

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 010006	(X3) Date Survey Completed 04/11/2019
Name of Provider or Supplier North Alabama Medical Center	Street Address, City, State 1701 Veterans Drive, Florence, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
A0749	<p>INFECTION CONTROL PROGRAM 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: Based on observations, review of facility policies and procedures, Centers for Disease Control and Prevention (CDC) Frequently Asked Questions (FAQ's) regarding Safe Practices For Medical Injections and interviews with the staff, it was determined the facility failed to ensure the staff: a) Followed the facility policy and procedure for proper hand hygiene and gloving. b) Cleaned the septum of medication vials prior to piercing the vial per CDC guidelines and facility policy. c) Discarded contaminated supplies and maintained clean surfaces in the Operating Room (OR). d) Followed the facility policy for labeling and disposing of spiked Intravenous (IV) fluids and tubing in the OR. e) Disposed of used IV fluids in non-handwashing sinks. f) Followed facility policy for sterile dressing change. g) Cleaned re-useable equipment after use. This did affect MR # 7, MR # 6, MR # 20, MR # 4, Emergency Department (ED) MR # 16, and unsampled patients. This was 4 of 22 MR's with observations, 1 of 1 ED MR observation and unsampled patients and had the potential to negatively affect all patients served by this facility. Findings include: Policy/Procedure: Standard and Transmission Based (Isolation) Policy Revised: 11/2018 1. STANDARD PRECAUTIONS Standard Precautions applies to all persons and assume every person is potentially infected or colonized with an infectious organism ... Components of Standard Precautions include: A. Hand hygiene (refer to Hand Hygiene in Healthcare Setting Policy) ...C. Use of personal protective equipment (PPE) ... 1. Gloves - Always perform HH (hand hygiene prior to donning gloves. Gloves will be used to prevent the contamination of healthcare workers hands ...The following apply to glove</p>

use: ...Use gloves if there is a possibility of touching contaminated patient care equipment, environmental surfaces ... Whenever gloves are changed, hand hygiene should be practiced before donning a clean pair of gloves. Gloves are removed before leaving a room and never removed or worn out in the hallways. ...After gloves are removed, hand hygiene must be performed. ... Change gloves between patient contact and mobile equipment contact such as computers. F. Safe Work Practices for Standard Precautions ... Liquid ... waste must be flushed down the sewer system via toilet or flush hopper (never down sink drains) ... Facility Policy: Parenteral Medication Revised Date: 09/2018 Purpose: To provide guidelines for the safe administration of ... parenteral medication. Procedure: 2. Wash or sanitize hands. 3. Prepare the medication as follows: d. Scrub the rubber cap with an alcohol sponge. CDC Frequently Asked Questions (FAQ's) regarding Safe Practices For Medical Injections "Medication Preparation Questions 1. How should I draw up medications? Parenteral medications should be accessed in an aseptic manner. This includes using a new sterile syringe and sterile needle to draw up medications while preventing contact between the injection materials and the non-sterile environment. Proper hand hygiene should be performed before handling medications and the rubber septum should be disinfected with alcohol prior to piercing it." Facility Policy: Medication Administration Revised Date: 01/2019 Purpose: To establish a practice that promotes safety in the administration of medications. Procedure: K. Procedure for Transferring Patient Medication: 1. The nurse will: b. Narcotics and medications removed from Pyxis (automated dispensing system) will be returned to the automated dispensing system and not be transported with the patient. Facility Policy: Maintenance and Set-Up of Invasive Monitoring and IV sets in the CVOR (Cardiovascular OR) Policy: Members of the Anesthesia Care Team will ensure that all invasive monitoring and IV administration sets are set up according to this policy ensuring patient safety and allow timely interventions on behalf of the patient. Procedure: 1. Transducers and IV administrations sets A. Transducers and IV administration sets that are set up in advance of any surgical procedure will be dated with expiration date 72 hours after initial set up. II. Pre-Spiking of IV Fluid Bags B. Spiked IV fluids are to have the expiration date of 72 hours after initial set up written on the bag. Central Venous Catheter (CVC) Dressing Change/Site Care/ Catheter Care Policy #: H110.PCS.151 Revised Date: 9/2018 Purpose To minimize the risk of the patient acquiring a central line-associated blood stream infection while providing intermediate to long-term venous access... Procedure: B. Process 5. Have patient turn head in direction opposite CVC insertion site and place mask on patient... 7. Carefully remove soiled dressing or tape without pulling on catheter... 8. Discard soiled dressing and gloves in proper receptacle. 11. Open CVC dressing tray... don mask and sterile gloves... Policy/ Procedure Title: ABG (Arterial Blood Gas) Policy #: H110.771.050 Revised Date: 11 /2018 2.14 Arterial Puncture/ Radial Artery 5. Locate the radial artery... 6. Cleanse the skin with 70% alcohol. 7. Insert the needle... Manufacturer's Guidelines for Cleaning Revised Date: 07-Mar-17 Cleaning the Analyzer and Downloader Clean the display screen and the case using a gauze pad moisten with Super Sani-Cloth. Wash hands through with soap and water after handling an analyzer or downloader. Exercise universal safety precautions at all times when handling the analyzer, cartridges, and peripherals to prevent exposure to blood-borne pathogens. 1. An observation was conducted by the surveyor and Employee Identifier (EI) # 8, Director of Surgical Services, on 4/9/19 from 10:30 AM to 11:22 AM in OR # 9 on MR # 7 for a Right Femoral Hernia Repair with TAP (Transverse Abdominis Plane) Block and the following was observed: At 10:35 AM EI # 37, Registered Nurse (RN) inserted a foley catheter in MR # 7 and removed his/her gloves without performing hand hygiene. At 10:39 AM EI # 7 applied gloves and began shaving and prepping the right femoral pre surgical site. EI # 7 removed his/her gloves, obtained a chloraprep swab

and applied clean gloves without performing hand hygiene as directed per the facility policy. When EI # 7 completed prepping the surgical site, EI # 7 left the OR wearing his/her dirty gloves to "dispose of the chloraprep swab" and upon returning removed his/her gloves without performing hand hygiene. At 10:41 AM EI # 3, Certified Registered Nurse Anesthetist (CRNA), placed a large roll of tape on the IV pole which fell to the floor. EI # 3 retrieved the roll of tape from the floor and placed the contaminated roll of tape on top of his/her clean anesthesia cart which contained labeled IV medications in syringes, thus contaminating the clean area. At 10:46 AM a large blue drape was placed to the upper field for MR # 7. EI # 3 retrieved the contaminated roll of tape, secured the left side of the blue drape to the IV pole and removed his/her gloves without performing hand hygiene. At 10:50 AM EI # 3 applied gloves and retrieved a tube of medication (Lacrilube) from the automated medication dispensing system. EI # 3 failed to perform hand hygiene before applying gloves and entering the automated medication dispensing system as directed per facility policy. EI # 3 then applied the medication to MR # 7's lips and removed his/her gloves without performing hand hygiene. At 10:55 AM EI # 3 applied gloves without performing hand hygiene and retrieved 2 vials of IV medication (Propofol and Neosynephrine). EI # 3 opened the vial's and withdrew the medication into a syringe without cleaning the vial tops with an alcohol sponge as directed per facility policy and CDC guidelines. EI # 3 then removed his/her gloves without performing hand hygiene. At 11:12 AM EI # 2, Physician /Surgeon, completed the procedure and removed his/her gloves and left the OR room without performing hand hygiene. EI # 3 applied gloves and emptied the foley catheter bag containing urine. EI # 3 then removed his/her gloves and began writing on the MR form without performing hand hygiene. At 11:18 AM EI # 5, Scrub Technician, completed preparing MR # 7 for transfer and removed his/her gloves without performing hand hygiene. EI # 4, Scrub Technician, completed preparing contaminated surgical instruments for transfer to central sterile and removed his/her gloves without performing hand hygiene. At 11:22 AM EI # 3 extubated MR # 7 and removed his/her gloves without performing hand hygiene. EI # 3 placed and prepared IV syringe of Fentanyl in his/her front shirt pocket and transported MR # 7 to the recovery room. EI # 3 failed to follow the facility policy of not transporting medications with the patient.

2. An observation was conducted by the surveyor and EI # 8 on 4/9/19 at 11:32 AM in Endoscopy Room # 3 on MR # 6 for an Esophagogastroduodenoscopy (EGD) with Stent Removal. At 11:35 AM EI # 7, Anestheologist, removed his/her gloves and exited the room with the dirty gloves in his/her left hand without performing hand hygiene. At 11:39 AM, wearing the dirty gloves used during the procedure, EI # 17, CRNA, transported MR # 6 down the hallway to the recovery room. EI # 17 failed to remove gloves prior to leaving the room and entering the hallway as directed per the facility policy. EI # 17 then removed his/her gloves and began writing on the MR without performing hand hygiene.

3. During a tour of the two (2) Cardiovascular OR Rooms on 4/9/19 from 1:33 PM to 2:45 PM the surveyor and EI # 8 observed the following: OR # 7: 0.9 % (Percent) Sodium Chloride 1000 cc (cubic centimeters) IV bag x (times) 3 spiked with IV tubing and labeled with a date of 4/4 (4/4/19) and connected to IV pumps, which had been expired per policy for 6 days. OR # 5: Plasma Lyte A 1000 ml (milliliters) x 2 bags spiked and connected to a perfusion pump. There were no labels on the IV bags or tubing indicating the expiration date as directed per the facility policy.

4. An observation was conducted by the surveyor and EI # 8 in the Endoscopy Center on 4/10/19 at 9:05 AM to observe EI # 9, RN, to perform Rapiocide disinfectant testing. EI # 9 completed the test and removed his/her gloves without performing hand hygiene as directed per the facility policy. An interview was conducted on 4/10/19 at 9:25 AM with EI # 8 who confirmed the aforementioned findings and stated the staff failed to

follow the facility policies and procedures. 5. At 9:50 AM on 4/10/19 in the Endoscopy Center the surveyor observed 2 discarded bags of IV Normal Saline lying in a sink which had handwashing soak and paper towels on the wall. The surveyor asked EI # 8, if the sink was a clean sink and EI # 8 stated, "Yes". The surveyor then asked EI # 8, if IV fluids should be discarded down a clean sink? EI # 8 stated, "No". An interview was conducted on 4/10/19 at 9:52 AM with EI # 9 who was also present where IV bags used IV bags are usually discarded. EI # 9 stated, "In that sink (clean sink)". 39098 6. MR # 20 was admitted to the hospital on 3/21/19 with diagnoses including Left Hip Fracture and Schizoaffective Disorder. MR # 20 was on contact precautions for ESBL (Extended Spectrum Beta Lactamase) UTI (Urinary Tract Infection). An observation was conducted on 4/10/19 at 9:30 AM to observe wound care on a stage II pressure ulcer of the coccyx, provided by EI # 19, RN. EI # 18, RN, WCC (Wound Care Certified), was also present and assisted during the wound care. EI # 19 unfastened the patient's adult diaper and discovered the patient had soiled the diaper with feces. EI # 19 removed gown and gloves to leave room to retrieve more diapers. EI # 19 failed to perform hand hygiene after removing gloves. EI # 19 cleaned the patient, then removed the soiled dressing. EI # 19 removed her/his contaminated gloves and donned clean gloves, without first performing hand hygiene. EI # 19 cleansed the wound with Shur-cleans wound cleanser, then patted dry with 4 x 4 gauze. EI # 19 used the back of her/his gloved hand to adjust her/his eye glasses, while measuring the wound. The wound was photographed, then covered with a Mepilex dressing. While wearing the same gloves used for wound care, EI # 19 repositioned the patient and covers, pulled out a wipe from the pack and cleaned the bedside table, and closed the lid on the wipes. Using the dirty wipe folded over, EI # 19 attempted to pick up the pack of wipes off the bed, but dropped them on the floor. EI # 18 picked up the pack of wipes off the floor and placed them on the shelf next to the new wound dressings, without first cleaning the pack. EI # 18 removed her/his gloves following the procedure, and donned clean gloves, without first performing hand hygiene. EI # 18 cleaned the camera, then placed the camera in EI # 19's uniform pocket. During an interview on 4/10/19 at 10:00 AM with EI # 18, the above findings were confirmed. 34107 7. During an observation of medication (med) administration on the Medical/ Surgical unit conducted on 4/9/19 at 11:55 AM the surveyor observed EI # 26 prepare insulin for administration. EI # 26 entered the med room and failed to perform hand hygiene. EI # 26 then removed insulin from the refrigerator, and withdrew 4 units of insulin from the vial. EI # 26 exited the med room and entered an unsampled patient's room where EI # 26 applied gloves and administered the 4 units of insulin to patient's upper left arm. EI # 26 then removed gloves and exited the patient room and failed to perform hand hygiene. The staff failed to perform hand hygiene when entering the med room, before preparing a medication for administration, when entering the patient's room, after glove removal, and before exiting the patient's room per policy. In an interview conducted on 4/9/19 at 12:05 PM, EI # 28, Clinical Coordinator, confirmed the RN failed to perform hand hygiene per policy. 8. During an observation of medication administration on the Cardiac Care Unit (CCU) conducted on 4/9/19 at 1:25 PM the surveyor observed EI # 40, RN, enter the med room, place their work cell phone on the Pyxis machine, obtain intravenous (IV) Merrium 500 milligram (mg)/250 milliliter (ml) bag from the Pyxis. EI # 40 then proceeded to patient room with IV med and cell phone in hand. EI # 40 entered the patient room placed the work cell phone on the med cart in the patient's room, applied gloves and hung the IV med. EI # 40 failed to perform hand hygiene when entering the med room, before obtaining medication from Pyxis and clean cell phone before placing on cart in patient room. After EI # 40 completed care, removed the dirty work cell phone from the cart and left the patient room, returned to med room and placed the dirty cell phone on the

counter and failed to clean the work cell phone. In an interview conducted on 4/9/19 at 2:30 PM, EI # 22 confirmed the staff failed to perform hand hygiene, and clean the dirty cell phone from med room, patient room and back to med room. 9. During an observation of a CVC dressing change on the CCU unit conducted on 4/10/19 at 9:10 AM with EI # 23, Registered Nurse, the surveyor observed EI # 23 apply hand sanitizer and rub hands together for 8 seconds. EI # 23 hands were still wet when she tried to apply the gloves. EI # 23 instructed MR # 4 to turn his/her head away from the CVC dressing. The patient stated, "I don't know what she said." The patient's family present in the room, stated, "He/she is very hard of hearing." EI # 23 failed to place a mask on MR # 4 per policy. EI # 23 removed the old transparent dressing and left the dirty Biopatch and stat-lock device. EI # 23 applied sterile gloves and then removed the old Biopatch disc and stat-lock device at the insertion site with sterile gloves and then continued to perform the dressing change with the contaminated gloves. The staff failed to follow the sterile CVC dressing policy. In an interview conducted on 4/11/19 at 10:20 AM, EI # 38, Chief Nursing Officer, confirmed the staff failed to follow facility policy. 10. On 4/10/19 at 11:45 AM the surveyor observed EI # 25, Respiratory Therapist Technician, obtain an Arterial Blood Gas (ABG) specimen from an unsampled patient in the Emergency Department (ED) using i-STAT machine (hand held ABG analyzer). EI # 23 cleaned the left radial area with an alcohol pad and then touched cleaned site several more times before actually performing the stick. During the procedure EI # 23 changed gloves several times using hand sanitizer for 5 to 12 seconds her hands were not dry before replacing gloves. EI # 23 placed the i-STAT machine on the patient's bed and then to the the supply cart. EI # 23 completed patient care removed gloves and washed hands with soap and water and then picked up the dirty i-STAT machine from the supply cart with ungloved hands and carried it to the nurse's station and placed the dirty i-STAT machine on the docking station. EI # 21, Ancillary Support Director, was present during the observations on 4/10/19 at 11:45 AM and confirmed the above findings at the time of the observations. 30952 11. During a tour of the (ED) Emergency Department on 4/9/19 at 9:20 AM, the surveyors observed EI # 39, ED RN, in the medication room obtaining patient supplies. EI # 39 retrieved one bag of intravenous (IV) solution and one package of IV tubing from the cabinet. EI # 39 dropped the IV tubing package on the floor then reached down and retrieved the tubing package from the floor. EI # 39 opened the tubing package and inserted the IV line into the IV solution bag in preparation for patient use. EI # 39 failed to perform hand hygiene after retrieving supplies from the floor and before preparing IV solution for patient use. On 4/10/19 at 2:30 PM, EI # 33, Nurse Educator, present during the observation, confirmed the above finding. 12. At 1:30 PM in the ED, EI # 1, ED RN removed the needle from a prepared syringe which contained Dilaudid injectable, then transferred the Dilaudid into another syringe in order to mix Phenergan for intramuscular injection for ED MR # 16. EI # 1 failed to clean the septum of the original syringe vial with alcohol prior to insertion of the needle. In an interview on 4/11/19 at 8:20 AM, EI # 43, Infection Preventionist confirmed staff failed to follow facility infection control practices. 32470 13. An observation was conducted on 4/10/19 at 8:20 AM at the Wound Care Center. EI # 13, RN, entered exam room # 4 to speak with the patient and EI # 14, physician, entered the room. After washing hands EI # 14 completed a debridement on the patients foot. Once complete EI # 14 removed gloves and exited the room without washing or sanitizing hands. At 8:25 AM EI # 16 entered exam room # 4 to wrap the patient's foot after the debridement. EI # 16 obtained supplies needed and donned gloves. EI # 16 failed to sanitize hands prior to donning gloves. EI # 16 completed the wound care. An interview was conducted at 8:30 AM with EI # 12, Assistant Administrator, who confirmed the above mentioned findings. 14. An observation was conducted on 4/10/19 at 8:45 AM

to 9:00 AM at the Wound Care Center. EI # 13, RN, and EI # 14 entered exam room # 8. After washing hands EI #14 donned gloves, plugged in the observation lamp and turned on, examined the patient's (unsampled patient) foot using the same gloves used to plug in and turn on the lamp. EI # 14 then began the debridement of the foot using the same gloves. When complete EI # 14 removed gloves and exited the room and failed to wash or sanitize hands prior to exiting. At 9:00 EI # 16, RN, entered exam room # 8. EI # 16 sanitized hands and donned gloves and removed the dressing to the foot. When complete EI # 16 removed gloves, obtained a roll of tape, donned clean gloves and failed to sanitize hands prior to donning gloves and applied a prism dressing to the wound bed. EI # 16 then prepped the foot and leg for a cast. After completing the wrapping of the leg EI # 16 removed gloves and donned a clean pair of gloves and failed to sanitize hands. EI # 16 then wrapped the foot and leg with padding for the cast. EI # 16 removed gloves donned clean gloves and failed to sanitize hands. At 9:20 AM EI # 14 entered exam room # 8 and donned gloves and gown and failed to wash or sanitize hands. EI #14 applied the cast to the foot and leg, removed the gown and gloves and exited the room. EI # 14 failed to wash or sanitize hands prior to leaving the exam room and went directly into the dictation room. An interview was conducted on 4/10/19 at 9:30 AM with EI # 12, who confirmed the above mentioned findings. 40119 15. An observation was conducted on 4/9/19 at 12:58 PM to observe EI # 32, Registered Nurse, administer IV (intravenous) medication and perform wound care to an unsampled patient. EI # 32 donned gloves without hand hygiene EI # 32 prepared syringe of Ketoralac 30 mg/ml 1 ml on the desktop surface of the computer without cleaning the computer surface prior to the preparation of medication. EI # 32 administered the IV Ketoralac without removing gloves and performing hand hygiene. EI # 32 removed gloves, performed hand hygiene at the patient's bathroom sink, then used bare hand to turn the sink faucet off. EI # 32 donned gloves, removed bandage to the patient's left lateral thigh with bloody drainage present on the bandage, removed gloves, and donned clean gloves without performing hand hygiene. EI # 32 placed gauze over left lateral thigh wound, secured with tape, removed gloves, obtained patient lunch tray and gave tray to another facility staff member without performing hand hygiene. An interview was conducted with EI # 33, who confirmed the above findings.