documentation of a fire drill since 10/25/19. An interview was conducted on 2/4/21 at 11:15 AM with Employee Identifier # 1, Director, who confirmed the facility has not conducted a fire drill since 10/25/19. Chapter 420-5-1-.03 Patient Care (2) Policies and Procedures The facility shall develop and follow detailed written policies and procedures that are consistent with all applicable federal, state, and local laws, these rules and current standards of care,.. (4) Admission and Examination Procedures (f) Informed Consent... 2. Prior to an abortion, the physician who is to perform the abortion, the referring physician, or a qualified counselor has informed the woman in person: (i) The name of the physician who will perform the abortion in writing or a business card. 3. The physician who is to perform the abortion or the referring physician is required to perform an	L 100 8	Quarterly meetings and drills were conducted and dated by quarter. Specific dates now will be entered to record the meeting. Clinic Director is responsible for this action.	

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L 100	Continued From page 7 ultrasound before the abortion. The woman has right to view the ultrasound... Based on review of medical records (MR), facility policies and procedures, and interviews, it was determined the facility failed to ensure: 1) A detailed, written policy regarding informed consent to include providing the woman with the name of the physician who will perform the abortion in writing, as required in the Alabama State Board of Health Alabama Department of Public Health Chapter 420-5-1-.03 rules, was developed and implemented. 2) Each woman admitted to the facility was informed of the name of the physician who will perform the abortion in writing prior to the abortion. 3) The Certification of Opportunity to View Ultrasound form clearly identified the physician who performed the abortion, also performed an ultrasound on the date of procedure. This affected 7 of 16 records reviewed, including Patient Identifier (PI) # 5, PI # 7, PI # 9, PI # 13, PI # 2, PI # 6, PI # 14, and had the potential to affect all persons served by the facility. Findings include: Facility Patient Policies 2. Informed Consent An abortion is performed only with the consent of the patient... Consent forms will include accurate information about the abortion procedure, the risks and benefits of abortion and possible	L 100 420-5-1 1-.03 2	State provided form will now list only the name of the attending physician performing the ultrasound and abortion. Empty spaces for physician will not be completed until the day of the procedure. Patient will be informed the of the name of the attending physician and the spaces on the state form then completed on that date by the administrative staff. Administrative staff responsible for informing patient and completing state informed consent was trained on this change in procedure on 03/01/2021 and changes were made to our paperwork to reflect these changes. No changes in policy made. State provided informed consent will only have one name - the name of the physician performing the ultrasound and abortion. Informed consent includes all accurate information including risks and benefits of abortion, as well as alternatives.	3/5/21 2/5/21

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L 100	Continued From page 8 complications. Patient consent will be informed, voluntary and written. The consent form will be signed prior to the abortion and placed in the patient's permanent record. 1. PI # 5 presented to the facility on 9/8/2020 for the initial visit and returned on 9/11/2020 for an abortion procedure. Review of the MR revealed Employee Identifier (EI) # 5, Physician 1, performed a surgical abortion on 9/11/2020. Review of the Certification of Voluntary and Informed Consent for Abortion (consent form) signed by PI # 5 on 9/8/2020 revealed "The abortion will be performed by" and the names of four physicians listed. The name of the physician that performed the abortion on 9/11/2020 was not listed. Review of the Certification of Opportunity to View Ultrasound (COVU) form signed by PI # 5 on 9/8/2020 revealed the names of five physicians listed and 2 names were circled. It was unclear which physician performed the ultrasound and gave the patient the opportunity to view the ultrasound prior to the abortion procedure. There was no documentation PI # 5 was informed which physician would perform the abortion procedure. An interview was conducted on 2/5/21 at 10:45 AM with EI # 1, Director, who stated the forms are completed on the first date the patient comes to the facility and if the procedure date is re-scheduled the physician may change. 2. PI # 7 presented to the facility on 9/8/2020 for	L 100		

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L 100	Continued From page 9 the initial visit and returned on 9/25/2020 for an abortion procedure. Review of the MR revealed EI # 7, Physician 2, performed a surgical abortion on 9/25/2020. Review of the consent form signed by PI # 7 on 9/8/2020 revealed "The abortion will be performed by" and the names of four physicians listed. There was no documentation PI # 7 was informed which physician would perform the abortion procedure. Review of the COVU form signed by PI # 7 on 9/8/2020 revealed the names of four physicians listed and 2 names were circled. It was unclear which physician performed the ultrasound and gave the patient the opportunity to view the ultrasound prior to the abortion procedure. An interview was conducted on 2/5/21 at 10:45 AM with EI # 1 who confirmed the consent forms did not specify which physician would perform the abortion and confirmed the COVU form had 2 physicians circled. 3. PI # 9 presented to the facility on 9/29/2020 for the initial visit and returned on 10/2/2020 for an abortion procedure. Review of the MR revealed EI # 5, Physician 1, performed a surgical abortion on 10/2/2020. Review of the consent form signed by PI # 9 on 9/29/2020 revealed "The abortion will be performed by" and the names of four physicians listed. The name of the physician that performed the abortion on 10/2/2020 was not listed. There was no documentation PI # 9 was informed which physician would perform the abortion procedure.	L 100		

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L 100	Continued From page 10 An interview was conducted on 2/5/21 at 10:50 AM with EI # 1 who confirmed the consent forms did not specify which physician would perform the abortion and the list of physicians on the form did not include EI # 5, the physician that performed the abortion procedure. 4. PI # 13 presented to the facility on 12/15/2020 for the initial visit and returned on 12/18/2020 for an abortion procedure. Review of the MR revealed EI # 5, Physician 1, performed a surgical abortion on 12/18/2020. Review of the consent form signed by PI # 13 on 12/15/2020 revealed "The abortion will be performed by" and the names of four physicians listed. The name of the physician that performed the abortion on 12/18/2020 was not listed. There was no documentation PI # 13 was informed which physician would perform the abortion procedure. An interview was conducted on 2/5/21 at 10:50 AM with EI # 1 who confirmed the consent forms did not specify which physician would perform the abortion and the list of physicians on the form did not include EI # 5, the physician that performed the abortion procedure. 5. PI # 2 presented to the facility on 8/3/2020 for the initial visit and returned on 8/14/2020 for a surgical abortion. Review of the MR revealed the surgical abortion was performed on 8/14/2020 by EI # 8, Physician # 3. Review of the COVU form signed by PI # 2 on	L 100		

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L 100	Continued From page 11 8/3/2020 revealed the names of four physicians, and two names were circled. It was unclear which physician performed the ultrasound and gave the patient the opportunity to view prior to the abortion procedure. An interview was conducted on 2/5/21 at 10:30 AM with EI # 1, who confirmed it was unclear from the documentation which physician performed the abortion procedure. 6. PI # 6 presented to the facility on 8/4/2020 for the initial visit and returned on 9/11/2020 for a surgical abortion. Review of the MR revealed the surgical abortion was performed on 9/11/2020 by EI # 5, Physician # 1. Review of the COVU form signed by PI # 6 on 8/4/2020 revealed the names of five physicians listed, and four names were circled. It was unclear which physician performed the ultrasound and gave the patient the opportunity to view prior to the abortion procedure. An interview was conducted on 2/5/21 at 10:30 AM with EI # 1, who confirmed it was unclear from the documentation which physician performed the abortion procedure. 7. PI # 14 presented to the facility on 12/2/2020 for the initial visit and returned on 1/7/2021 for a surgical abortion. Review of the MR revealed the surgical abortion was performed on 1/7/2021 by EI # 6. Review of the COVU form signed by PI # 14 on 12/2/2020 revealed the names of five physicians	L 100		

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L 100	Continued From page 12 listed, and two names were circled. It was unclear which physician performed the ultrasound and gave the patient the opportunity to view prior to the abortion procedure. An interview was conducted on 2/5/21 at 10:30 AM with EI # 1, who confirmed the documentation was unclear which physician performed the ultrasound. Chapter 420-5-1-.03 Patient Care (7) Pharmaceutical Services. (b) ...Oral and telephone orders shall be received only by a physician, nurse practitioner, ...registered professional nurse, licensed practical nurse... 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. (g) Emergency Kit or Emergency Drugs. 1. Each abortion clinic shall maintain upon the advice and written approval of the facility's medical director an emergency kit or stock supply of drugs and medicines for treating the emergency needs of patients. 5. Emergency kits and the stock supply of drugs shall be inspected with sufficient frequency to permit the removal of all outdated drugs. Each kit shall contain a log documenting such inspections. Based on review of medical records (MR), facility policies and procedures, Alabama Board of	L 100 420-5-1 .03 (b)	All verbal orders will be written down and signed as directed by the physician and a registered nurse. This means all new chart materials will be created and printed to reflect this change. All internal paperwork is approved by the Clinic Director.	3/5/21

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 _____	02/05/2021

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L 100	Continued From page 13 Nursing Administrative Code, facility's Monthly Inspection of ER (Emergency) Drugs and Cart log, and interviews, it was determined the facility failed to ensure: 1) Verbal orders were written in the medical record and signed by the person receiving the order. 2) Verbal orders were written to include the drug strength and route of administration. 3) Changes to the medical record were signed by the licensed nurse making the changes. 4) The policy, signed by the Medical Director, for medications received by patients was followed. 5) Medications on the crash cart were not expired. This affected11 of 16 records reviewed, including PI # 5, PI # 7, PI # 9, PI # 13, PI # 14, PI # 11, PI # 10, PI # 3, PI # 1, PI # 8, and PI # 12, and had the potential to affect all patients served by the facility. Findings include: Facility Policy and Procedure Changes Relating to Changes in Medication Received by Patients No Date Signed by the medical director and clinic director and not dated: "Changes have been made to three medications received or prescribed for patients of Reproductive Health Services:	L 100 1) 2) 3) 5)	All verbal orders will be written down and signed as directed by the physician and a registered nurse. Medications have now been discarded and replaced. New policy created to prevent this requires sign off of monthly inventory by both the Clinic Director EI#1 and Assistant Director EI#3 after review of the log and Assistant Director will be responsible for ordering replacement meds and assure replacement is signed off on by the Clinic Director.	3/5/21

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L 100	Continued From page 14 1. Due to a decrease in availability and back order of Vistaril 50 mg (milligrams), PO (by mouth), provided to patients as a pre-operative medication, the clinic is changing to Promethazine 25 mg, PO... Forms have been changed to reflect the above changes..." Alabama Board of Nursing, Administrative Code 610-X-6-.06 Documentation Standards ...f. Corrections to a record by a licensed nurse shall include the name or initials of the individual making the correction. 610-X-6-.07 Medication Administration and Safety (1) The registered nurse... shall have applied knowledge of medication administration and safety, including but not limited to: ...(j) Safety precautions, including but not limited to: ...IV. Right dose. ...V. Right route. ...VII. Right documentation. (4) Documentation of medication administration shall comply with the principles of documentation and include safety precautions of medication administration... Facility Policy: V. Emergency Procedures Date: None Listed ...E. Emergency Cart This facility maintains a centrally located emergency cart which is checked regularly and kept fully assembled for emergency situations...	L 100 (1) (3)	Chart paperwork will be changed to clarify the attending physician orders for pre-op medications which will be administered by the nurse.	

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L 100	Continued From page 15 F. Anaphylactic Shock Treatment ...6. Benadryl/ diphenhydramine 20 mg IV (Intravenous) 1. PI # 5 presented to the facility on 9/11/2020 for an abortion procedure. Review of the MR revealed Promethazine, 25 mg, PO, listed as a "...routine pre-operative medication..." The drug 'Promethazine, 25 mg' had a line drawn through it, and 'Vistaril 50 mg' was hand written on the form. There was no verbal order written for the Vistaril 50 mg, and no route documented as to how the drug was administered. There was no documentation of who made the change in the MR. The surveyor was unable to determine when the change was made. An interview was conducted on 2/5/21 at 10:45 AM with EI # 1, Director, who confirmed the verbal order was given by the physician, but confirmed there was no written order for the Vistaril 50 mg and no route of administration was documented. 2. PI # 7 presented to the facility on 9/25/2020 for an abortion procedure. Review of the MR revealed Promethazine, 25 mg, PO, listed as a "...routine pre-operative medication..." The drug 'Promethazine, 25 mg' had a line drawn through it, and 'Vistaril 50 mg' was hand written on the form. There was no verbal order written for the Vistaril 50 mg, and no route documented as to how the drug was administered. There was no documentation of who made the change in the MR. The surveyor	L 100 F. ...6 F. ...1	This outdated drug was discarded and replaced with new stock. New policy created to prevent this requires sign off of monthly inventory by both the Clinic Director AND Assistant Director after review of the log and Assistant Director will be responsible for ordering replacement meds and assure replacement is signed off on by the Clinic Director. Promethazine was discontinued as a pre-op medication in our office. Chart materials will be updated to reflect all pre-op medications, the dose and the route ordered by the physician.	3/1/21 3/5/21

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L 100	Continued From page 16 was unable to determine when the change was made. An interview was conducted on 2/5/21 at 10:45 AM with EI # 1 who confirmed the verbal order was given by the physician, but confirmed there was no written order for the Vistaril 50 mg and no route of administration documented. 3. PI # 9 presented to the facility on 10/2/2020 for an abortion procedure. Review of the MR revealed Promethazine, 25 mg, PO, listed as a "...routine pre-operative medication..." The drug 'Promethazine, 25 mg' had a line drawn through it, and 'Vistaril 50 mg' was hand written on the form. There was no verbal order written for the Vistaril 50 mg, and no route documented as to how the drug was administered. There was no documentation of who made the change in the MR. The surveyor was unable to determine when the change was made. An interview was conducted on 2/5/21 at 10:50 AM with EI # 1 who confirmed the verbal order was given by the physician, but confirmed there was no written order for the Vistaril 50 mg and no route of administration documented. 4. PI # 13 presented to the facility on 12/18/2020 for an abortion procedure. Review of the MR revealed Promethazine, 25 mg, PO, listed as a "...routine pre-operative medication..." The drug 'Promethazine, 25 mg' had a line drawn through it, and 'Vistaril 50 mg' was hand written on the form. There was no verbal order written for the Vistaril 50 mg, and no route documented as to how the drug was	L 100		

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L 100	Continued From page 17 administered. There was no documentation of who made the change in the MR. The surveyor was unable to determine when the change was made. An interview was conducted on 2/5/21 at 10:50 AM with EI # 1 who confirmed the verbal order was given by the physician, but confirmed there was no written order for the Vistaril 50 mg and no route of administration documented. 5. PI # 14 presented to the facility on 1/7/2021 for a surgical abortion. Review of the MR revealed Promethazine, 25 mg, PO, listed as a "...routine pre-operative medication..." The drug 'Promethazine, 25 mg' had a line drawn through it, and 'Vistaril 50 mg' was hand written on the form. There was no verbal order written for the Vistaril 50 mg, and no route documented as to how the drug was administered. There was no documentation of who made the change in the MR. The surveyor was unable to determine when the change was made. An interview was conducted on 2/5/21 at 10:30 AM with EI # 1, who confirmed the verbal order was given by the physician, but confirmed there was no written order for the Vistaril and no route administered documented. 6. PI # 11 was admitted to the facility for a surgical abortion on 10/8/2020. Review of the MR revealed Promethazine, 25 mg, PO, listed as a "...routine pre-operative medication..." The drug 'Promethazine, 25 mg' had a line drawn through it, and 'Vistaril 50 mg' was hand written on the form. There was no	L 100		

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L 100	Continued From page 18 verbal order written for the Vistaril 50 mg, and no route documented as to how the drug was administered. There was no documentation of who made the change in the MR. The surveyor was unable to determine when the change was made. An interview was conducted on 2/5/21 at 10:30 AM with EI # 1, Director, who stated the verbal order was given by the physician, but confirmed there was no written order for the Vistaril and no route administered documented. 7. PI # 10 was admitted to the facility for a surgical abortion on 8/14/2020. Review of the MR revealed Promethazine, 25 mg, PO, listed as a "...routine pre-operative medication..." The drug 'Promethazine, 25 mg' had a line drawn through it, and 'Vistaril 50 mg' was hand written on the form. There was no verbal order written for the Vistaril 50 mg, and no route documented as to how the drug was administered. There was no documentation of who made the change in the MR. The surveyor was unable to determine when the change was made. An interview was conducted on 2/5/21 at 10:30 AM with EI # 1, who stated the verbal order was given by the physician, but confirmed there was no written order for the Vistaril and no route administered documented. 8. PI # 3 was admitted to the facility for a surgical abortion on 8/28/2020. Review of the MR revealed Promethazine, 25 mg, PO, listed as a "...routine pre-operative medication..." The drug 'Promethazine, 25 mg'	L 100		

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L 100	Continued From page 19 had a line drawn through it, and 'Vistaril 50 mg PO' was hand written on the form and documented as administered at 0700 (7:00 AM). There was no verbal order written for the Vistaril 50 mg. There was no documentation of who made the change in the MR. The surveyor was unable to determine when the change was made. An interview was conducted on 2/5/21 at 10:45 AM with EI # 1, who confirmed there was no written order for the Vistaril 50 mg. 9. PI # 1 was admitted to the facility for a surgical abortion on 8/14/2020. Review of the MR revealed Promethazine, 25 mg, PO, listed as a "...routine pre-operative medication..." The drug 'Promethazine, 25 mg' had a line drawn through it, and 'Vistaril' was hand written on the form. There was no verbal order written for the Vistaril, and no strength or route documented as to how the drug was administered. There was no documentation of who made the change in the MR. The surveyor was unable to determine when the change was made. An interview was conducted on 2/5/21 at 10:45 AM with EI # 1, who stated the verbal order was given by the physician, but confirmed there was no written order for the Vistaril and no strength or route administered documented. 10. PI # 8 was admitted to the facility for a surgical abortion on 9/25/2020. Review of the MR revealed Promethazine, 25 mg, PO, listed as a "...routine pre-operative medication..." The drug 'Promethazine, 25 mg' had a line drawn through it, and 'Vistaril 50 mg'	L 100		

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L 100	Continued From page 20 was hand written on the form. There was no verbal order written for the Vistaril 50 mg, and no route documented as to how the drug was administered. There was no documentation of who made the change in the MR. The surveyor was unable to determine when the change was made. An interview was conducted on 2/5/21 at 10:45 AM with EI # 1, who stated the verbal order was given by the physician, but confirmed there was no written order for the Vistaril 50 mg and route of administration documented. 11. PI # 12 was admitted to the facility for a surgical abortion on 10/6/2020. Review of the MR revealed Promethazine, 25 mg, PO, listed as a "...routine pre-operative medication..." The drug 'Promethazine, 25 mg' had a line drawn through it, and 'Vistaril 50 mg' was hand written on the form. There was no verbal order written for the Vistaril 50 mg, and no route documented as to how the drug was administered. There was no documentation of who made the change in the MR. The surveyor was unable to determine when the change was made. An interview was conducted on 2/5/21 at 10:45 AM with EI # 1, who stated the verbal order was given by the physician, but confirmed there was no written order for the Vistaril 50 mg and no route of administration documented. 12. A tour of the clinic was conducted 2/5/21 at 8:15 AM. Review of the emergency medications, located in a locked box, revealed two vials of	L 100		

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L 100	Continued From page 21 diphenhydramine 50 mg/ ml (milliliter) with expiration dates of 1/21. Review of the Monthly Inspection of ER Drugs and Cart log revealed the cart was checked on 2/1/21, and documented the medications were checked by EI # 1. An interview was conducted on 2/5/21 at 8:30 AM with EI # 10, Assistant Director, who verified the expired medications. Chapter 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... (c) The facility must maintain a record for all equipment containing the following information: ...date and description of all tests, maintenance, or repairs... (d) Medications or 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... (7) Housekeeping Services. (a) Personnel. Sufficient personnel are to be	L 100 (6) (b) (c)	The outdated diphenhydramine in question was discarded and replaced with new stock. A new change in our drug checklist policy was created and implemented 03/01/21 to prevent this in the future and now requires sign off of monthly inventory by both the Clinic Director EI#1 AND Assistant Director EI#3 after review of the log and Assistant Director EI#3 will be responsible for ordering replacement meds and assure replacement is signed off on by the Clinic Director. Equipment This is preventatively checked monthly by the clinic director and annually by an outside company. New change in policy will now require the monthly inspection be performed by two employees.	3/1/21

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L 100	Continued From page 22 employed to maintain the facility clean and orderly. Based on observations, policies and procedures, and interviews, it was determined facility staff failed to ensure: 1) Preventive maintenance was performed on all equipment in the clinic. 2) Supplies available for patient use were not expired. 3) Procedure rooms were clean and free of dust and rust. This had the potential to affect all patients served by the facility. Findings include: Facility Policy and Procedure Manual Document title: Policy Change and Review Date: 02/01/2019 A. It is the policy of Reproductive Health Services to inspect and maintain equipment in safe and working order. An annual inspection by an independent contractor will be completed to comply with this goal... Equipment used in treatment area will be inspected on a monthly basis. Fans will now be included in that monthly list and have been inspected and tagged to verify said inspection... Staff should be alert to any equipment problems or concerns and bring this to the attention of the director or assistant director. B. ...All staff should be careful when restocking supplies and rotate items to assure current dates. All expiring items that will not be used by the	L 100	420-5-1 .04 A Equipment log will be changed to also indicate outer exterior. Suction machines sent to our inspector to be cleaned, repaired, and refurbished to include exterior repair and removal of rust and noted on log by no less than two employees.	3/5/21

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L 100	Continued From page 23 dates of expiration should be discarded appropriately. Facility Document Title: Pursuant to State Regulations 420-5-1-.02 Administration The clinic shall implement a Quality Improvement program to evaluate patient care, surgical outcomes and facility services. To this end, the clinic will do the following: ...4. The clinic will continue to strive to provide a clean and safe working environment for patients and staff. The clinic will maintain appropriate records to reflect working order of all equipment and environmental conditions, monthly check of equipment and continue to strive to assure staff and patient safety. The staff will be encouraged to be alert for anything or anyone not in keeping with this policy. Facility Policy: Infection Control Date: None Listed Policy: Infection control is a multdimensional task that includes such issues as... decontamination and sterilizaton... Procedure: II. Cleaning and Disinfection A. Patient care areas such as exam rooms, laboratory and recovery room: 1. All soil and dust will be removed from surfaces with a clean cloth and a disinfectant cleaner... A tour of the lab was conducted on 2/4/21 at 10:00 AM with Employee Identifier (EI) # 3,	L 100 420-5-1 .02 (II)	Equipment Inspection Log will be completed monthly by no less than two employees and Procedure Room Technician internal checklists will both now include a check for the exterior of equipment for rust or damage. Equipment Log will be completed and signed by two employees once monthly. Decontamination record where needed. Inspection of cleaning will be done to assure disinfection of all equipment weekly. Supervised by the Procedure Technicians weekly and signed off monthly by the Scrub Tech. Log kept in scrub room. Blinds will be removed and window coverings that don't hold bacteria will be installed as approved by the Clinic Director.	3/5/21 3/5/21

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L 100	Continued From page 24 Procedure Technician and Laboratory. In a drawer under the counter, the surveyor observed 31 red top blood sample tubes, with an expiration date of 1/10/21. The surveyor asked if there were any other red top tubes available for patient use, and EI # 3 stated, "No." A tour of the clinic was conducted on 2/5/21 at 8:15 AM. EI # 2, Practical Nurse, was also present during the tour. The following was observed in Procedure Room 1: a. Suction cart with multiple areas of brown rust. The rubber bumper around the bottom of the cart, above the wheels, was dislodged and hanging down, exposing sharp, rusted edges. b. Under the sink, an opened and partially used gallon of 10% Povidine Iodine was sitting in brown rust particles. The surveyor asked EI # 2 if the solution was currently being used. EI # 2 stated, "Yes, it's used on the cotton balls for the (abortion) procedures." c. On the counter, near the head of the patient exam table, was an electric Lasko fan. The preventive maintenance sticker on the fan listed the last date of inspection as 8/28/19. d. The exam table was positioned in an upright position. Under the table top was dust and balls of dust. The drawers contained paper sheets, used for patient care, with dust particles on them. The top drawer on the left side of the exam table contained rust particles the length of the drawer. The following was observed in Procedure Room 2:	L 100 420-5-1 .02 420-5-1 .02 (a) 420-5-1 .02 (d)	Expired red top tubes have been discarded. EI#3 now trained to check all equipment and supplies. New internal checklist policy and training put into place on 03/01/2021 to ensure this by completion of a weekly checklist by the laboratory technician. Lab personnel will complete checklist weekly and report to the Assistant Director monthly. Suction machines will be cleaned and refurbished. They will be now be inspected monthly on exterior by and logged in Equipment log by two employees Exam tables will be cleaned and all dust and rust removed. Checklist Policy and training put in place 03/01/2021 indicates procedure room technicians were given a checklist to be completed weekly and reported monthly to and signed off on by the Scrub Technician.	3/5/21 3/5/21 3/5/21

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	C5103	A. BUILDING: _____ B. WING _____	02/05/2021

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	Continued From page 25 a. Suction cart with multiple areas of brown rust. The rubber bumper around the bottom of the cart, above the wheels, was dislodged and hanging down, exposing sharp, rusted edges. b. The exam table was positioned in an upright position. Under the table top was dust and balls of dust. The drawers contained dust and black particles on top of paper sheets used for patient care. During the tour, the above observations were confirmed by EI # 2.	L 100 420-5-1 .02 (a)	Exam table and drawers will be cleaned weekly as part of exam room inspection per the internal checklist policy put into place on 03/01/2021 Suction Machines will be sent out for repair and will be evaluated monthly thereafter by procedure staff.	3/5/21