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| <b>Statement of Deficiencies</b>   | <b>(X1) Provider/Supplier/CLIA Identification Number</b><br><br>010001       | <b>(X3) Date Survey Completed</b><br><br>09/29/2017 |
| <b>Name of Provider or Supplier</b><br><br>Southeast Health Medical Center   | <b>Street Address, City, State</b><br><br>1108 Ross Clark Circle, Dothan, AL |   |
| For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency. |  |   |

| <b>(X4) ID Prefix Tag</b> | <b>Summary Statement of Deficiencies</b><br><br>(Each deficiency should be preceded by full regulatory or LSC identifying information)   |
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| <b>A0749</b>              | <p><b>INFECTION CONTROL PROGRAM</b><br/>CFR(s): 482.42(a)(1)</p> <p>The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.</p> <p>This STANDARD is not met as evidenced by:<br/>Based on review of facility policy and procedure, Centers for Disease Control (CDC) frequently asked questions (FAQs), observations and interviews it was determined the facility failed to ensure: 1. Patient care staff, including Certified Registered Nurse Anesthetist and Anesthesiologist performed hand hygiene before and after glove removal. 2. Single-dose syringes were not carried from patient room to other areas of the treatment floor. This affected Patient Identifier (PI) # 45, PI # 46, PI # 47 and had the potential to negatively affect all patients care for by this facility. Findings include: Facility Policy: Infection Prevention and Control Manual Standard Isolation Precautions Effective date: 10/1/1978 Reviewed: 07/11, 05/17, 02/15, 02/16, 01/17 Policy: Southeast Alabama Medical Center promotes the basic isolation precaution guideline published by the Healthcare Infection Control Practices Advisory Committee /Centers for Disease Control and Prevention (HICPAC/CDC). Purpose: To follow research based guidelines/recommendations that are applicable across the continuum of care. Procedure:Standard Precautions should be used in the care of all patients. 1. Perform Hand Hygiene: a. Before having direct contact and after direct contact with patients. b. After contact with blood, body fluids, or excretions, mucous membranes, nonintact skin or wound dressings. c. After contact with a patient's intact skin (e.g. when taking a pulse or blood pressure or lifting a patient). d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. f. After removing gloves. ... 3. Soiled Patient Care Equipment:</p> |

handle in a manner that prevents transfer of microorganisms to others and to the environment... ... 5. Medications packages as single-use vials should not be used for more than one patient... Facility Procedure: Anesthesia - Department Protocol Procedure for Subarachnoid Block (SAB) Effective date: 7/1/1990 Date Reviewed /Revised: 01/00, 01/09, 2/10, 3/11, 2/17, 9/17 Purpose: Placement Epidural, and SAB with aseptic technique for procedures requiring Neuraxial anesthesia. Procedure: ... Spinal and Epidural injection procedures are performed in a manner consistent with hospital infection control policies and procedures to maximize the prevention and communicable diseases. This includes: 1) Hand hygiene performed before and after the procedure. 2) The spinal injection procedure is performed using aseptic technique... CDC - FAQs regarding Safe Practices for Medical Injections ... Questions about Single-dose/Single-use Vials What is a single-dose or single-use vial? A single-dose or single-use vial is a vial of liquid medication intended for parenteral administration (injection or infusion) that is meant for use in a single patient for a single case/procedure/injection. Single-dose or single-use vials are labeled as such by the manufacturer and typically lack an antimicrobial preservative. ... What are examples of the "immediate patient treatment area"? Examples of immediate patient treatment areas include operating and procedure rooms, anesthesia and procedure carts, and patient rooms or bays. 1. An observation was conducted on 9/26/17 at 10:00 AM in the Cat Scan (CT) area. During the observation, Employee Identifier (EI) # 5, CT Technician, was observed preparing an Intravenous (IV) dye machine for injection. Once machine was completed EI # 5 returned to the viewing area with the gloves on and waited until the CT scan was complete. Once complete EI # 5 returned in to the room with the patient disconnected the IV and flushed the site with 10 ml (milliliters) of Normal Saline (NS). EI # 5 then assisted the patient onto the hospital bed and transported out of the CT area with the same gloves on. EI # 5 returned to the CT area removed gloves and donned a clean pair of gloves without sanitizing or washing hands and cleaned the CT machine. An interview was conducted on 9/26/17 at 10:35 AM with EI # 16, Director of Radiology who confirmed the above mentioned findings. 2. An observation was conducted on 9/27/17 at 8:25 AM on 6-East Neurosurgery/Neurology Unit with EI # 25, Registered Nurse (RN) to observe medication administration. During the observation, EI # 25 checked the patient's pedal pulse with gloved hands and used the same gloves to: Document the patient's information on the computer system. Listen to the patient's anterior breath sounds and Apical heart rate. Flush the patient's right arm IV (Intravenous) line. EI # 25 failed to remove gloves and sanitize his/her hands per policy. An interview was conducted on 9/27/17 at 12:00 AM with EI # 2, Quality Outcomes Team Leader who confirmed the above mentioned findings. 3. An observation was conducted on 9/27/17 at 8:25 AM on 6-East Neurosurgery/Neurology Unit with EI # 32, LPN (Licensed Practical Nurse) to observe medication administration. During the observation, EI # 32 administered oral, and topical medications and used the same gloves to: Document the patient's information on the computer system. Assessed the patient's feet. Listen to the patient's anterior breath sounds and Apical heart rate. Reached into his/her pockets where he /she stored multiple 10 ml NS syringes to remove his/her pen to write information on a piece of paper. EI # 32 failed to remove gloves and sanitize his/her hands per policy. An interview was conducted on 9/27/17 at 12:00 AM with EI # 2 who confirmed the above mentioned findings. 32470 4. An observation was conducted on 9/27/17 at 8:35 AM to observe EI # 3, RN administer medications in the Critical Care Unit (CCU). During the observation, EI # 3 administered medications per an OG (Oral Gastric) tube. Once complete, EI # 3 removed gloves and donned a clean pair of gloves without sanitizing or washing his/her hands. EI # 3 then gave IV medication and administered a NS flush per IV. EI # 3 then removed gloves cleaned the area of used

supplies and donned a clean pair of gloves without sanitizing or washing hands. An interview was conducted on 9/27/17 at 10:00 AM with EI # 10, Director of CCU, who confirmed the above mentioned findings. 5. An observation of medication administration was conducted on 9/27/17 at 8:40 AM with EI # 20, RN for an unsampled patient (PI # 45). During this observation, EI # 20 failed to perform hand hygiene prior to obtaining clean gloves. After oral medication was administered, EI # 20 exited the patient's room. It was observed located in EI # 20's pants pocket were three (3) syringes. The surveyor asked what were in the syringes and EI # 20 stated NS flush. She stated she carries them around, "just in case she needs to flush a patient's IV line" 6. On 9/27/17 at 8:50 AM, the surveyor observed EI # 21, RN had prepared medications for an unsampled patient (PI # 46). Just prior to administration of medications, EI # 21 had assisted the Patient Care Technician (PCT) with cleaning the patient. EI # 21 removed her gloves and donned clean gloves. EI # 21 failed to perform hand hygiene prior to obtaining and donning clean gloves. The surveyor asked EI # 21 to step outside the room, at which time, EI # 21 removed her gloves and performed hand hygiene. EI # 21 verified she had not performed hand hygiene prior to obtaining and donning clean gloves and that she should have done so. 7. An observation was conducted on 9/27/17 at 9:00 AM in the CCU with EI # 4, RN to observe a medication administration. During the observation, EI # 4 administered subcutaneous (SQ) medication and using the same gloves, EI # 4 crushed oral medications and dissolved them in a medication cup. EI # 4 then donned a second pair of gloves over the dirty gloves and applied a topical lotion to the patient's abdominal folds and thigh folds. EI # 4 removed the second pair of gloves and administered the dissolved medication per the OG tube and cleared the tube by flushing. EI # 4 then removed gloves and donned a clean pair of gloves without sanitizing or washing hands and applied a duoderm to the patient's left knee. EI # 4 then flushed the IV line with 10 ml (milliliters) of NS without cleaning the IV port prior to flushing. An interview was conducted on 9/27/17 at 10:00 AM with EI # 10 who confirmed the above mentioned findings. 39098 9. An observation was conducted on 9/27/17 at 9:45 AM on the 7-East nursing unit to observe EI # 24, RN, change the dressing on an Infusaport of an unsampled patient. EI # 24 prepared the patient, opened the kit, donned sterile gloves, then reached in kit and picked up sterile mask and place around ears. EI # 24 removed his personal eye glasses with sterile gloves. Realizing this, he removed the sterile gloves, left room to retrieve another kit and failed to perform hand washing or sanitize hands before leaving room. On the second attempt, EI # 24 donned sterile gloves before reaching into the sterile kit and putting on the mask looping it around the ears. EI # 24 failed to maintain sterile technique for the infusaport dressing change. After leaving the room, EI # 7, RN, Infection Control, confirmed the above findings. 10. On 9/27/17 at 10:40 AM, the surveyor observed surgical staff setting up the operating room (OR) in preparation for Caesarian section (C-section) for an unsampled patient (PI # 47). During this observation time, the surveyor observed EI # 22, RN perform hand hygiene using hand sanitizer. EI # 22 applied hand sanitizer and rubbed hands together for approximately 5 seconds. Once the patient was brought to the OR, EI # 23, Anesthesiologist picked up a rolling stool to move it and the stool fell apart with pieces landing on the floor. EI # 23 picked up the parts, put the stool back together and donned gloves for the Epidural anesthesia. EI # 23 failed to perform hand hygiene after picking up the stool parts from the floor prior to donning gloves. After the patient's lower back was prepared for Epidural anesthesia, EI # 23 removed gloves and donned sterile gloves. EI # 23 failed to perform hand hygiene after glove removal and prior to donning sterile gloves. 37268 8. An observation was conducted on 9/27/17 at 9:41 AM on 6-East Nursing Unit with EI # 33, RN to observe medication administration. During the observation, EI # 33 removed the end

connector from Ganciclovir Sodium (Cytovene) 400 mg (milligrams) in 100 ml NS and connected the medline pump to the IV port. EI # 33 used the same gloves to turn on the blood pressure monitor machine. EI # 33 did not remove gloves and sanitize his /her hands per policy. An interview was conducted on 9/27/17 at 12:00 AM with EI # 2 who confirmed the above mentioned findings.