State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING: _____ B. WING _____	02/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
U 000	INITIAL COMMENTS At the time of the survey, Summit Medical Associates was not in compliance with Chapter 290-5-33, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a State licensure survey. The following deficiencies were written as the result of that survey.	U 000		
U 069 SS=D	290-5-33-.10(c) PHYSICAL PLANT & OPERATIONAL STANDARDS Equipment, electrical appliances, wiring, elevators, heating and cooling systems, surgery rooms and special service areas shall be constructed so as to assure the safety of all occupants. It shall be the responsibility of the governing body to assure that the center is in a safe condition at all times and that a fire inspection record is maintained on equipment, systems, and areas that may present a hazard to occupants. This Rule is not met as evidenced by: . Based on review of facility records and staff interview, it was determined that the governing body failed to assure that the center was in a safe condition at all times and that a fire inspection record was maintained. Findings: Review of facility records failed to reveal evidence of a fire inspection report. During an interview on 02/17/10 at 5:00 p.m. in the consultation room, the administrator (employee #8) stated that he/she had been employed at the facility for [redacted] years and did not recall a fire inspection ever	U 069		

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U 069	Continued From page 1 having been conducted in the facility.	U 069		
U 075 SS=D	290-5-33-.10(g)(2) PHYSICAL PLANT & OPERATIONAL STANDARDS The walls and floors in procedure rooms shall be of material that will permit frequent washing and cleaning; This Rule is not met as evidenced by: . Based on observations during the facility tour, it was determined that the facility failed to ensure that the walls and flooring in the procedure room were in a condition that would permit effective washing and disinfecting of the surgical area. Findings were: During a tour of the procedure room at 1:30 p.m. on 02/17/2010 and accompanied by the facility's administrator (employee #8) and the certified registered nurse anesthetist (CRNA-credential file #5), observations revealed peeling paint on the ceiling of the room, deep gouged out areas (damage) on three (3) of the four (4) walls, and separation of the seams of the floor around the procedure table as well as at the edges of the flooring. These conditions decreased the facility's ability to effectively clean and disinfect the procedure room before and between procedures, thus increasing the risk of infections. The facility's administrator acknowledged the condition of the room and the risk of infections.	U 075		
U 091 SS=D	290-5-33-.10(l) PHYSICAL PLANT & OPERATIONAL STANDARDS	U 091		

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U 091	Continued From page 2 The center shall be arranged and organized in such a manner as to ensure the comfort, safety, hygiene, privacy, and dignity of patients treated therein. This Rule is not met as evidenced by: . Based on observations during tour of the pre-operative and post-operative areas and staff interview, it was determined that the center was not arranged to ensure and respect the privacy and dignity of the patients. Findings were: Observations during a tour of the pre-operative and post-operative areas at 1:30 p.m. on 02/17/2010 accompanied by the administrator (employee #8) and a registered nurse (RN-employee #1) revealed the following: 1. The pre-operative area contained twelve (12) chairs touching each other that the patients used. No curtains or screens were available to ensure the individual privacy and dignity of the patients in the area; 2. The post-operative area contained six (6) chairs next to each where patients would be moved from stretchers once sufficiently recovered. No curtains or screens were available to ensure the individual privacy and dignity of the patients in the area. During an interview at 2:15 p.m. on 02/17/10 in the facility's post-operative area, the RN (employee #1) stated that the patients waited together in the chairs provided in the pre-operative area and were recovered together in the chairs located in the post-operative area. The RN stated that no screens or curtains were available to be	U 091		

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U 091	Continued From page 3 placed between the chairs in these areas.	U 091		
U 093 SS=D	290-5-33-.10(n) PHYSICAL PLANT & OPERATIONAL STANDARDS Medicines shall be stored in a conveniently located cabinet with lock, and only licensed persons shall have access. This Rule is not met as evidenced by: . Based on observations during a facility tour and staff interview, it was determined that the facility failed to ensure that drugs were stored in a locked cabinet and only accessible by licensed personnel. Findings were: During a tour of the facility's procedure room at approximately 1:30 p.m. on 02/17/2010, and accompanied by the administrator (employee #8) and the certified nurse anesthetist (CRNA-credential file #5), medications were observed on the top of the anesthesia cart and accessible to a non-licensed staff member who was cleaning the room. The medications located on top of the anesthesia cart included: a) An opened vial of Fentanyl (narcotic) labeled for single use only. The CRNA stated that he/she only used a small amount at a time out of the vial so the contents of the vial were used for more than one patient; b) Three (3) small white tablets in a medication cup that was unlabeled. The CRNA stated that the tablets were Cytoxan (an antineoplastic drug used to induce abortion); c) An unopened vial of Robinul (anesthetic) and	U 093		

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U 093	Continued From page 4 an unopened vial of Succinylcholine (anesthetic); and d) Two (2) opened vials of Propofol (anesthetic), each labeled for single use only, were not labeled as to when the vials were opened. The administrator and CRNA acknowledged that non-licensed personnel had access to the medications located on top of the anesthesia cart.	U 093		
U 119 SS=D	290-5-33-.15(1) HOUSEKEEPING,LAUNDRY,MAINTENANCE (1) Each center shall provide sufficient space and equipment and ensure that housekeeping and maintenance is sufficient to keep the center and equipment in a clean and tidy condition and state of good repair. Proper maintenance shall be provided as necessary to correct, prevent, or adjust faulty equipment and/or correct other undesirable conditions. This Rule is not met as evidenced by: . Based on review of facility policies and procedures, facility tour, and staff interview, it was determined that the facility failed to ensure that the physical environment was sanitary, free of dust and debris, and in good repair. Findings were: During a tour of the procedure room at 1:30 p.m. on 02/17/2010 and accompanied by the facility's administrator (employee #8) and the certified registered nurse anesthetist (CRNA-credential file #5), observations revealed peeling paint on the ceiling of the room, deep gouged out areas	U 119		

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U 119	Continued From page 5 (damage) on three (3) of the four (4) walls, and separation of the seams of the floor around the procedure table as well as at the edges of the flooring. These conditions decreased the facility's ability to effectively clean and disinfect the procedure room before and between procedures, thus increasing the risk of infections. The facility's administrator acknowledged the condition of the room and the risk of infections. Review of facility policy, entitled Sanitation Policy For The Procedure Room Suite, Policy Number NURS 10082-D, revision date August 13, 2002, revealed that acceptable sanitation techniques were to be used by all personnel to reduce the possibility of infection of both patients and staff. The policy required that prior to the first procedure of the day all horizontal surfaces of tables, equipment, overhead lights, and other ceiling and wall mounted equipment was to be damp-dusted with a germicide. During the tour of the facility conducted at approximately 1:30 p.m. on 2/17/10 and accompanied by the administrator (employee #8), the following were observed: a) The ventilation vent in the room with the sterilizer was covered with dust; b) A visible gap was around the top of the facility's back exit door and the door frame; c) Numerous stained ceiling tiles were observed throughout the facility; d) Water stains were noted in the florescent light fixtures in the procedure room; e) Dust was noted on all the flat surfaces in the procedure room, on the surgical light, and other equipment in the room; f) Dust was noted in the recovery area on the counter at the head of the stretchers, on the top of	U 119		

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U 119	Continued From page 6 the crash cart and the suction machine, and on the intubation set-up tray, which was covered only by a towel. The tray also contained a pair of surgical gloves with an expiration date of 12/31/2009; and g) A ceiling tile was observed to have been pushed open in the pre-operative area hallway. Per the administrator this was for workmen access to the heating and air conditioning area, located above the ceiling. During the tour the administrator acknowledged the above observations.	U 119		
U 129 SS=D	290-5-33-.19(3) ELECTRICAL POWER Centers which utilize general anesthesia shall provide an emergency electrical system so controlled, that, after interruption of the normal electric power supply, an acceptable auxiliary power source is available and capable of being brought into use within ten seconds with sufficient voltage and frequency to reestablish essential in-house services and other emergency equipment needed to effect a prompt and efficient transfer of patients to an appropriate licensed hospital, when needed. This Rule is not met as evidenced by: . Based on review of facility policies and procedures, the facility's generator log, and staff interview, it was determined that the facility, which used general anesthesia, failed to ensure that the facility's generator, their auxiliary power source, was capable of being brought into use within ten	U 129		

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U 129	Continued From page 7 seconds following interruption of normal power. Findings were: Review of facility policy, entitled Emergency Power, Policy Number ADMIN 10017, effective January 27, 1997, revealed that an emergency generator was operational in the event of a power failure and that records of maintenance were on file in the administrator's office. Review of the generator log failed to reveal evidence of testing to ensure that the generator was capable of being brought into use within ten seconds of interruption of the normal power supply. During an interview at 4:30 p.m. on 02/16/2010 in the consultation room, the facility's administrator (employee #8) stated that the facility used general anesthesia; however, the administrator was unaware that the generator's capability of use, within ten seconds of interruption of normal power, had to be tested.	U 129		

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M 001	Opening Comments At the time of the survey, Summit Medical Associates was in compliance with Chapter 290-5-45, Rules and Regulations for Disaster Preparedness Plans, as the result of a State licensure survey.	M 001		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/24/11

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

David A. Cook., Commissioner

Nathan Deal, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

February 10, 2011

Ms. Merriam McLendon, Administrator
Summit Medical Associates
1874 Piedmont Rd., NE, Suite 500-E
Atlanta, GA 30324-4869

Dear Ms. McLendon:

Enclosed is a Report of Licensure Inspection completed at your facility on **December 21, 2010** by surveyor(s) from this office. This report contains one or more violations which must be corrected.

Your plan to correct these violations should be entered in the right hand column entitled "Providers Plan of Correction" with a projected completion date entered in the column "Completion Date". After you have completed the form, sign and date it in the space provided, return the ORIGINAL to our office no later than **February 25, 2011**.

Thank you for the courtesies extended to our representatives during this visit. If I can be of further assistance, please contact me at (404) 657-5449.

Sincerely,

James E. Courtney, Acting Director
Acute Care Section
Healthcare Facility Regulation Division
Department of Community Health

JEC:

EXHIBIT 'B'

[redacted] 8K 3/2[redacted]

PRINTED: 02/10/2011
FORM APPROVED

State of GA, Healthcare Facility Regulation Division

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U 000	INITIAL COMMENTS At the time of the survey, Summit Medical Associates was not in compliance with Chapter 290-5-33, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a State licensure survey. The following deficiencies were written as the result of that survey.	U 000	**INITIAL COMMENTS** Summit Medical Associates, P.C. has always placed a high priority on Patient Safety and Infection Control, and will continue to do so. Pursuant to the State Inspection conducted on December 21, 2010, Summit has responded by implementing the following corrective actions:	
U 028 SS=D	290-5-33-.03(3) ORGANIZATION & ADMINISTRATION. AMENDED The governing body of the center shall be responsible for appointing the professional staff and shall establish effective mechanisms for quality assurance and to ensure the accountability of the center's medical and/or dental staff and other professional personnel. This Rule is not met as evidenced by: Based on review of facility quality assurance data, facility credential files, and staff interview, it was determined that the facility lacked effective quality assurance mechanisms to ensure accountability of the medical and professional staff for five (5) of five (5) sampled credential files (#s 1, 2, 3, 4, and 5). Findings were: Review of the facility's Quality Assurance Management Report, dated January 25, 2010, indicated that peer review (quality review) would be conducted on a random number of charts and that peer review for anesthesia would be conducted on random charts on a monthly basis. Five (5) of five (5) credential files reviewed (#s 1, 2, 3, 4, and 5) lacked evidence that peer review	U 028	**290-5-33-.03(3)** **ORGANIZATION & ADMINISTRATION. AMENDED** **CORRECTIVE ACTION** Summit Medical Associates, P.C. respectfully disagrees with the Anesthesia Peer Review portion of this deficiency. One of the Facility's doctors performs anesthesia peer reviews for each anesthetist. The review and summary forms are kept in a separate file folder, which was given to the Surveyors for review at the time of the Inspection. Peer review data (which is also kept in a separate file folder) is also kept on all medical and professional staff; however, this data file was not available at the time of the Inspection. It had been inadvertently placed in a box headed for storage. A new form has been developed that will become a part of each medical and professional staff member's personnel file, which will ensure that the documentation is always on site and available for review. **MONITORING** Copies of completed Peer Review forms for all medical and professional staff will be kept in their personnel files, and a copy will be sent to a member of the Governing Body on a quarterly basis for review, and to ensure compliance.	2/24/11

tate of GA Inspection Report

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Marion M Lyndon, Administrator TITLE (X6) DATE 2/24/11

TATE FORM 6899 O4DB11 If continuation sheet 1 of 8

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U 028	Continued From page 1 had been conducted. During an interview at 5:30 p.m. on 12/21/2010 in one of the facility's offices, the Administrator (employee # 1) stated that peer review was conducted on unexpected outcomes and that physician #3 compiled the peer review data; however, the Administrator was unable to provide documentation that peer review on random cases had been completed. The Administrator also stated that physician #3 completed the peer review on the certified registered nurse anesthetist (CRNA-credential file #5), but that there was no peer review data on the CRNA for review.	U 028		
U 062 SS=D	290-5-33-.09(8) PROFESSIONAL SERVICES Each center will have effective policies and procedures for handling infection control and for recording complications which occur during or after surgery, which includes a reporting mechanism for patients who develop infections or postoperative complications after discharge. This Rule is not met as evidenced by: Based on review of facility policies and procedures, observation and staff interview, it was determined that the facility lacked effective infection control policies and procedures by ensuring that acceptable standards regarding temperature and humidity in the operating room (OR) were followed. Findings were: Review of facility policies and procedures failed to reveal evidence of a policy/procedure regarding acceptable ranges for temperature and humidity in the OR, and for the recording and tracking of	U 062	290-5-33-.09(8) **PROFESSIONAL SERVICES** **CORRECTIVE ACTION** Summit Medical Associates respectfully disagrees with this deficiency. Summit has always placed a high priority on infection control and proper documentation of the same. The Center has had policies and procedures in place for a number of years that ensures acceptable standards regarding proper temperature and humidity in the operating room. There is a Temperature and Humidity log kept in the operating room that is completed prior to each clinic. Neither the Administrator nor the operating room supervisor was aware that this log had been requested by the Surveyors. Also, the unavailability of this log was not mentioned during the exit interview that the Surveyors conducted with the Administrator; consequently, it is the Facility's position that sufficient opportunity was not given to provide this log, which was, in fact, in the operating room at the time of the survey. The Director of Nursing has been advised to always check with the operating room supervisor and the Administrator regarding the current location of any requested logs during an Inspection in the event they have been temporarily moved or are in use.	2/18/11

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U 062	Continued From page 2 the OR temperature and humidity on the days that the facility had scheduled procedures. The facility lacked evidence of a temperature and humidity log for the OR. During a tour of the OR suite at 3:30 p.m. on 12/21/2010, observation revealed a thermometer in the OR. During the tour, the director of nursing (DON-employee # 2) stated that the temperature and humidity was obtained, but that she/he did not know where the readings were recorded.	U 062		
U 093 SS=E	290-5-33-.10(n) PHYSICAL PLANT & OPERATIONAL STANDARDS Medicines shall be stored in a conveniently located cabinet with lock, and only licensed persons shall have access. This Rule is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to ensure that drugs were stored in a locked cabinet and only accessible by licensed individuals. Findings were: During a tour of the facility's operating room (OR) at 3:30 p.m. on 12/21/2010 with the director of nursing (DON-employee #2) and the certified registered nurse anesthetist (CRNA-credential file #5), observation revealed an open OR door, and medications on top of the anesthesia cart and accessible to non-licensed individuals. Medications on top of the anesthesia cart and accessible included: a. Twenty (20) 25 cubic centimeter (cc) syringes of pre-drawn Propofol (anesthetic	U 093	**290-5-33-.10(n)** **PHYSICAL PLANT & OPERATIONAL STANDARDS** **CORRECTIVE ACTION** Patient safety is of utmost importance to Summit Medical Associates. The Medical Director has warned the CRNA that all medications and drugs must be kept locked when he/she leaves the room unless the attending physician is present. The Medical Director in-serviced the CRNA to ensure that he understands that non-licensed personnel should never have access to either medications *or* controlled drugs. He acknowledged his understanding that further instances of non-compliance would not be tolerated, and would lead to more stringent disciplinary action, which could include dismissal. **MONITORING** The Medical Director and Administrator will conduct random inspections/observations of the operating room to observe the CRNA's compliance.	2/15/11

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SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

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U 093	Continued From page 3 sedative) 1%; b. Twenty (20) 6 cc syringes of pre-drawn Lidocaine (local anesthetic); c. Two (2) 50 cc vials of opened 1% Lidocaine (local anesthetic), marked "Vaso" and initialed. At the time of discovery, the CRNA stated that vasopressin (drug used to increase arterial blood pressure) 20 units had been added to the vials; and d. Three (3) 1 cc vials of Methylergonovine (blood vessel constrictor). The anesthesia cart was also observed to contain numerous medications and to have been left unlocked. The administrator and CRNA acknowledged that non-licensed individuals had access to the medications located on top of and in the anesthesia cart, but that they believed this regulation only applied to narcotics. This rule was previously cited on 02/17/2010.	U 093		
U 106 SS=D	290-5-33-.12(2)(c) RECORDS Contents of individual medical records shall normally contain the following at least: Treatment data: 1. Practitioner's orders. 2. Progress notes. 3. Nurse notes. 4. Medication. 5. Temperature-pulse-respiration (Graphic chart; surgical purposes only). 6. Special examinations(s) and reports (include x-ray and lab reports). 7. Signed informed consent form.	U 106	**290-5-33-.12(2) (c)** **RECORDS** **CORRECTIVE ACTION** The Pre-op/Post op orders form has been revised to include date and time next to the physician's signature. All physicians have been notified to begin using the revised form, and to document date and time along with their signature. **MONITORING** The signature, date and time will be checked as part of normal Quality Assurance checks by both the Administrator and the Medical Director.	3/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING _____ B. WING _____	12/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
U 106	Continued From page 4 8. Operation record. 9. Anesthesia record (if applicable). 10 Consultation record (if applicable). 11. Tissue findings when performed. 12. Where dental services are rendered, a complete dental chart with dental diagnosis, treatment, prescription and progress notes shall be part of the clinical record. This Rule is not met as evidenced by: Based on review of medical records and staff interview, it was determined that the facility failed to ensure that practitioner orders were dated and timed for six (6) of six (6) sampled patient records (#s 1, 2, 3, 4, 5, and 6). Findings were: Six (6) of six (6) medical records reviewed (#s 1, 2, 3, 4, 5, and 6) revealed that the practitioners' orders lacked a date or time when signed. During an interview at 11:30 a.m. on 12/21/2010 in one of the facility's offices, the Administrator (employee #1) stated that the date on the top of the record indicated the date that the physician signed the orders, even though the date was written by another staff member. The Administrator confirmed that the practitioner's orders did not have a date or time next to the physician's signature, as to when the orders were written.	U 106	290-5-33-.12(6) RECORDS CORRECTIVE ACTION Medical records that are boxed and ready for storage will be kept in a secure, locked area until picked up by the off-site storage company. All staff members have been in-serviced regarding the proper method of staging and securing medical records for storage pick-up. MONITORING The Administrator will monitor annual medical records staging for off-site storage to ensure compliance.	2/24/11
U 110 SS=D	290-5-33-.12(6) RECORDS Patient records shall be current and shall be entitled to the same protection as provided for any medical records under Georgia law.	U 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING _____ B. WING _____	12/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
U 110	Continued From page 5 This Rule is not met as evidenced by: . Based on review of facility policies and procedures, observation during facility tour, and staff interviews, it was determined that the facility failed to ensure that all patient records were protected from unauthorized access. Findings were: Review of facility policy, entitled Storage and Maintenance of Records, Policy Number Admin 10046, effective date January 27, 1997, last revised July 11, 2000, revealed that patient and personnel files were under the control of the director and must be kept in a controlled and secured area. The policy further noted that all patient charts were secured in the file room in alphabetical order. During a facility tour at 5:15 p.m. on 12/21/2010 with a medical assistant (MA-employee #8), observation revealed boxed medical records stored in an open area off the patient waiting room. The MA stated that the boxed records were from 2009 and needed to be picked up for off-site storage. He/she also confirmed that the housekeeping staff did access the area in the evenings while performing their duties. During an interview at 5:30 p.m. on 12/21/2010, the administrator (employee #1) acknowledged that the medical records were unprotected, and stated that the records could be moved into another area to await pick up.	U 110		
U 119 SS=E	290-5-33-.15(1) HOUSEKEEPING,LAUNDRY,MAINTENANCE (1) Each center shall provide sufficient space	U 119	**290-5-33-.15(1)** **HOUSEKEEPIG, LAUNDRY, MAINTENANCE** **CORRECTIVE ACTION** Summit Medical Associates places a high priority on the maintenance and upkeep of the facility and medical equipment. During the second - fourth quarters of 2010, all stretchers were sent to the company's medical maintenance company for repairs	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING _____ B. WING _____	12/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
U 119	Continued From page 6 .and equipment and ensure that housekeeping and maintenance is sufficient to keep the center and equipment in a clean and tidy condition and state of good repair. Proper maintenance shall be provided as necessary to correct, prevent, or adjust faulty equipment and/or correct other undesirable conditions. This Rule is not met as evidenced by: Based on observation during facility tours and staff interviews, it was determined that the facility failed to ensure that the center was kept in a clean and tidy condition and that equipment was properly maintained. Findings were: Observation during facility tours at 3:30 p.m. on 12/21/2010 with the director of nursing (DON-employee #2) and at 5:15 p.m. on 12/21/2010 with a medical assistant (MA-employee #8) revealed the following: a. Four (4) of four (4) stretchers in the post-operative area were observed with broken/missing plastic along the tops of the siderails and rusted areas with peeling paint along the bottom areas of the siderails. The DON acknowledged the condition of the stretchers at the time of discovery, and stated that the facility had ordered new stretchers which would arrive soon; and b. Heavy lint and a washcloth were observed behind the clothes dryers, and one (1) of two (2) clothes dryers was observed with approximately one quarter (1/4) inch layer of dust in the dust trap. At the time of discovery, the MA stated that the housekeepers were responsible for cleaning the area, and should have removed the lint and washcloth.	U 119	A. New stretchers have been ordered and scheduled for delivery within the next three weeks. In the interim, the existing stretchers are being painted and checked for aesthetic appearance and to bring them within acceptable standards. B. Medical staff has been in-serviced to properly clean the lint filter after each laundry load to prevent lint build-up. They have also been in-serviced to keep the laundry area in a clean and tidy condition. **MONITORING** A. The Medical Director will accompany the Administrator and DON on a monthly tour of the facility to inspect the physical plant and medical equipment to ensure that all is kept in a state of good repair. B. A Daily Check-list has been developed for the laundry area. This check –list must be reviewed and signed off by the operating room supervisor at the end of each clinic day, and a copy must be placed in the Administrator's box for review.	3/1/11 & 3/28/11 2/15/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING _____ B. WING _____	12/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

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U 119	Continued From page 7 This rule was previously cited on 02/17/2010.	U 119		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025-115	A. BUILDING: _____ B. WING _____	06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH MEDICAL CLINIC	120 East 34th Street SAVANNAH, GA 31401

(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
V 000	Opening Comments At the time of the survey, Savannah Medical Clinic was in compliance with Chapter 290-5-32, Performance of Abortions After the First Trimester of Pregnancy and Reporting Requirements for All Abortions, as the result of a State licensure survey.	V 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025-115	A. BUILDING: _____ B. WING _____	06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH MEDICAL CLINIC	120 East 34th Street SAVANNAH, GA 31401

(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
U 000	INITIAL COMMENTS At the time of the survey, Savannah Medical Clinic was in substantial compliance with Chapter 290-5-33, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a State licensure survey. The following deficiency was written as the result of that survey.	U 000		
U 091 SS=D	290-5-33-.10(l) PHYSICAL PLANT & OPERATIONAL STANDARDS The center shall be arranged and organized in such a manner as to ensure the comfort, safety, hygiene, privacy, and dignity of patients treated therein. This Rule is not met as evidenced by: Based on observations during tour of the pre-operative and post-operative areas and staff interview, it was determined that the center was not arranged to ensure and respect the privacy and dignity of the patients. Findings were: Observations during a tour of the pre-operative and post-operative areas at approximately 4:30 p.m. on 06/23/2010 and accompanied by the administrator (employee #9) and a registered nurse (RN-employee #3) revealed the following: 1. The pre-operative area contained three love seats (sofas for two (2) people) for the use of the patients before their procedure. No curtains or screens were in place to ensure the individual privacy and dignity of the patients in the area; and 2. The post-operative area contained six (6) chairs, three (3) chairs each on opposite sides of the room facing each other. No curtains or screens were in place to ensure the individual	U 091		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025-115	A. BUILDING: _____ B. WING _____	06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH MEDICAL CLINIC	120 East 34th Street SAVANNAH, GA 31401

(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
U 091	Continued From page 1 privacy and dignity of the patients in the area. During an interview at approximately 5:00 p.m. on 06/23/10 in the facility's post-operative area, the RN (employee # 3) stated that the patients waited together on the love seats (sofas) provided in the pre-operative area and then were recovered together in the recliner chairs located in the post-operative area. The RN added that patients were brought from the procedure room into the post-op area on stretchers. The stretcher was then placed between the two rows of chairs where the patient remained until sufficiently recovered enough to be moved to a recliner. The RN acknowledged that no screens or curtains were in place between the sofas in the pre-op area and the recliner chairs in the post-op areas. The RN added that should the patient's condition require it, the patient could be taken to the other side of the room.	U 091		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	06/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
V 000	Opening Comments At the time of the survey, Atlanta Women's Medical Center was in compliance with Chapter 290-5-32, Performance of Abortions After the First Trimester of Pregnancy and Reporting Requirements for All Abortions, as the result of a State licensure survey.	V 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	06/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U 000	INITIAL COMMENTS At the time of the survey, Atlanta Women's Medical Center was in compliance with Chapter 290-5-33, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a State licensure survey.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING: _____ B. WING _____	R 03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
{V 000}	Opening Comments	{V 000}		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
{U 000}	INITIAL COMMENTS At the time of the survey, Summit Medical Associates was in compliance with Chapter 290-5-33, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a follow-up survey to the State licensure survey of 12/21/2010.	{U 000}		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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
{M 001}	Opening Comments	{M 001}		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

David A. Cook, Commissioner

Nathan Deal, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

April 4, 2011

Ms. Golda Melnik, Administrator
Atlanta Women's Medical Center
235 West Wieuca Road
Atlanta, GA 30342-3321

Dear Ms. Melnik:

Enclosed is a Report of Licensure Inspection completed at your facility on **March 17, 2011** by surveyor(s) from this office. This report contains one or more violations which must be corrected.

Your plan to correct these violations should be entered in the right hand column entitled "Providers Plan of Correction" with a projected completion date entered in the column "Completion Date". After you have completed the form, sign and date it in the space provided, return the ORIGINAL to our office no later than **April 14, 2011.**

Thank you for the courtesies extended to our representatives during this visit. If I can be of further assistance, please contact me at (404) 657-5449.

Sincerely,

James E. Courtney, Director
Acute Care Section
Department of Community Health
Healthcare Facility Regulation Division

JEC:rf

Americans United for Life

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	03/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
M 001	Opening Comments At the time of the survey, Atlanta Women's Medical Center was in compliance with Chapter 290-5-45, Rules and Regulations for Disaster Preparedness Plans, as the result of a State licensure survey.	M 001		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

accepted 5/6/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING _____ B. WING _____	03/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

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M 001	Opening Comments At the time of the survey, Atlanta Women's Medical Center was in compliance with Chapter 290-5-45, Rules and Regulations for Disaster Preparedness Plans, as the result of a State licensure survey.	M 001	The Atlanta Women's Medical Center remains committed to provding high quality patient care and services. HEALTHCARE FACILITY REG. APR 28 2011 RECEIVED	NA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Administrator (X6) DATE 4/26/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING _____ B. WING _____	03/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
V 000	Opening Comments At the time of the survey, Atlanta Women's Medical Center was not in compliance with Chapter 290-5-32, Rules and Regulations for Performance of Abortions After the First Trimester of Pregnancy and Reporting Requirements for All Abortions, as the result of a State licensure survey. The following deficiency was written as the result of that survey.	V 000	HEALTHCARE FACILITY REG. APR 28 2011 RECEIVED	
V 030 SS=D	290-5-32-.03(1) Procedure for Filing Certificate of Abortion In addition to the medical records requirements of Chapters 290-5-6 and 290-5-33 of the Rules and Regulations of the Georgia Department of Human Resources, the physician who performs the abortion shall file with the Commissioner of Human Resources or [redacted] designee, within ten (10) days after an abortion procedure is performed, a Certificate of Abortion. It is expressly intended that the privacy of the patient shall be preserved and, to that end, the Certificate of Abortion shall not reflect the name of the patient but shall carry the same facility number, or other identifying number reflected on the patient's medical records. A duplicate of the Certificate of Abortion will [redacted] made a part of the patient's Medical record and neither the aforesaid duplicate certificate nor the Certificate of Abortion which is filed with the Commissioner or [redacted] designee shall be revealed to the public unless the patient executes a proper authorization which permits such a release or unless the records must be made available to the District Attorney of the Judicial Circuit in which the hospital or health facility is located as provided by Code Section 16-12-141 (d) of the Official Code of Georgia Annotated. This REQUIREMENT is not met as evidenced	V 030	See Attachment A-V 030.	4/22/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Golda Melnik TITLE Administrator (X6) DATE 4/26-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
V 030	Continued From page 1 by: Based on review of medical records, facility policy, and staff interview, it was determined that the facility failed to ensure that Certificates of Abortion were filed with the Georgia Department of Community Health within 10 days following abortion procedures for eight (8) of ten (10) sampled patient records (#1, 2, 4, 5, 6, 7, 8 and 10). Findings were: Review of the current Georgia Code, O.C.G.A. § 16-12-141, revealed a requirement that the physician who performed an abortion file a certificate of abortion with the Commissioner of Community Health within 10 days following the procedure. Review of facility policy, entitled AB Policy-VEIS / ITOPS Policy, last revised 01/06/11, also required that the facility file the required information with the State within ten (10) days of the abortion, and that a copy of the certificate be stapled into the patient's medical record for reference and verification purposes. Nine (9) of ten (10) medical records reviewed (#s 2, 4, 5, 6, 7, 8, 9, 10 and 11) contained a document which included the date the abortion procedure was performed and an unidentified date at the bottom of the page. During an interview at 2:00 p.m. on 03/17/2011 in the Administrator's office, the Administrator (employee #8) identified the date at bottom of the document as being the date the document was printed, not the date the required information was actually filed with the State. When asked to provide documented evidence of the date each certificate was filed, the Administrator explained that the person responsible for filing the	V 030		

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V 030	Continued From page 2 certificates had gone home for the day, was expected to return the next day, and that he/she was the only staff member with access to that program. As of noon on 03/21/2011, no further information had been provided by the facility.	V 030		

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U 000	INITIAL COMMENTS At the time of the survey, Atlanta Women's Medical Center was not in compliance with Chapter 290-5-33, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a State licensure survey. The following deficiencies were written as the result of that survey.	U 000	APR 28 2011 RECEIVED HEALTHCARE FACILITY REG.	
U 028 SS=D	290-5-33-.03(3) ORGANIZATION & ADMINISTRATION. AMENDED The governing body of the center shall be responsible for appointing the professional staff and shall establish effective mechanisms for quality assurance and to ensure the accountability of the center's medical and/or dental staff and other professional personnel. This Rule is not met as evidenced by: Based on review of the facility's Quality Assurance Plan, quality assurance documentation, and staff interview, it was determined that the Governing Body failed to establish effective mechanisms for quality assurance, and to ensure accountability of the center's professional personnel. Findings were: Review of the facility's Quality Assurance Program, revealed that: 1) the administrator would periodically choose an area of patient care to monitor for quality of care as defined by the Center's Policy and Procedures; 2) that the data would be thirty (30) patient charts pulled randomly for that quarter; 3) that the data would be analyzed to assure quality care was achieved,	U 028	See Attachment B - U 028.	4/28/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Calda Moly- TITLE Administrator (X6) DATE 4/26-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING _____ B. WING _____	03/17/2011

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U 028	Continued From page 1 and 4) that the results would be summarized on the QA monitor form and reviewed by the medical team. Review of the facility's Quality Assurance Program documents failed to include mention of specifically identifiable quality indicators, achievement goals, or documentation of ongoing review or results. During an interview on 3/17/2011 at 12:00 p.m. in the administrator's office, the Administrator (employee #8) confirmed the absence of quality indicators, and stated that he/she would randomly choose an area to review, providing an example of a time when he/she had monitored infection control practices on one (1) registered nurse for one (1) day. He/she stated that he/she never found any deficient practices on his/her reviews, so, he/she did not do any follow up reviews/monitoring.	U 028		
U 062 SS=D	290-5-33-.09(8) PROFESSIONAL SERVICES Each center will have effective policies and procedures for handling infection control and for recording complications which occur during or after surgery, which includes a reporting mechanism for patients who develop infections or postoperative complications after discharge. This Rule is not met as evidenced by: Based on review of facility policies and procedures and staff interview, it was determined that the facility failed to maintain a policy/procedure for recording complications which occur during or after surgery. Findings were:	U 062	See Attachment C - U 062.	4/26/11

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U 062	Continued From page 2 Review of the facility's policies and procedures failed to reveal a policy/procedure for the recording of infections or complications which occurred during or after surgery. This information was requested from the facility's Administrator (employee #8) on 3/17/2011 at 9:00 a.m., 12:00 p.m., 2:00 p.m., and 4:00 p.m., but was never received.	U 062		
U 065 SS=D	290-5-33-.09(11) PROFESSIONAL SERVICES Each center shall establish policies for patient care and procedures for maintaining these policies. This Rule is not met as evidenced by: . Based on review of facility policies, medical records, and staff interview, it was determined that the facility failed to establish procedures for maintaining patient care policies related to surgical time-out. Findings were: Review of facility Policies and Procedures failed to reveal a policy addressing performance and documentation of a surgical time-out (a pause before surgical incision to verify the correct patient, correct surgical site/side, and correct procedure). Six (6) of six (6) medical records reviewed (#s 1, 4, 5, 7, 9, 11) lacked evidence that a surgical time-out had been conducted. During an interview on 3/17/2011 at 12:00 p.m. in the administrator's office, the administrator (employee #8) confirmed that the facility did not have a Time Out policy, and did not document	U 065	See Attachment D - U 065.	4/25/11

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U 065	Continued From page 3 such in the patient's medical record.	U 065		
U 068 SS=D	290-5-33-.10(b) PHYSICAL PLANT & OPERATIONAL STANDARDS The physical plant of the center shall meet all Federal, State and local laws, codes, ordinances and regulations which apply to its location, construction, maintenance and operation. This Rule is not met as evidenced by: . Based on observations during a facility tour, and staff interview, it was determined that the facility failed to ensure that temperature, humidity and air pressures in the surgery center were monitored. Findings were: Upon arrival to the facility at 9:00 a.m. on 03/17/2011, surveyors provided the facility's Administrator (employee #8) with a list of documents for review that included documentation related to the facility's monitoring and maintenance of the temperature and humidity of the two (2) procedure rooms and of the air pressures in the instrument processing and sterilizing rooms. Requests for the documents were made at 12:00 p.m., 2:00 p.m. and 4:00 p.m., and as of the close of the survey at 6:00 p.m. on 03/17/2011, the documents had not been provided. Observations during a tour of the facility with the facility's Administrator (employee #8) at 5:30 p.m. on 03/17/2011 revealed that the facility's dirty instrument cleaning area and clean instrument sterilizing and storage area were located inside a	U 068	See Attachment E - U 068. 5/6/11 - Original POC Not acceptable e u068, See revision rec'd 5/5/11, which is accepted. w	4/22/11

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U 068	Continued From page 4 room which was partitioned by a floor-to-ceiling wall, with sufficient space allotted between the edge of the wall and the entrance door for staff to walk through. The entrance door to the room was found open, and several attempts to close the door and keep it closed were unsuccessful. As the door could not be kept closed, the facility was unable to maintain the required air pressures in each area, negative air pressure for the dirty instrument cleaning area and positive air pressure for the clean instrument sterilizing and storage area. During the tour, the facility's Administrator revealed that the room's door was supposed to be kept closed, and that he/she had been unaware that it was broken. The Administrator also related that he/she had been unaware of the air pressures required in the clean/sterilizing areas and soiled instrument areas.	U 068		
U 101 SS=D	290-5-33-.11(6) PERSONNEL Fire and internal disaster drills shall be conducted at least quarterly and results documented. There shall be an ongoing program of continuing education for all personnel concerning aspects of fire safety and the disaster plan for moving personnel and patients to safety, and for handling patient emergencies. This Rule is not met as evidenced by: . Based on review of the facility's Disaster Preparedness Plan, fire and disaster drills, and staff interview, it was determined that the facility failed to ensure that internal disaster drills were conducted at least quarterly and results documented.	U 101	See Attachment F - U 101.	4/26/11

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U 101	Continued From page 5 Findings were: Review of the facility's Disaster Preparedness Plan, no date, revealed that the emergency situations to be addressed were: fire, explosion, bomb threat, unanticipated interruption of electricity and/or water, loss of air conditioning or heat, damage to the physical plant, invasion by protestors, and anthrax threats. The plan called for the center to conduct quarterly rehearsals with the circumstances varied as to create full staff participation in differing situations. Review of the facility's fire and disaster drills failed to reveal evidence that a disaster drill had been conducted during the second quarter of 2010. The review also revealed that, of the three (3) drills that were performed during the last four (4) quarters, two (2) of the drills were discussions only which did not include movement of staff or evaluations. During an interview on 3/17/2011 at 5:00 p.m. in the administrator's office, the Administrator (employee #8) stated that he/she thought that all drills had been done during the last four (4) quarters, and was unaware that the drills needed to include results.	U 101		
U 106 SS=D	290-5-33-.12(2)(c) RECORDS Contents of individual medical records shall normally contain the following at least: Treatment data: 1. Practitioner's orders. 2. Progress notes. 3. Nurse notes. 4. Medication.	U 106	See Attachment G - U 106.	4/26/11

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U 106	Continued From page 6 5. Temperature-pulse-respiration (Graphic chart; surgical purposes only). 6. Special examinations(s) and reports (include x-ray and lab reports). 7. Signed informed consent form. 8. Operation record. 9. Anesthesia record (if applicable). 10 Consultation record (if applicable). 11. Tissue findings when performed. 12. Where dental services are rendered, a complete dental chart with dental diagnosis, treatment, prescription and progress notes shall be part of the clinical record. This Rule is not met as evidenced by: . Based on review of facility policies and procedures, medical records and staff interview, it was determined that the facility failed to ensure that each patient undergoing an abortion procedure certified in writing that, 24 hours in advance of the procedure, [redacted] had been provided all information required to make a fully informed consent for ten (10) of ten (10) sampled patient records (#1, 2, 4, 5, 6, 7, 8, 9, 10 and 11). Findings were: Review of current Georgia Code, O.C.G.A. § 31-9A-3, revealed that, in order to ensure that a female considering an abortion makes a fully informed decision regarding whether to undergo the procedure, facilities provide the female with certain information at least 24 hours in advance of the procedure, and that the female certify in writing that she received the information. The Code required that, as part of the information provided, the female be given information regarding how to obtain a list of health care	U 106		

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U 106	Continued From page 7 providers, facilities and clinics that offer to perform ultrasounds free of charge, arranged geographically, and which included the name, address, hours of operation, and telephone number of each listed entity. Ten (10) of ten (10) medical records reviewed (#1, 2, 4, 5, 6, 7, 8, 9, 10 and 11) included a document entitled Client Certification Form, which delineated the information that was required by Code to be given to each prospective abortion patient. Each form also included a patient's signature certifying that [redacted] had been provided the information required by the Code. However, closer review of the Certification form revealed that information regarding how to obtain a list of health care providers, facilities and clinics that offer to perform ultrasounds free of charge was not included. During an interview in his/her office at 4:10 p.m. on 03/17/2011, the facility's Administrator (employee #8) related that the Certification form had been amended to include the required information related to obtaining free ultrasounds, but that the facility had not implemented it yet.	U 106		
U 118 SS=A	290-5-33-.14(5) CLINICAL LABORATORY SERVICES The center shall report to the Department all communicable diseases detected or reported for patients. This Rule is not met as evidenced by: . Based on review of facility policies and procedures, facility logs, and staff interview, it was determined that the facility lacked a	U 118	See Attachment H - U 118.	4/26/11

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U 118	Continued From page 8 policy/procedure and log for the reporting of communicable diseases to the Department. Findings were: Review of the facility's policies and procedures failed to reveal evidence of a policy/procedure for the reporting of communicable diseases. Review of facility logs failed to reveal a log for Reportable Diseases. This information was requested on 3/17/2011 at 9:00 a.m., 12:00 p.m., 2:00 p.m., and 4:00 p.m., but was never received.	U 118		

Atlanta Women's Medical Center

Corrective Action Plan – V030
290-5-32-.03(1) Procedure for Filing Certificate of Abortion

Existing policy of the AWMC required the timely filing of the VEIS/ITOP information with the State and inclusion of the required information in the patient's medical record. Staff responsible for timely submitting the VEIS/ITOP information has received specific instructions and updated information about the importance of consistently submitting this data within the required timeframe. Written policy has been revised to insure timely filing and on-going monitoring of timely filing. This re-training occurred on April 19, 2011 and included a review of the revised policy and upgraded tracking system to insure compliance with timeliness requirements.

An ITOP Log form has been implemented that tracks all patients, the date of the abortion procedure and the date of filing of the ITOP report.

The Medical Records Quality Assurance Form now includes a specific reference to the VEIS-ITOP submission and requires chart reviewers to verify that the data was submitted in a timely fashion. Any deviation from the required timing will be brought to the Administrator's attention for correction.

Staff Education: Re-training of relevant Staff covering the revised VEIS/ITOP Policy, the proper confirmation of filing with DCH, and upgraded tracking system occurred April 21, 2011. The Office Manager was also included in this re-training.

Monitoring: For the next six months (through October 2011), the Clinic Administrator will check on a weekly basis the ITOP Log and audit random patient records to insure that the ITOP reports have been timely filed for each patient, and confirm that proper documentation has been provided in the ITOP Log, the Copy of the VEIS Certificate in the patient chart, and the Medical Chart Quality Assurance Form in each patient chart.

The Medical Chart Quality Assurance Form has been revised to include the submission of VEIS-ITOP information on the patient record checklist and monitoring of compliance will occur through the Quality Improvement Committee. Any patient record that does not include a computer copy of the ITOP filing is to be reviewed immediately by the Clinic Administrator and Quality Improvement Committee.

Responsible Persons: Clinic Administrator, ITOP Reporting Staff, Office Manager and Quality Improvement Committee

ATTACHMENT A – V 030

Americans United for Life

Atlanta Women's Medical Center

Corrective Action Plan – U028
290-5-33-.03(3): ORGANIZATION & ADMINISTRATION. AMENDED

AWMC had in place at the time of the survey extensive policies and procedures with effective mechanisms for quality assurance that ensured accountability of the Center's professional personnel and the delivery of quality care.

The Quality Improvement Plan for Atlanta Women's Medical Center has been revised to augment existing policies with specifically identifiable quality indicators, achievement goals and documentation of ongoing review and/or results. The Identifiable Quality Indicators include: Complication Rates, Anesthesia Complication Rates, Physician Performance, Medical Records, Therapeutic Environment, and Patient Satisfaction. This Policy was updated on April 22, 2011 and was reviewed in detail with key members of the Quality Improvement Committee and approved by the Medical Director.

Staff Education: A full staff in-service training is scheduled for April 27, 2011 to review changes to the Quality Improvement Plan.

Monitoring: The Clinic Administrator, Nursing Supervisor, Medical Director and Quality Improvement Committee will monitor implementation, emphasizing identifiable quality indicators, achievement goals, and documentation of on-going review and results associated with the Quality Improvement Plan.

Responsible Persons: Clinic Administrator, Nursing Supervisor, Medical Director, and Quality Improvement Committee.

Atlanta Women's Medical Center

Corrective Action Plan – U062
290-5-33-.09(8): PROFESSIONAL SERVICES

Existing policy and procedures of the AWMC at the time of the survey provided for recording complications that occur during or after surgery and were available and offered for inspection at the time of the survey. All patient calls received after clinic hours are reported on the Hotline Reporting Form, reviewed by appropriate nursing or medical personnel, followed up on as appropriate and retained. In addition, all infections or complications are recorded, summaries are documented monthly, important complications are subjected to detailed peer review through the Quality Improvement Committee, and data summarizing all infections and complications are reported quarterly to the National Abortion Federation.

To further insure the monitoring and evaluation of all abortion complications, a Complication Tracking Form (log) of all reportable complications has been created and will be utilized by medical staff involved with such cases. A copy of the new Complication Tracking Form and existing Reportable Quality Indicators Definitions form are attached hereto. Patient information will be entered, and the Medical Director and Administrator will review this log at each quarterly Quality Improvement Committee meeting. This log will allow for consistent detailed review of all reportable incidents, discussion of corrective measures, and recommendations for training or retraining for staff and physicians involved. The Complication Tracking Log will be kept in the Medical Director's office for access by Nursing staff and Physicians.

The Complication Tracking Log will also be signed and reviewed by either the Medical Director or Nursing Director after five entries to verify that staff is completing the form appropriately.

All reportable complications will continue to be submitted to the National Abortion Federation – the facility's national professional association.

Staff Education: The Nursing Supervisor was trained regarding this new policy and log on April 20, 2011 and will conduct an in-service training with the appropriate medical staff by April 26, 2011.

Monitoring: The Clinic Administrator will be informed of each complication upon its occurrence, and will receive and review each page of the Complication Tracking Log upon completion – each page lists a maximum of five patients. Each case included in this Log will be reviewed in the quarterly Quality Improvement Committee meeting.

Responsible Persons: Nursing Supervisor, Medical Director, Clinic Administrator, and Quality Improvement Committee.

Americans United for Life

Atlanta Women's Medical Center

Corrective Action Plan U065
290-5-33-.09(1): PROFESSIONAL SERVICES

The policy and procedures of AWMC in place at the time of the survey included repeated steps that involved confirmation of patient identity and the procedure the patient is to receive in order to insure patient safety and proper care and avoid misidentification or error.

Corrective Action: AWMC policies have been revised to include a specific record of a "Time Out" prior to laminaria insertion, digoxin injection, and for the abortion procedure in order to confirm patient identity, surgical site and correct procedure..

The revised Time Out policy was reviewed and approved by the Medical Director and Clinic Administrator. An entry has been added to the Procedure/Physician Exam Notes form to document "Time Out performed." In addition, "Time Out documented" has been added as an entry to the Medical Records Quality Assurance Form to confirm that this has been performed and documented. Each patient chart is reviewed with this form. Failure to perform or record the Time Out will be addressed by the Administrator and Medical Director's quarterly Quality Improvement reviews.

Staff Education: A memorandum was distributed to affected staff and an in-service training was conducted for the Operating Room staff on April 22, 2011. Personnel who review charts were informed of this change on the same day.

Monitoring: "Time Out documented" now appears on the Medical Record Quality Assurance checklist which is used to review each patient chart. Any patient record that does not indicate that a Time Out occurred will be brought to the Nursing Supervisor who will alert the physician of record and the CRNA of record, if appropriate. The Medical Record Quality Assurance form will be reviewed in the next quarterly Quality Improvement meeting. Compliance with this record keeping will be integrated into the Quality Improvement review process.

Responsible Persons: Medical Director, Clinic Administrator, Nursing Supervisor, OR Staff and Quality Improvement Committee.

Rec'd 5/5/11 Jt. emailed

Atlanta Women's Medical Center

REVISED Corrective Action Plan – U068
290-5-33-.10(b): PHYSICAL PLANT & OPERATIONAL STANDARDS

AWMC had in place policies and procedures to measure and maintain the temperature and humidity of the two procedure rooms with temperature between 68 and 73° F and relative humidity between 30 and 60%. Staff will continue to separately measure and record temperature and humidity on logs (that were provided to the surveyor) kept in Operating Room 1 and Operating Room 2 each day prior to the commencement of procedures. Deviations are appropriately addressed to maintain the correct temperature and humidity levels. The Temperature and Humidity Log has been updated to differentiate between the two OR's so that specific data can be accurately tracked back to the appropriate room and is attached. The Clinic Administrator will review and sign off on each log sheet upon completion to insure compliance.

The door to the Sterile Room was repaired on March 28, 2011. Additionally, a barrier will be added to the bottom of the door to the OR hallway to prevent infectious material from being sucked into the hallway when soiled instruments are being cleaned. The medical staff has been alerted to the importance of keeping this door closed at all times – verbally and in a written memo. To monitor the status of this door, a Log is now posted on the door for the Administrator and/or the Nursing Director to sign daily indicating the status of the door and is attached here. This continual monitoring is a very visible action to demonstrate the importance of separating this room from the rest of the OR hallway.

A new policy has been implemented to require staff to protect clean and sterilized instruments from exposure to dirty instruments by performing tasks on only one side of the room at a time. When soiled instruments and/or equipment are being processed there is to be no activity or exposed instruments on the "clean" side of the room.

Staff Education: The medical staff was informed of this policy update on April 21, 2011. The revised Logs for Temperature and Humidity were installed on April 22, 2011 and the Log for monitoring the status of the door to Sterile was installed on April 22, 2011.

The Instrument Processing policy will be effective May 11, 2011, and a copy will be provided to and reviewed with medical staff members on that date by the Nursing Supervisor.

Monitoring: The Administrator will review and sign each completed Temperature and Humidity Log. The Administrator and/or Nursing Supervisor will make a daily entry in the Sterile Door Log and monitor adherence to the new Instrument Processing Policy. Completed logs will be reviewed by the Clinic Administrator.

Responsible Persons: Nursing Supervisor, Clinic Administrator and Quality Improvement Committee.

Revised May 5, 2011

Americans United for Life

Atlanta Women's Medical Center

OT Found not accepted — see revised U068 POC attached.

Corrective Action Plan – U068
290-5-33-.10(b): PHYSICAL PLANT & OPERATIONAL STANDARDS

AWMC had in place policies and procedures to measure and maintain the temperature and humidity of the two procedure rooms with temperature between 68 and 73° F and relative humidity between 30 and 60%. Staff will continue to separately measure and record temperature and humidity on logs (that were provided to the surveyor) kept in Operating Room 1 and Operating Room 2 each day prior to the commencement of procedures. Deviations are appropriately addressed to maintain the correct temperature and humidity levels. The Temperature and Humidity Log has been updated to differentiate between the two OR's so that specific data can be accurately tracked back to the appropriate room and is attached. The Clinic Administrator will review and sign off on each log sheet upon completion to insure compliance.

The door to the Sterile Room was repaired on March 28, 2011. The medical staff has been alerted to the importance of keeping this door closed at all times – verbally and in a written memo. To monitor the status of this door, a Log is now posted on the door for the Administrator and/or the Nursing Director to sign daily indicating the status of the door and is attached here. This continual monitoring is a very visible action to demonstrate the importance of separating this room from the rest of the OR hallway.

Staff Education: The medical staff was informed of this policy update on April 21, 2011. The revised Logs for Temperature and Humidity were installed on April 22, 2011 and the Log for monitoring the status of the door to Sterile was installed on April 22, 2011.

Monitoring: The Administrator will review and sign each completed Temperature and Humidity Log. The Administrator and/or Nursing Supervisor will make a daily entry in the Sterile Door Log. Completed logs will be reviewed by the Clinic Administrator.

Responsible Persons: Nursing Supervisor, Clinic Administrator and Quality Improvement Committee.

ATTACHMENT E – U068

Americans United for Life

Atlanta Women's Medical Center

Corrective Action Plan – U101
290-5-33.11(6) PERSONNEL

The Office Manager and Clinic Administrator have revised the existing policy for quarterly fire and internal disaster drills to provide for active drills to address fire safety, moving personnel and patients to safety and for handling patient emergencies. An active drill was held on March 31, 2011 for the entire staff. Drills will vary and include: storm response, bomb threat, fire, patient crisis, etc. with results documented as to whether there were problems with carrying out the various disaster plans, how much time it took to perform the drill, and whether staff were able to perform as directed.

Staff Education: The Office Manager shared the objectives of the disaster drill with the staff – emphasizing the importance and the frequency of future drills. In service trainings provided to staff will include trainings in fire safety issues and disaster plans for moving personnel and patients to safety, and handling patient emergencies.

Monitoring: The Clinic Administrator and Quality Improvement Committee will monitor participation, timing and outcomes of disaster drills to insure active quarterly drills, insure that results are documented, and provide on-going in-service trainings for staff in disaster preparedness and responses.

Responsible Persons: The Clinic Administrator, Facility and Safety Manager and Quality Improvement Committee

Americans United for Life

Atlanta Women's Medical Center

Corrective Action Plan – U106
290-5-33-.12(2)(c) RECORDS

AWMC has revised its Proof of Client Certification Form to include a statement certifying that the woman has received, at least 24 hours in advance of the procedure, information about how to obtain a list of providers, facilities and clinics that offer to perform ultrasounds fee of charge, arranged geographically, and including the name, address, hours of operation and telephone number of each listed entity.

Updated information about facilities providing free ultrasounds will be collected from the State's Department of Community Health website on a monthly basis to provide to patients who wish to receive this information at the clinic rather than directly from the State's website.

Staff Education: The Office Manager shared this revised form with the staff on April 12, 2011, and provided an educational in-service training about the updated form and the information about access to free ultrasound services.

Monitoring: Chart reviewers will document the presence of the revised Proof of Client Certification Form during the Quality Improvement review of each patient record. Any record missing this form will be brought to the immediate attention of the Clinic Administrator. The Office Manager will be responsible for downloading and providing copies of the updated list of facilities providing free ultrasounds on a monthly basis.

Responsible Persons: Office Manager and Clinic Administrator.

Americans United for Life

Atlanta Women's Medical Center

Corrective Action Plan – U118
290-5-33-.14 (5) CLINICAL LABORATORY SERVICES

AWMC had in place at the time of the survey policies and procedures to report to the Department of Community Health communicable diseases detected or reported for patients, including sexually transmitted diseases (gonorrhea, chlamydia, and/or syphilis), venereal diseases or AIDS.

The AWMC policy was revised on April 12, 2011, in response to survey comments to record and report all statutorily required communicable diseases to the Department of Community Health. A Notifiable Disease/Condition Reporting Log was created and is kept in the AWMC Laboratory. The laboratory staff person is required to enter appropriate patient information into the Notifiable Disease/Condition Reporting Log and alert the Nursing Supervisor immediately regarding any patient entry. The Georgia Department of Community Health Notifiable Disease/Condition Reporting poster will be posted in the laboratory to provide information about the range of reportable diseases and the timeframes for reporting. A copy is attached here.

The Nursing Supervisor will then utilize the appropriate DCH reporting forms found on the Department's website to report such patients with the prescribed time period indicated for each disease or condition.

Staff Education: Laboratory staff was verbally alerted to this new Log and procedure on April 12, 2011. The Nursing Supervisor drafted the Revised Policy and is aware of its requirements.

Monitoring: The Nursing Supervisor will review and sign off on the Notifiable Disease/Condition Reporting Log every Friday and will submit any appropriate patient information at that time to DCH and notify the Clinic Administrator. The Quality Improvement Committee will monitor the log and implementation of the reporting requirements.

Responsible Persons: The Nursing Supervisor, Clinic Administrator and Quality Improvement Committee.

Americans United for Life

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	C 11/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U 000	INITIAL COMMENTS At the time of the survey, Atlanta Women's Medical Center, Inc. was not in compliance with Chapter 290-5-33, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of complaint investigation #GA00103576 and #GA00104379. The following deficiencies were written as a result of the survey.	U 000		
U 106 SS=D	290-5-33-.12(2)(c) RECORDS Contents of individual medical records shall normally contain the following at least: Treatment data: 1. Practitioner's orders. 2. Progress notes. 3. Nurse notes. 4. Medication. 5. Temperature-pulse-respiration (Graphic chart; surgical purposes only). 6. Special examinations(s) and reports (include x-ray and lab reports). 7. Signed informed consent form. 8. Operation record. 9. Anesthesia record (if applicable). 10 Consultation record (if applicable). 11. Tissue findings when performed. 12. Where dental services are rendered, a complete dental chart with dental diagnosis, treatment, prescription and progress notes shall be part of the clinical record. This Rule is not met as evidenced by: Based on review medical records and staff interview, it was determined that the facility failed to ensure adequate nursing documentation	U 106		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	C 11/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U 106	Continued From page 1 related to post anesthesia unit (PACU) monitoring and care provided for 1 of 1 (#1) patient requiring emergency transfer to an acute care facility. Review of medical record #1 revealed that the patient was admitted to the facility for an abortion procedure (surgical removal of the contents of the uterus to end pregnancy). The surgeon's documentation reflected a complication (possible perforation of the uterus) was identified during the surgical procedure. The procedure was immediately stopped. The patient remained stable without active bleeding. The surgeon made arrangements for the transfer of the patient to a local acute care hospital for further evaluation and treatment. The anesthesia record indicated that the patient was transferred from surgery to the post anesthesia care unit (PACU). The PACU record lacked documented evidence of ongoing monitoring of the patient prior to the arrival of the emergency medical services (EMS). The record also lacked documentation related to the time of arrival of EMS, transfer of patient's care to EMS and the condition of the patient at the time of transfer from the facility to the hospital. An interview was conducted at 12:00 p.m., in the Administrator's private office, with the registered nurse (employee #1) responsible for the patient's (medical record #1) care, in the PACU. The interviewee reviewed the patient's record during the interview and was unable to explain the missing documentation. He/she remembered providing care for the patient, but was unable to recall completion of the documentation. He/she stated that the patient was continuously monitored and remained stable until the transfer of care to the EMS staff. The interviewee confirmed that	U 106		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	C 11/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U 106	Continued From page 2 there was no documentation in the record to reflect care and monitoring of the patient in PACU or documentation related the arrival and transfer of the patient's care to EMS.	U 106		
U 123 SS=D	290-5-33-.15(5) HOUSEKEEPING,LAUNDRY,MAINTENANCE (5) A recognized method of checking sterilizer performance shall be adopted. This Rule is not met as evidenced by: Based on review of facility policy, sterilization temperature logs, facility tour and employee interview it was determined, that the facility lacked documented evidence that required autoclave (equipment used for sterilization of surgical instruments) temperatures had been reach for effective sterilization of surgical instruments. Findings were: Facility policy entitled Autoclave Procedure 15.4 revealed that two autoclaves were located in the sterilizing room. The policy required the autoclaves to reach a temperature of 270 degrees fahrenheit (F) for effective sterilization of surgical instruments. A tour of the facility was conducted at 1:50 p.m. with the facility's Administrator and the operating room technician (employee #4). Two autoclaves were observed in the sterilization room. Employee #4 confirmed that both autoclaves were used for the sterilization of surgical instruments. Sterilization temperature log from 07-01-11 to 11-21-11 for both autoclaves (autoclave #1 and autoclave #2) were reviewed. Documentation on the logs reflected that the autoclaves had only	U 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	C 11/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U 123	Continued From page 3 reached a temperature of 229 degrees F. everytime they were checked during this time period. The Administrator and employee #4 confirmed that facility policy required the autoclaves to reach a temperature of 270 degrees F for effective sterilization. They were unable to explain the discrepancy between the required temperature and the temperature documentation on the logs.	U 123		
U 135 SS=D	290-5-33-.22 WAIVER OF RULE The Department may waive any rule for a stated period of time when it is shown that the specific rule is not applicable or when a waiver is needed to permit experimentation and demonstration of new and innovative approaches to the delivery of services which will not jeopardize the health and safety of the patients, staff or others utilizing the center. Results of such experimentation and demonstration projects shall be submitted to the Department as prescribed by the plan under which the waiver is approved. The Department shall maintain a record of and make available to interested persons information on all waivers granted under this rule. This Rule is not met as evidenced by: /Based on review of conditions required by the Department for Waiver of Rule 290-5-33-.10(f), staff interviews and patient observation, it was determined that the facility failed to comply with one of the conditions or alternative standards required for granting and continuation of the wavier. Findings were:	U 135		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	C 11/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U 135	Continued From page 4 Condition #1 of Waiver of Rule 290-5-33-.10(f) (requirement for an elevator for ambulatory surgical services provided in multistory buildings) granted by the Department 08/30/2005 until 08/31/12 required that the facility will assess the patient's condition at the time of discharge and determine the type of assistance and the number of escorts needed to help the patient safely down the stairs. The facility will be required to maintain evidence of this assessment of patients, which will be provided to the Department upon request. At least one escort will accompany each patient down the stairs upon discharge. At 10:00 a.m. a patient was observed leaving the facility post procedure. The PACU supervisor (employee #1) talked with the patient in the waiting room prior to the patient's exit from the building. The patient walked down a flight of eighteen (18) stairs with a companion/designated driver, unaccompanied by facility staff escort. The patient and the companion/designated driver exited the building without staff escort and walked in the parking lot to their private vehicle. An interview was conducted with the PACU supervisor (employee #1) at 12:00 p.m. in the Administrator's private office. The interviewee stated that he/she did not routinely escort patients down the stairs at discharge. He/she stated that it was his/her understanding that it was alright to discharge the patient at the door and allow the patient to walk down the stairs with his/her driver. The interviewee confirmed that he/she was not aware of the waiver requirement for facility staff escort to accompany each patient down the stairs upon discharge from the facility.	U 135		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	C 11/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U 135	Continued From page 5 An interview was conducted with the Administrator at 3:30 p.m. in his/her private office. The interviewee stated that he/she had instructed the staff not to escort the patients out of the building at discharge. The decision was made for staff safety after a staff member became involved in a patient/ family altercation at discharge.	U 135		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U 000	INITIAL COMMENTS At the time of the survey, Atlanta Women's Medical Center was in compliance with Chapter 290-5-33, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a State licensure survey.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	10/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
U 000	INITIAL COMMENTS AMENDED At the time of the survey, Atlanta Women's Medical Center was not in compliance with Chapter 290-5-33, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a State licensure monitoring visit. The following deficiency is being written as a result of that survey.	U 000		
U 072 SS=D	290-5-33-.10(f) PHYSICAL PLANT & OPERATIONAL STANDARDS Ambulatory surgical services provided in multistory buildings shall be accessible by an elevator of adequate size to accommodate a standard wheeled litter patient and two attendants. A stairway or ramp of adequate dimensions shall be available for transfer of a patient in case of power failure. This Rule is not met as evidenced by: AMENDED Based on facility documentation, observation, and staff interviews, it was determined that the facility failed to provide an elevator of adequate size to accomodate a standard wheeled litter patient and two attendants. Findings were: An unannounced monitoring visit was conducted at 9:00 a.m. on 10/15/2012. Surveyors entered the premises through an open door and walked up the stairs to the entrance. No operable elevator was observed in use. At the top of the stairs was a locked door that required a button to be pressed	U 072		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	10/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
U 072	Continued From page 1 to allow entry from the staff that was inside. The Surgical log for the year 2012 was requested. Review of the facility's surgical log revealed that surgical procedures were performed as follows: Thirteen (13) procedures were performed on 10/10/12, twelve (12) procedures were performed on 10/11/12, eighteen (18) procedures were performed on 10/12/12 and thirty-five (35) procedures were performed on 10/13/12. According to documentation in the log, seventy-eight (78) surgical procedures had been performed 10/10/2012 through 10/13/2012. Surveyors also reviewed six (6) medical records during the survey. During an interview on 10/15/12 at 10:15 a.m. in the facility's break room, the facility's Administrator (personnel file #1- interview only), Director of Nursing (personnel file #2- interview only), and Business Office Manager (personnel file #3- interview only) confirmed that surgical procedures were still being performed and were also scheduled for the week of the on-site monitoring visit.	U 072		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	C 10/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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U 072 SS=D	290-5-33-.10(f) PHYSICAL PLANT & OPERATIONAL STANDARDS Ambulatory surgical services provided in multistory buildings shall be accessible by an elevator of adequate size to accommodate a standard wheeled litter patient and two attendants. A stairway or ramp of adequate dimensions shall be available for transfer of a patient in case of power failure. This Rule is not met as evidenced by: AMENDED Based on facility documentation, observation, and staff interviews, it was determined that the facility failed to provide an elevator of adequate size to accomodate a standard wheeled litter patient and two attendants. Findings were: An unannounced monitoring visit was conducted at 9:00 a.m. on 10/15/2012. Surveyors entered the premises through an open door and walked up the stairs to the entrance. No operable elevator was observed in use. At the top of the stairs was a locked door that required a button to be pressed to allow entry from the staff that was inside. The Surgical log for the year 2012 was requested. Review of the facility's surgical log revealed that surgical procedures were performed as follows: Thirteen (13) procedures were performed on 10/10/12, twelve (12) procedures were performed on 10/11/12, eighteen (18) procedures were performed on 10/12/12 and thirty-five (35) procedures were performed on 10/13/12. According to documentation in the log, seventy-eight (78) surgical procedures had been	U 072		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	C 10/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

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U 072	Continued From page 1 performed 10/10/2012 through 10/13/2012. Surveyors also reviewed six (6) medical records during the survey. During an interview on 10/15/12 at 10:15 a.m. in the facility's break room, the facility's Administrator (personnel file #1- interview only), Director of Nursing (personnel file #2- interview only), and Business Office Manager (personnel file #3- interview only) confirmed that surgical procedures were still being performed and were also scheduled for the week of the on-site monitoring visit.	U 072		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	10/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
V 000	Opening Comments AMENDED At the time of the survey, Atlanta Women's Medical Center was in compliance with Chapter 290-5-32, Rules and Regulations for Abortions, as the result of a State licensure monitoring visit.	V 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING: _____ B. WING _____	03/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
U 000	INITIAL COMMENTS At the time of the survey, Summit Medical Associates was not in compliance with chapter 290-5-33, Rules and Regulations for Ambulatory Surgical Treatment Centers, as a result of complaint investigation #GA00105953. Allegation not substantiated. The following deficiency was written as a result of the survey process.	U 000		
U 135 SS=D	290-5-33-.22 WAIVER OF RULE The Department may waive any rule for a stated period of time when it is shown that the specific rule is not applicable or when a waiver is needed to permit experimentation and demonstration of new and innovative approaches to the delivery of services which will not jeopardize the health and safety of the patients, staff or others utilizing the center. Results of such experimentation and demonstration projects shall be submitted to the Department as prescribed by the plan under which the waiver is approved. The Department shall maintain a record of and make available to interested persons information on all waivers granted under this rule. This Rule is not met as evidenced by: Based on review of conditions required by the Department for Waiver of Rule 290-5-33-.09 (4), medical record, policy and procedure, call log, and staff interview, it was determined that the facility failed to comply with one of seven (#2) conditions required for granting and continuation of the waiver. Findings were: Review of Condition #2 revealed that the facility	U 135		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING: _____ B. WING _____	03/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
U 135	Continued From page 1 was required to provide the patient with a twenty-four (24) hour emergency telephone contact number that would be operational when the facility is closed which would put the patients in touch with a facility nurse with whom the patients could discuss unusual symptoms which might require medical intervention prior to the facility's regular business hours. The facility would need to maintain documentation of the protocols that the facility nurse would use to assess whether the patient, who was admitted for a two (2) day procedure, should return to the facility prior to regular business hour for evaluation and/or treatment by a physician and evidence that the nurse manning the hotline was trained appropriately to use the protocols and handle the emergency the telephone calls. Review of facility policy #ADMIN 071499, entitled "Answering Service Protocol" last revised 07/124/09, revealed that after hours medical calls will be forwarded by the answering service to the on call staff. The policy indicated what signs/symptoms required notification to the on call staff. The policy lacked evidence of a nurse being involved in any of the after hours calls. Review of the the facility's call log for the past three (3) months (January-March) revealed that after hours calls received from patients were being responded to by a medical assistant. One (1) of the calls was in regard to a patient (#9) seeking advise regarding symptoms related to a two (2) day procedure. Review of the medical record for patient #9 revealed that the patient had a two (2) day procedure and placed an after hours call (1:25 a.m.) to the facility for advise regarding symptoms	U 135		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING: _____ B. WING _____	03/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
U 135	Continued From page 2 related to the procedure. The record indicated that the patient talked with employee #2, a medical assistant (MA), who instructed the patient to take pain medication. The medical assistant, according to the documentation, spoke with the patient's physician and the physician suggested that the patient not return to the facility unless the patient experienced contractions. The MA called the patient's caregiver with the physician's instructions. An interview was conducted at 1:55 p.m. on 3/10/12 in the facility call center with the Administrator. The interviewee related that employee #2 was assigned to receive after hours calls, including emergency calls and calls related to concerns/complications with the two (2) day procedure. Patients were instructed to call the answering service phone number. The answering service then contacted employee #2 to follow up with patient's concerns. The Administrator stated that employee #2 was a medical assistant. Additionally, the administrator related that he/she also received after hours calls if the medical assistant was not available. In a later interview at 3:30 p.m. on 3/12/12, the Administrator confirmed that the contact person for patient #9 was not a nurse and also confirmed that after hours calls for the facility had not been assigned to a nurse. Corrective action received from the facility Administrator on 03/12/12: Effective immediately, the facility will have a Registered Nurse to respond to all after hours calls from patients who were receiving two (2) day procedures. The Medical Director will conduct training on 03/13/12 to ensure that the facility protocols were followed	U 135		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING: _____ B. WING _____	03/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
U 135	Continued From page 3 regarding after hours calls.	U 135		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING: _____ B. WING _____	04/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
U 000	INITIAL COMMENTS At the time of the survey, Summit Medical Associates was in compliance with Chapter 290-5-33, Rules and Regulations for Ambulatory Surgical Treatment Centers.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING: _____ B. WING _____	07/18/2013

approved 8/5/13 mgt

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
U 000	Initial Comments. At the time of the survey, Summit Medical Associates was not in compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a State licensure survey. The following deficiencies were written as the result of that survey.	U 000	U 000 **INITIAL COMMENTS** Summit Medical Associates strives to provide quality, compassionate care to our patients. The care and safety of our patients is of utmost priority and as such, Summit Medical Associates endeavors to meet all standards set forth by the Georgia Department of Community Health. Summit Medical Associates welcomes the opportunity to address these deficiencies by implementing the following corrective actions:	
U1007 SS C	111-8-4-.10(g) Physical Plant and Operational Standards. All procedure rooms shall be constructed, equipped, and maintained to assure the safety of patients and personnel. This RULE is not met as evidenced by: Based on the facility policy and procedures, observation and staff interview, it was determined that the facility failed to maintain construction and equipment to assure the safety of patients and personnel. Findings were: Review of the facility policy entitled Title: Sanitation Policy For The Procedure Room Suite, Policy Number: Nurs 10082-D, reviewed 1/4/2013 revealed that acceptable sanitation techniques would be used by all personnel to reduce the possibility of infection to patients and staff. Further review of the policy reveled that horizontal surfaces of tables, equipment, overhead lights and other ceiling and wall mounted equipment would be damp dusted with germicide. During a tour of the facility's surgical suite between 10:40 a.m. and 12:30 p.m. on 7/18/2013 with the facility Assistant Administrator (employee file #8), the surveyor observed the following:	U1007	**U1007** **PHYSICAL PLANT AND OPERATIONAL STANDARDS** **CORRECTIVE ACTION** Maintaining a clean and safe environment has always been a priority at Summit Medical Associates. - Over the past several weeks, the facility has had ceiling leaks in multiple locations due to problems caused when a new surgical center was built out upstairs. Plumbers have had to make numerous visits, removing ceiling tile to access the plumbing pipes overhead. In some instances, the ceiling tiles were chipped in the process. The building management was notified and was working closely with the facility to replace the tiles. - A meeting was held with the janitorial service representative to stress that a higher level of overall cleaning must be delivered per contract. The janitorial closet was better organized to reduce clutter. - A new ultrasound machine will be ordered. - The small section of chair rail on the wall outside of exam room #2 has been caulked and repainted. - The staff has been in-serviced to properly cover all opened supplies, and to discard any stained linen. - The cardboard covering the vent in the biohazard was immediately removed. - The intubation set up tray has been placed in a covered container. - Going forward, the Administrator and DON or OR Supervisor will conduct a weekly facility inspection and complete a newly developed Facility Inspection checklist that will cover all areas. The Administrator and Medical Director will conduct monthly Facility Inspections.	8/27/13

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	060-141	A. BUILDING: _____ B. WING _____	07/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
U1007	Continued From page 1 Broken ceiling tiles and cracks in the patient's bathroom Dust in the pre-op room, the Janitorial closet was cluttered with soiled mops and pails TTe sonogram machine in the sono room was cracked with large openings and chipped along the keyboard The wall outside of exam room #2 was a broken chair molding with exposed sharp wood An uncovered cart with exposed sanitary napkins The vent in the Biohazard room was taped off with cardboard The operating room supply cart was covered with soiled/stained linen The intubation tray set up on the counter in a patient's bay was covered with a chuck (large pad used to place under patients to absorb fluids/secretions) 1 rusted, dirty silver looking food tray wrapped with aluminum foil Damaged ceiling tiles in the Recovery room Torn stretchers in the recovery room The Assistant Administrator confirmed all findings.	U1007	**MONITORING** The weekly and monthly check lists will be included as part of the monthly Administrative Report sent to the Governing Body monthly. Summit Medical Associates has appointed an Executive Director who will conduct announced and unannounced site visits on at least a semi-annual basis to ensure total compliance to the facilities' protocols as well as the standards set forth by the Georgia Department of Community Health.	
U1501 SS C	111-8-4-.15(2) Housekeeping, Laundry, Maint, Sterile Supply. Laundry service shall be provided. Separate space and facilities shall be provided for receiving, sorting, and storing soiled laundry, and for the sorting, storing and issuing of clean laundry, if reusable items are utilized. This RULE is not met as evidenced by: Based on the facility policy and procedures, observation, and staff interview, it was determined that the facility failed to maintain	U1501	**U1501** **HOUSEKEEPING, LAUNDRY, MAINTENANCE, STERILE SUPPLY** **CORRECTIVE ACTION** The facility will contract with an outside company to provide linen service for its patients. Further, covered laundry carts have been ordered to house the laundry once inside the facility. An educational in-service was conducted to re-train staff on infection control with emphasis on the importance of inspecting all linen for Betadine or any other type of stain. Any linen that has such stains will not by used in this facility. A copy of the in-service has been placed in the employee training manual.	8/27/13

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SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

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U1501	Continued From page 2 separation between clean and soiled laundry. Findings were: Review of the facility policy entitled Title: Sanitation Policy For The Procedure Room Suite, Policy Number: Nurs 10082-D, reviewed 1/4/2013 revealed that acceptable sanitation techniques would be used by all personnel to reduce the possibility of infection to patients and staff. Further review of the policy reveled that reusable linens, soiled or not would be placed in laundry bags and closed. During a tour of the facility's surgical suite between 10:40 a.m. and 12:30 p.m. on 7/18/2013 with the facility Assistant Administrator (employee file #8), the surveyor observed laundry supplies in the laundry room. Those supplies included Arm and Hammer detergent and Clorox liquid. The Assistant Administrator was asked if those products were used to wash the facility's contaminated linen and he/she stated that was the products used. Further observation in the laundry room revealed uncovered clean linen positioned next to a garbage can and soiled linen was positioned next to dirty linen. During an interview at 2:45 p.m. on 7/18/2013 in the facility office, the Administrator (employee file #7- interview only) was asked if the facility laundered their own linen, and he/she stated that the linen was laundered on site. The Administrator was asked if he/she used commercial grade laundry cleaning products (for hospital use) for the the facility's linens. The Administrator stated that he/she did not, and asked if it was necessary to do so. The Administrator was asked if he/she knew what the temperature of the water that was being used to	U1501	MONITORING The Administrator and DON will conduct weekly random spot checks of the linen used in the facility. Any laundry that fails inspection will not be used. The Administrator will document results on the weekly Inspection Report and include any adverse findings in the Monthly Administrator's Report sent to the Governing Body each month.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING: _____ B. WING _____	07/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

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U1501	Continued From page 3 launder the facility's linen, and he/she stated that he/she did not know what the temperature of the wash water that was being used to launder contaminated laundry. The Administrator confirmed all findings.	U1501		
U1503 SS C	111-8-4-.15(4) Housekeeping, Laundry, Maint, Sterile Supply. Special precaution shall be taken to ensure that sterile instruments and supplies are kept separate from non-sterile instruments and supplies. Sterilization records shall be kept and sterile items shall be dated and utilized, based on established procedures. This RULE is not met as evidenced by: Based on the facility policy and procedures, observation, and staff interview, it was determined that the facility failed to ensure sterile supplies would be kept separate from non-sterile supplies. Findings were: Review of the facility policy entitled Title: Sanitation Policy For The Procedure Room Suite, Policy Number: Nurs 10082-D, reviewed 1/4/2013 revealed that acceptable sanitation techniques would be used by all personnel to reduce the possibility of infection to patients and staff. During a tour of the facility's surgical suite between 10:40 a.m. and 12:30 p.m. on 7/18/2013 with the facility Assistant Administrator (employee file #8) the surveyor observed a dirty traffic cone; sterile and non-sterile supplies stored in the same area.	U1503	U1503 **HOUSEKEEPING, LAUNDRY, MAINTENANCE, STERILE SUPPLY** **CORRECTIVE ACTION** A traffic cone (used by one the building workers) was inadvertently placed on the floor just inside the door of the supply area. All staff has been in-serviced to be alert for any items out of place, and to keep such items out of the supply room. **MONITORING** Continued educational in-services on infection control for all staff will be conducted and results documented in the staff training logbook. Weekly and monthly Inspections will be conducted by the Administrator and Medical Director, and the Physical Plant Inspection Checklist completed to ensure compliance. Results will be documented in the Administrator's monthly report and sent to the Governing Body each month.	8/13/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

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U1503	Continued From page 4 The Assistant Administrator confirmed the findings.	U1503		
U1600 SS C	111-8-4-.16 Drug Storage and Dispensing. Each center shall provide adequate space and equipment and staff to assure that drugs are stored and administered in compliance with State and Federal laws and regulations. Authority O.C.G.A. Secs. 31-2-4 et seq. and 31-7-1 et seq.. Administrative History. Original Rule entitled "Drug Storage and Dispensing" was filed on January 22, 1980; effective March 1, 1980, as specified by the Agency. This RULE is not met as evidenced by: Based on the facility policy and procedures, observation and staff interview, it was determined that the facility failed to assure that medications were stored in compliance with State and Federal laws and regulations. Findings were: Review of the facility policy entitled Title: Labeling Pre Drawn Medications, Policy number ANES010197, reviewed 1/4/13 revealed that filing and labeling all containers of drugs that were to be administered, and to be accountable for all pharmaceutical materials. During a tour on 7/18/2013 between 10:40 a.m. to 12:35 p.m. with the Assistant Administrator (employee file #8- interview only), a one (1) liter bag of intravenous (IV) fluids labeled with Pitocin (medication that induces contractions in the uterus) was observed hanging in the surgical suite.	U1600	U1600 **DRUG STORAGE AND DISPENSING** **CORRECTIVE ACTION** Patient safety is of utmost importance to Summit Medical Associates. All nurses have been in-serviced on the importance of properly storing and securing all drugs and medications at the end of each clinic per Summit's protocols, as well as remaining in compliance with State and Federal laws and regulations. **MONITORING** The Recovery Room Daily Checklist will be revised to include a section for the nurse to indicate that all drugs and medications have been securely locked. Any adverse findings can result in disciplinary action by the facility management. The Administrator and DON will conduct random spot checks, in addition to the weekly and monthly Facility Plant Inspection Checklist. Results will be documented and included in the Administrator's Monthly Checklist and sent to the Governing Body for review. As an additional measure, the Executive Director will conduct announced and unannounced site visits to inspect the clinic to ensure compliance.	9/8/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING: _____ B. WING _____	07/18/2013

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SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
U1600	Continued From page 5 During an interview at 2:30 p.m. on 7/18/2013 in the facility office, the facility Administrator (personnel file #7-interview only) stated that the nurses should have disposed of the bag of IV fluids at the end of the work day. The Administrator and the Assistant Administrator confirmed the findings.	U1600		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	08/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
V 000	Opening Comments At the time of the survey, Atlanta Women's Medical Center was not in compliance with Chapter 290-5-32, Rules and Regulations for Performance of Abortions After the First Trimester of Pregnancy and Reporting Requirements For All Abortions, as the result of a State licensure survey.The following deficiency was written as a result of that survey.	V 000		
V 030 SS=A	290-5-32-.03(1) Procedure for Filing Certificate of Abortion In addition to the medical records requirements of Chapters 290-5-6 and 290-5-33 of the Rules and Regulations of the Georgia Department of Human Resources, the physician who performs the abortion shall file with the Commissioner of Human Resources or [redacted] designee, within ten (10) days after an abortion procedure is performed, a Certificate of Abortion. It is expressly intended that the privacy of the patient shall be preserved and, to that end, the Certificate of Abortion shall not reflect the name of the patient but shall carry the same facility number, or other identifying number reflected on the patient's medical records. A duplicate of the Certificate of Abortion will he made a part of the patient's Medical record and neither the aforesaid duplicate certificate nor the Certificate of Abortion which is filed with the Commissioner or his designee shall be revealed to the public unless the patient executes a proper authorization which permits such a release or unless the records must be made available to the District Attorney of the Judicial Circuit in which the hospital or health facility is located as provided by Code Section 16-12-141 (d) of the Official Code of Georgia Annotated.	V 030	Corrective Action: The internal process for filing the Certificate of Abortion has been updated to include defined roles and responsibilities of staff members that will be held accountable for filing the certificates of abortion. Additional documentation has been added to ensure all abortion procedures have been filed, including: • An "ITOP Worksheet" to be used internally has been instituted and will be used by staff to complete filing. • A column has been added to the Post-anesthesia Care Unit (PACU) Log for staff to indicate a completed submission/filing of each abortion procedure performed each day. Staff Education: Staff members responsible for filing the certificates of abortion have been assigned responsibility for specific days of service (i.e. Wed, Thurs, Fri, Sat) and were trained on the updated procedures and documents to ensure that all records are filed within the required 10 day time period. Monitoring: Daily PACU Logs will be reviewed under supervision of Clinic Administrator within 10 days. Random chart reviews will continue to be conducted as part of the Quality Assurance process to ensure that "Proof of Filing" form is included in medical chart. Staff members will be held accountable for any violations of the Policy for Filing Certificate of Abortion, including termination of duties, and possible termination of employment.	8/28/13

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacey C. [illegible]

TITLE: Administrator

(X6) DATE: 10/3/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	08/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
V 030	Continued From page 1 Repealed: F. Dec. 18, 2012; eff. Jan. 7, 2013. This REQUIREMENT is not met as evidenced by: Based on review of Georgia Code, O.C.G. 16-12-14, medical record reviews and staff interview it was determined that the facility failed to ensure that the Certificate of Abortion was filed with the Department for two (2) of ten (10) sampled medical records (#'s 2 and 8). Findings include: Review of the current Georgia Code, O.C.G. 16-12-14 on 8/9/2013, revealed a requirement that the physician who performs an abortion file a Certificate of Abortion with the Commissioner of Community Health within ten (10) days following the abortion procedure. 1. Patient #2, abortion was completed on [redacted] the Commissioner of Community Health notification was [redacted] 2. Patient #8, abortion was completed on [redacted] the Commissioner of Community Health notification was [redacted] Interview on 8/9/2013 at 6:30 p.m., the Administrator confirmed the findings.	V 030	Responsible Persons: Assigned Staff Members and Clinic Administrator	

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	08/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U 000	Initial Comments. A State Licensure survey conducted on 8/9/2013 at Atlanta Women's Medical Center, was not in compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a State licensure survey. The following deficiencies were written as the result of that survey.	U 000		
U1005 SS=G	111-8-4-.10(e) Physical Plant and Operational Standards. Entrances for patients shall be connected to the public right-of-way by a hard-surfaced, unobstructed walkway in good repair. Handicapped patients confined to a wheel chair or otherwise impaired shall be able to access the center building without climbing any stairs or steps. A ramp with handrails over existing stairs or steps may be utilized in meeting this requirement. A hard-surfaced, unobstructed road or driveway for use by ambulances or other emergency fire or police vehicles shall run from at least one entrance of the building to the public right-of-way. The doorway of such entrance shall be immediately adjacent to the road or driveway. This RULE is not met as evidenced by: Based on observation, it was determined that the facility failed to provide for handicapped patients confined to a wheelchair or otherwise impaired to access the facility without climbing any stairs or steps Findings include: Observation on 08/08/2013 at 9:00 a.m. revealed two (2) parking spaces labeled with the blue handicapped symbols (wheelchair) painted on the	U1005	Corrective Action: On Sept. 16, 2013, Administrator contacted the property owner to notify it of the parking violation and request purchase of "No Parking" signage. On Sept. 17, 2013, a property owner representative sent receipt of purchase of signage to AWMC Clinic Administrator with expected delivery date of Sept. 27, 2013. "No Parking" signage will be installed, visible to the public, prohibiting any parking that would block access to the ramp. In the event a vehicle parks illegally in that spot, a towing company will be called to remove the vehicle. Staff Education: AWMC staff and contractors and first floor building tenants were notified of this parking enforcement regarding the striped area in front of the sidewalk ramp on Sept. 18, 2013. All were informed that signage prohibiting parking in this area will soon be posted. Monitoring: AWMC Security Officer will report any visible parking violations to AWMC Clinic Administrator, who will notify property owners to handle appropriately. Responsible Persons: AWMC Security Officer and AWMC Clinic Administrator	10/4/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacey C. Yates — TITLE: Administrator — (X6) DATE: 10/3/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	08/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U1005	Continued From page 1 pavement. Continued observations revealed a ramp that was level with the pavement and the sidewalk located between the entrances of two businesses. The ramp was painted with white stripes to indicate no parking (the ramp was to be used for wheelchairs to maneuver the curb). A large size black car was parked in the stripped area completely blocking the ramp, thus preventing handicapped patients confined to a wheelchair, ambulances with stretchers, and emergency vehicles such as fire and/or police, easy access to the facility.	U1005		
U1006 SS=G	111-8-4-.10(f) Physical Plant and Operational Standards. Ambulatory surgical services provided in multistory buildings shall be accessible by an elevator of adequate size to accommodate date a standard wheeled litter patient and two attendants. A stairway or ramp of adequate dimensions shall be available for transfer of a patient in case of power failure. This RULE is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to provide an elevator for patient transport to the second floor on which the ASC is located. Findings include: Observation on 8/8/2013 at 9:30 a.m. revealed entrance to the premises through an open door and up a flight of eighteen steps to the entrance of the center. There was no evidence of an elevator on the premises.	U1006	First Corrective Action: In order to ensure that AWMC's lack of elevator access does not adversely affect patient safety or care, AWMC will comply with the following policies and procedures: • Patients who receive IV sedation will be accompanied to the center by a personal escort. • Following her procedure, a patient receiving IV sedation will be escorted down the stairs by her personal escort and a clinic staff member. • The patient's personal escort will accompany the patient to her transportation. • All staff escorts will document the escorting of patients in the Staff Escort Log. • Patients who have not received IV sedation but who have been determined to need assistance to safely navigate the stairs will also be escorted down the stairs by a clinic staff member. • If a patient must be transferred to another facility, the clinic administrator or a designee will call the ambulance service to arrange for transfer and alert the operator that the center is on the second floor and that access to the center is via a stairway.	Immediate (these are ongoing practices already in place prior to the inspection)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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U1006	Continued From page 2 Interview on 08/09/2013 at 6:00 p.m., the Administrator acknowledged that there was not an elevator in the facility.	U1006	• Prospective patients will be notified that AWC is on the second floor and that access to AWMC is via a stairway. Such notification will be documented in patient appointment notes. • The center will maintain in its file a statement signed by its current medical director that in his/her medical judgment, walking down stairs following surgery presents minimal, if any, risk to the patient. Staff Education: Staff Meeting for review of procedures Oct. 9. Monitoring: Administrator will perform periodic quality assurance checks to ensure policies are being followed. Responsible Party Administrator Second Corrective Action: From the time this facility was first licensed in 1994 until last year, the Department continuously granted AWMC variances from the elevator requirement. The most recent of those variances expired in 2012. We have applied for a new variance from the elevator requirement and are currently in the midst of pending proceedings on that matter -- on 9/13/13, we filed a new variance request, adding additional alternative standards, and we are also in the midst of administrative proceedings regarding two earlier-filed requests. Additionally, we are in the process of seeking a settlement conference with the Department to try and reach a suitable resolution agreeable to all. Our plan for compliance is to pursue each of these avenues with the goal of finding a feasible means of compliance that is acceptable to the Department. Staff Education: Staff will be appropriately notified of decisions resulting from the pending administrative proceedings and any changes that may be implemented as a result of such decisions.	Unknown
U1502 SS=G	111-8-4-.15(3) Housekeeping, Laundry, Maint, Sterile Supply. There shall be adequate space and facilities for receiving, packaging and proper sterilizing and storage of supplies and equipment, consistent with the services to be provided. This RULE is not met as evidenced by: Based on observation of the facility's surgical suite, review of facility's policies and procedures and staff interview, it was determined that the facility failed to ensure proper sterilizing and storage of supplies and equipment for four (4) of four (4) patients. Finding include: Observation on 8/8/2013 at 3:30 p.m. of the facility's operating room #1 revealed four (4) surgical cervical dilators (instruments used to open the lower portion of the uterine cervix) in a cabinet drawer with visible moisture inside the packages. Review of facility's policy and procedure entitled, "Autoclave & Sterilization", no policy number or date, revealed that both autoclaves were to reach 270 degrees and the cycle continues until drying time was reached. Interview on 8/8/2013 at 5:00 p.m., the Administrator confirmed the findings.	U1502		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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U1006	Continued From page 2 Interview on 08/09/2013 at 6:00 p.m., the Administrator acknowledged that there was not an elevator in the facility.	U1006	Monitoring: Legal Counsel & Administrator will continue monitoring progress of all administrative proceedings on this matter. Responsible Persons: Legal Counsel & Clinic Administrator	
U1502 SS=G	111-8-4-.15(3) Housekeeping, Laundry, Maint, Sterile Supply. There shall be adequate space and facilities for receiving, packaging and proper sterilizing and storage of supplies and equipment, consistent with the services to be provided. This RULE is not met as evidenced by: Based on observation of the facility's surgical suite, review of facility's policies and procedures and staff interview, it was determined that the facility failed to ensure proper sterilizing and storage of supplies and equipment for four (4) of four (4) patients. Finding include: Observation on 8/8/2013 at 3:30 p.m. of the facility's operating room #1 revealed four (4) surgical cervical dilators (instruments used to open the lower portion of the uterine cervix) in a cabinet drawer with visible moisture inside the packages. Review of facility's policy and procedure entitled, "Autoclave & Sterilization", no policy number or date, revealed that both autoclaves were to reach 270 degrees and the cycle continues until drying time was reached. Interview on 8/8/2013 at 5:00 p.m., the Administrator confirmed the findings.	U1502	Corrective Action: Nurse Coordinator reviewed appropriate sterilization techniques and monitoring with the Medical Assistant who performs instrument sterilization. Autoclaves were sent to preventative maintenance vendor for thorough cleaning and new filters to ensure proper working order. Autoclave policy and procedure reviewed and date noted on policy. Staff Education: Medical Assistant was retrained on proper sterilization techniques, acceptable loading of autoclaves, and accurate monitoring of sterilization. Training was documented on 8/30. Monitoring: Sterilization techniques, policies, and procedures will be reviewed monthly to ensure compliance. Nurse Coordinator will perform staff observation monthly; any required action will be planned accordingly and reported to Administrator and Quality Assurance Committee. Responsible Persons: Nurse Coordinator, Administrator & Quality Assurance Committee	8/30/13

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U1902	Continued From page 3	U1902		
U1902 SS=G	111-8-4-.19(3) Electrical Power. Centers which utilize general anesthesia shall provide an emergency electrical system so controlled, that, after interruption of the normal electric power supply, an acceptable auxiliary power source is available and capable of being brought into use within ten seconds with sufficient voltage and frequency to reestablish essential in-house services and other emergency equipment needed to effect a prompt and efficient transfer of patients to an appropriate licensed hospital, when needed. Authority O.C.G.A. Secs. 31-2-4 et seq. and 31-7-1 et seq. Administrative History. Original Rule entitled "Electrical Power" was filed on January 22, 1980; effective March 1, 1980, as specified by the Agency. This RULE is not met as evidenced by: Based on review of the policies and procedures, generator log, and staff interview, it was determined that the facility, which has a generator, failed to produce evidence that the facility's auxiliary power source, was capable of being brought into use within ten (10) seconds following interruption of normal power. Findings include: Review of policy entitled, "Generator Testing and Maintenance", no date, revealed that preventative maintenance will be performed twice each year. Review of the generator logs, failed to reveal evidence that the generator was tested to assure power transfer within ten (10) seconds following interruption of normal power.	U1902	Corrective Action: AWMC will not provide (and do not currently provide) general anesthesia, making the generator rule inapplicable to the facility. AWMC has never provided general anesthesia. Staff Education: Staff in-service scheduled for 10/9 to review the proper terminology for the level/type of anesthesia/sedation provided at the center, which is IV sedation/MAC (monitored anesthesia care) and/or local anesthesia. Monitoring: Clinic administrator will ensure that all policies and chart paperwork reflect the appropriate terminology regarding type of anesthesia provided at the center. Responsible Persons: Administrator	10/9/13

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U1902	Continued From page 4 On 08/08/13 at 1:00 p.m., the Administrator confirmed the findings.	U1902		

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

August 6, 2013

Ms. Elizabeth Johnson, Administrator
Summit Medical Associates
1874 Piedmont Rd, Ne, Suite 500-E
Atlanta, GA 30324-4869

Dear Ms. Johnson:

The Healthcare Facility Regulation Division acknowledges receipt of your plan of correction for the deficiencies that were cited as the result of your **July 18, 2013** survey. The plan of correction has been reviewed and accepted as appropriate to correct the cited deficiencies.

If a follow-up visit is not conducted, please be advised that the implementation of your plan of correction will be monitored at your next on-site visit.

If you have any questions, please contact my office at (404) 657-5440 or write to the address listed above.

Sincerely,

Marsha Fricks

Marsha Fricks, Interim Program Director
Acute Care Programs
Department of Community Health
Healthcare Facility Regulation Division

MF:rf

Americans United for Life

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Nathan Deal, Governor | Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

July 23, 2013

Ms. Merriam McLendon, Administrator
Summit Medical Associates
1874 Piedmont Road, NE, Suite 500-E
Atlanta, GA 30324-4869

Dear Ms. McLendon:

Enclosed is a annual Report of Licensure Inspection completed at your facility on **July 18, 2013** by surveyor(s) from this office. This report contains one or more violations which must be corrected.

Your plan to correct these violations should be entered in the right hand column entitled "Providers Plan of Correction" with a projected completion date entered in the column "Completion Date". After you have completed the form, sign and date it in the space provided, return the ORIGINAL to our office no later than **August 5, 2013**.

Thank you for the courtesies extended to our representatives during this visit. If I can be of further assistance, please contact me at (404) 657-5440.

Sincerely,

Marsha Fricks

Marsha Fricks, Interim Program Director
Acute Care Programs
Department of Community Health
Healthcare Facility Regulation Division

MF:rf

Americans United for Life

Reviewed approved 9/9/13 mps

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-287	A. BUILDING: _____ B. WING _____	08/07/2013

HEALTHCARE FACILITY REG

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIFF VALLEY CLINIC	1924 CLIFF VALLEY WAY, NE ATLANTA, GA 30329

SEP 09 2013

(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
U 000	Initial Comments. At the time of the survey, Cliff Valley Clinic was in substantial compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a State licensure survey. The following deficiency was written as the result of that survey.	U 000		
U1600	111-8-4-.16 Drug Storage and Dispensing. Each center shall provide adequate space and equipment and staff to assure that drugs are stored and administered in compliance with State and Federal laws and regulations. Authority O.C.G.A. Secs. 31-2-4 et seq. and 31-7-1 et seq.. Administrative History. Original Rule entitled "Drug Storage and Dispensing" was filed on January 22, 1980; effective March 1, 1980, as specified by the Agency. This RULE is not met as evidenced by: Based on review of the facility's policies and procedures, observations during facility tour and interview, it was determined that the facility failed to ensure that expired medications were not available for patient's use. Findings were: Review of the facility's policies and procedures entitled Equipment and Supplies, and General Policy to Prevent Transmission of Infections, last revised 09/2009, revealed all medications were checked for expiration dates on a monthly basis by a full time registered nurse. A tour of the facility with the Clinical Director on 8/6/2013 at 3:30 p.m., revealed the following medications were expired and available for	U1600	Corrective Action: Drug expiration removal and logging. The responsibility of checking all medications that is shared between all Registered Nurses on staff shall also include checking supplies. All Nurses are expected to check the area that they are assigned to (Pre-op (exam room), Post-Op (aftercare) and each OR) for any and all expired medications and supplies to include test strips and supplies used for non surgical services. Any pre-drawn normal saline flush shall be marked with 1) Name of medication 2) Initials of RN and 3) Date drawn. Flushes will be discarded at the end of each shift.	8/9/13

State of GA, Healthcare Facility Re[redacted]tion Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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U1600	Continued From page 1 patient care use: 1) Exam room #2 in a locked wall cabinet: a. One (1) full box and one (1) partially full box of One Step test fecal occult blood packages (used to identify hidden blood in the stool), expired January 2013; and b. One (1) box of Povidone -Iodine swabs (used to prevent surgical wound infections) expired 08/2002. 2) Operating room cart drawer, located in the post-operative area: a. Three (3) boxes each containing Junior strength acetaminophen 160 mg tab ([redacted] pain reliever) expired on 8/5/2013; and b. Seventeen (17) pre- drawn 3 ml syringes containing a clear fluid, labeled NS dated 8/5/13. 3) Locked cabinet in the in post-operative area: a. One (1) vial Procainamide HCL 10 ml (used for treatment of abnormal heart-beats) expired 04/2013; and b. Two (2) Normal Saline IV bags 500 ml (fluid given in the vein to prevent dehydration and/or to administer medication) expired on 04/1/2013. An interview was conducted in the facility's post-operative area between on 8/6/2013 at 3:10 p.m. with the Clinical Director. He/she confirmed that the above named medications were expired, and explained that the one step fecal blood test swabs were used by the Wellness clinic on their days of service. He/she stated that the pre-filled syringes were drawn up by the Certified Nurse Anesthetist the day prior to the surgical procedures.	U1600	Staff Education: Each Nurse upon return to clinic will receive a refresher inservice on the proper way to check all work areas, cabinets, and carts for expired medications and supplies to include the proper disposal and replacement of each. Monitoring: To ensure that all expired medications and supplies are removed from patient care areas within a timely manner, the Clinic Director will include an inspection of all patient care areas along with the quarterly check of medication logs. Responsible Persons: Clinical Director	started 8/9/13 completed 8/16/13

State of GA, Healthcare Facility R[redacted]ation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 000	Opening Comments At the time of the survey,Cliff Valley Clinic was not in compliance with 290-5-32 Rules and Regulations for Performance of Abortion After the First Trimester of Pregnancy and Reporting Requirements for All Abortions, as a result of a State licensure survey. The following deficiency was written as a result of that survey.	V 000	Upon further internal investigation, it was found that the computer system used to file the Certificate of Abortion (ITOP forms) was experiencing technical difficulties due to system upgrades intermittently between the dates of 1/25/13 to 3/27/13. Corrective Action: To ensure compliance all employees trained to submit ITOP forms shall cross reference all chart numbers with the pathology log and all appointments listed as "kept" in the computer system for each clinic day to be sure no chart has been left out for reporting. Any patient's chart that needs medical follow up shall have the ITOP form submitted before being placed in the follow up area for Nurse or Physician. Monitoring: For each clinic day a form shall be completed to document which charts have had ITOP forms completed and any reason why a chart has not yet been reported.	8/10/13 9/4/13
V 030 SS=A	290-5-32-.03(1) Procedure for Filing Certificate of Abortion In addition to the medical records requirements of Chapters 290-5-6 and 290-5-33 of the Rules and Regulations of the Georgia Department of Human Resources, the physician who performs the abortion shall file with the Commissioner of Human Resources or his designee, within ten (10) days after an abortion procedure is performed, a Certificate of Abortion. It is expressly intended that the privacy of the patient shall be preserved and, to that end, the Certificate of Abortion shall not reflect the name of the patient but shall carry the same facility number, or other identifying number reflected on the patient's medical records. A duplicate of the Certificate of Abortion will he made a part of the patient's Medical record and neither the aforesaid duplicate certificate nor the Certificate of Abortion which is filed with the Commissioner or his designee shall be revealed to the public unless the patient executes a proper authorization which permits such a release or unless the records must be made available to the District Attorney of the Judicial Circuit in which the hospital or health facility is located as provided by Code Section 16-12-141 (d) of the Official Code of Georgia Annotated. Repealed: F. Dec. 18, 2012; eff. Jan. 7, 2013.	V 030		

State of GA, Healthcare Facility R[redacted]ation Division

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V 030	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of policy and procedure, medical reviews, and staff interview it was determined that the facility failed to ensure that the Certificate of Abortion was filed with the Department for two (2) of ten (10) patients. Findings: No Policy was identified during the survey. Review of ten (10) sampled medical records (#'s 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10) revealed that MR #'s 5 and 7 failed to reveal evidence that the required Certificate of Abortion was filed with the Department within the regulatory timeframe of ten (10) days. Medical Record # 5's date of abortion was [redacted] and the Certificate of Abortion was filed on [redacted] Medical Record #7's date of abortion was [redacted] and the Certificate of Abortion was filed on [redacted] The Clinical Manager on 8/7/2013 at 6:30 p.m. in staff break room, confirmed the above findings.	V 030	A quarterly inspection of daily forms shall be conducted by Admissions Supervisor to ensure all Certificates of Abortion have been filed. Staff Education: All admissions staff that are trained to submit ITOP forms shall receive an inservice to review the form to be filled out for each clinic day and how to cross reference the chart numbers with the pathology log. Responsible Persons: Admissions Supervisor, and Clinical Director	9/4/13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

August 29, 2013

Ms. Joline Milord, Administrator
Cliff Valley Clinic
1924 Cliff Valley Way, NE
Atlanta, GA 30329

Dear Ms. Milord:

Enclosed is a annual Report of Licensure Inspection completed at your facility on **August 7, 2013** by surveyor(s) from this office. This report contains one or more violations which must be corrected.

Your plan to correct these violations should be entered in the right hand column entitled "Providers Plan of Correction" with a projected completion date entered in the column "Completion Date". After you have completed the form, sign and date it in the space provided, return the ORIGINAL to our office no later than **September 9, 2013**.

Thank you for the courtesies extended to our representatives during this visit. If I can be of further assistance, please contact me at (404) 657-5440.

Sincerely,

for Marsha Fricks, Interim Program Director
Acute Care Programs
Department of Community Health
Healthcare Facility Regulation Division

MF:rf

Americans United for Life

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

September 9, 2013

Ms. Joline Milord, Administrator
Cliff Valley Clinic
1924 Cliff Valley Way, NE
Atlanta, GA 30329

Dear Ms. Milord:

The Healthcare Facility Regulation Division acknowledges receipt of your plan of correction for the deficiencies that were cited as the result of your **August 7, 2013** survey. The plan of correction has been reviewed and accepted as appropriate to correct the cited deficiencies.

If a follow-up visit is not conducted, please be advised that the implementation of your plan of correction will be monitored at your next on-site visit.

If you have any questions, please contact my office at (404) 657-5440 or write to the address listed above.

Sincerely,

Marsha Fricks

Marsha Fricks, R.N., Program Director
Acute Care Unit
Department of Community Health
Healthcare Facility Regulation Division

MF:rf

Americans United for Life

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING: _____ B. WING _____	C 01/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	**1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324**

(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
U 000	INITIAL COMMENTS At the time of the survey, Summit Medical Associates was in compliance with Chapter 290-5-33, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of complaint investigation #GA00119494.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025-115	A. BUILDING: _____ B. WING _____	02/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH MEDICAL CLINIC	**120 East 34th Street SAVANNAH, GA 31401**

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U 000	INITIAL COMMENTS At the time of the survey, Savannah Medical Clinic was in compliance with Chapter 290-5-33, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a State licensure survey.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

August 29, 2013

Ms. Joline Milord, Administrator
Cliff Valley Clinic
1924 Cliff Valley Way, NE
Atlanta, GA 30329

Dear Ms. Milord:

Enclosed is a annual Report of Licensure Inspection completed at your facility on **August 7, 2013** by surveyor(s) from this office. This report contains one or more violations which must be corrected.

Your plan to correct these violations should be entered in the right hand column entitled "Providers Plan of Correction" with a projected completion date entered in the column "Completion Date". After you have completed the form, sign and date it in the space provided, return the ORIGINAL to our office no later than **September 9, 2013**.

Thank you for the courtesies extended to our representatives during this visit. If I can be of further assistance, please contact me at (404) 657-5440.

Sincerely,

for Marsha Fricks, Interim Program Director
Acute Care Programs
Department of Community Health
Healthcare Facility Regulation Division

MF:rf

Americans United for Life

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	060-011	A. BUILDING: _____ B. WING _____	C 04/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U 000	Initial Comments. At the time of the survey, Atlanta Women's Medical Center was in compliance with Chapter 290-5-33, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of complaint investigation #GA00123252.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

approved 10/13/14

PRINTED: 10/07/2014
FORM APPROVED

State of GA, Healthcare Facility Regulation Division

HEALTHCARE FACILITY REGULATION DIVISION

OCT 10 2014

RECEIVED

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	044-287	A. BUILDING: _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIFF VALLEY CLINIC	1924 CLIFF VALLEY WAY, NE ATLANTA, GA 30329

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V 000	Opening Comments A State re-licensure survey was conducted on September 22, 2014. Cliff Valley Clinic was not in compliance with Chapter 290-5-32 Rules and Regulations for Performance of Abortion After the First Trimester of Pregnancy and Reporting Requirements for All Abortions. The following deficiency was cited.	V 000	Corrective Action: As noted, the Certificate of Abortion had been filed online but the form printed out did not include the second page with the date submitted. When filing the Certificate of Abortion staff will now document on a printout of the encounter list for each abortion day, the date, time and signature of the person submitting each certificate online and place in the book marked "Itops" along with a pathology sheet for the day. Staff Education: All staff that are trained to complete worksheets will be reminded to print both sheets that are generated after submitting the Certificate of Abortion and instructed on how to document their submissions, as well as where the "itops" book will be located. Monitoring: Lead Health Educator will be responsible for monitoring book for compliance and will work closely with the Quality Care Team Leader to assure compliance monthly and notify Clinic Director of any issues with submitting or printing worksheets.	09/25/14 10/08/14
V 030 SS=F	290-5-32-.03(1) Procedure for Filing Certificate of Abortion In addition to the medical records requirements of Chapters 290-5-6 and 290-5-33 of the Rules and Regulations of the Georgia Department of Human Resources, the physician who performs the abortion shall file with the Commissioner of Human Resources or [redacted] designee, within ten (10) days after an abortion procedure is performed, a Certificate of Abortion. It is expressly intended that the privacy of the patient shall be preserved and, to that end, the Certificate of Abortion shall not reflect the name of the patient but shall carry the same facility number, or other identifying number reflected on the patient's medical records. A duplicate of the Certificate of Abortion will [redacted] made a part of the patient's Medical record and neither the aforesaid duplicate certificate nor the Certificate of Abortion which is filed with the Commissioner or [redacted] designee shall be revealed to the public unless the patient executes a proper authorization which permits such a release or unless the records must be made available to the District Attorney of the Judicial Circuit in which the hospital or health facility is located as provided by Code Section 16-12-141 (d) of the Official Code of Georgia Annotated. Repealed: F. Dec. 18, 2012; eff. Jan. 7, 2013.	V 030		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Clinic Director

State of GA, Healthcare Facility Regulation Division

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V 030	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that the Certificate of Abortion was filed with the Department for two (2) patients (#4 and #7) of ten (10) patients. Findings include: Review of the policy manual revealed no evidence of a Policy addressing filing of Certificate of Abortion. Review of patient #4, revealed the date of abortion as [redacted] however there was no evidence that the Certificate of Abortion was filed with the Department within the regulatory timeframe of ten (10) days. Review of patient #7, revealed the date of abortion as [redacted] however there was no evidence of that the Certificate of Abortion was filed with the Department within the regulatory timeframe of ten (10) days. Interview conducted with the facility's Clinical Manager on 9/23/2014 revealed that the certificate was a two page document and that the second page which contained the date of filing was inadvertently omitted and could not be retrieved.	V 030	Responsible Persons: Lead Health Educator, Quality Care Team Leader, and Clinic Director.	

State of GA. Healthcare Facility Regulation Division

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U 000	Initial Comments. A State re-licensure survey was conducted on September 22, 2014. Cliff Valley Clinic was not in substantial compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers. The following deficiencies were cited.	U 000		
U1026 SS=D	111-8-4-.10(m) Physical Plant and Operational Standards. Equipment for sterilizing instruments and supplies shall be conveniently located and of adequate capacity for the workload. Records shall be maintained to assure quality control, including date, time and temperature of each batch of sterilized supplies and equipment. This RULE is not met as evidenced by: Based on record review and interview the facility failed to ensure sterilized speculum instruments were not expired, and that expired sterilized instruments were not stored with unexpired sterilized instruments. Findings include: Observation on 9/23/14 at 12:00 p.m., with the Clinical Director and Health Advocate of the clean sterile room revealed fifteen (15) sterile wrapped instruments in a sterilized container of which three (3) speculum instruments, dated 6/19/14, 8/1/14 and 9/16/14 respectively were expired. Review of the facility's Central Log revealed three (3) expired speculum instruments. Interview on 9/23/14 at 12:30 p.m. in the sterilization clean room with the Health Advocate who confirmed the above findings.	U1026	Corrective Action: Each sterilized instrument found to be out dated was removed from the container, recleaned and sterilized in the autoclave. All instruments are to be checked every Tuesday for expirations. Any instrument that is found to be due to expire that week will be pulled, cleaned, sterilized and correctly marked with date completed, date of expiration, initials of person completing and autoclave machine used. Documentation will also be recorded on instrument cleaning log. Staff Education: All Health workers will be retrained on weekly duties and reminded of importance of checking all instruments especially those instruments that are not in regular use. Monitoring: Quality Care Team member will be assigned to check all instruments monthly for compliance and will report any issues of noncompliance to Team Leader and Health Worker Supervisor. Responsible Persons: Health Worker Supervisor, Quality Care Team Leader and Clinic Director	09/25/2014 10/18/2014
U1027 SS=C	111-8-4-.10(n) Physical Plant and Operational Standards.	U1027		

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U1027	Continued From page 1 Medicines shall be stored in a conveniently located cabinet with lock, and only licensed persons shall have access. This RULE is not met as evidenced by: Based on interview and observation, the facility failed to ensure medications were secured with only licensed persons having access. Findings include: Review of the facility's policies and procedures entitled 'Medication Policies and Procedures', last reviewed 11/2013, revealed that upon receipt, all medications must be immediately stored in locked medication cabinets. the narcotics cabinet (if they are a controlled substance), or in the refrigerator (if they are a medication which requires refrigeration). Observation on 9/23/2014 at 12:20 p.m., accompanied by the facility's Administrator revealed the following unsecured medications in an unlocked storage cabinet in the Operating Room Suite: A plastic bin full of multiple bags of 0.9 NaCL (Normal Saline) 1000 ml (intravenous fluid). At the time of the discovery the Administrator acknowledged that the storage cabinet was kept unlocked and unlicensed staff had access to it.	U1027	Corrective Action: Bin containing normal saline IV fluids was removed from medical suite storage closet and placed in locked cabinet in aftercare until new key for storage closet can be obtained from Facilities. Once replacement key is obtained for lock, fluids will be returned to medical suite storage closet, closet will be locked and key will be placed on key ring for medication access and placed in secure locker with Nurse access only. Staff Education: All nurses will be instructed on which key opens medical suite storage closet, and instructed to open and lock closet as they do with all medication storage areas and return key to secure locker at the end of shift. Monitoring: Upon closing at end of day, RN on duty will assure that all cabinets and closets are locked. Quality Care team member will be assigned task of checking medical suite for compliance and report to Clinic Director any discrepancies or unlocked areas. Responsible Persons: All Registered Nurses on schedule, Quality Care Team, and Clinic Director.	09/25/14 10/11/14 10/18/14
U1104 SS=C	111-8-4-.11(5) Personnel. There shall be a separate personnel folder maintained for each employee. This file shall	U1104		

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U1104	Continued From page 2 contain all personnel information concerning the employee, including the application and qualifications for employment, physical examination (including laboratory and x-ray reports, if applicable), job description and attendance record. This RULE is not met as evidenced by: Based on review of record review and staff interview the facility failed to ensure employees had met the required training for Certified Pulmonary Resuscitation (CPR) as outlined in their job description whereby compromising patient safety for two (2) patients (#1 and #2) of four (4) sampled. Findings include: Review of employee records for Registered Nurses (RN) #1 and an Ultrasound Technician #2 revealed employee's records #1 and #2 no evidence of training for CPR as required as qualifications for their job description. Review of the facility's job description dated 05/28/14 revealed for Registered Nurses and Ultrasound Technician will have CPR training. Interview on 9/23/14 at 1:00 p.m. the Clinical Director confirmed the above findings.	U1104	Corrective Action: Documentation obtained from PRN RN of completed CPR renewal obtained. Ultrasound Technician present for CPR training at clinic and renewal obtained. All PRN staff and contracted staff will be notified that they must send in updated copies of renewals or be removed from staff list until obtained. Staff Education: CPR classes will be held biyearly for staff to assure renewals in a timely manner. Monitoring: Quality Care Team member will be assigned task of maintaining an updated list of all staff members dates for renewal and reporting to Quality care team Leader the need for additional classes. Clinic Director will be notified of all upcoming professional license renewal dates and will obtain documentation from PRN staff. Responsible Persons: Quality Care Team Leader and Clinic Director	09/29/2014 10/10/14
U1600 SS=F	111-8-4-.16 Drug Storage and Dispensing. Each center shall provide adequate space and equipment and staff to assure that drugs are stored and administered in compliance with State and Federal laws and regulations. Authority O.C.G.A. Secs. 31-2-4 et seq. and 31-7-1 et seq.. Administrative History. Original Rule entitled "Drug Storage and Dispensing" was filed on January 22, 1980; effective March 1,	U1600		

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U1600	Continued From page 3 1980, as specified by the Agency. This RULE is not met as evidenced by: Based on review of the facility's policies and procedures, and observations the facility failed to ensure that expired medications were not available for patient's use; multidose medications were discarded per faciilty policy; single dose medication was discarded per medication label, and narcotic counts were accurate per facility policy. Findings include: Review of the facility's policies and procedures entitled 'Medication Policies and Procedures', last reviewed 11/2013, revealed the following: 1. All medications are checked for expiration dates on a monthly basis by the full time RN or a designee of the Clinic Administrator, with the exception of controlled drugs, which must be checked by a Nurse. 2. Upon receipt, all medications must be immediately stored in locked medication cabinets. the narcotics cabinet (if they are a controlled substance), or in the refrigerator (if they are a medication which requires refrigeration). 3. Any medication remaining in a multi-dose vial at the end of the clinic day must be labeled with the date opened and the initials of the person opening the vial. The vial must then be discarded within 30 days of opening or after vial expiration date, which ever comes first. Observation on 9/23/14 at 12:30 p.m. with the Clinic Administrator revealed the following medications were expired and available for	U1600	Corrective Actions: All expired medications removed and discarded according to DEA regulations. Medication expiration log reviewed and RN that signed off as checking all medications on September 18th, 2014 has been relieved of duties and will no longer be working at clinic. Policy for checking medications has been updated to include removing medications at least 30 days before they are due to expire and all medications that are on anesthesia cart but not in regular use will be removed from carts and stored in aftercare cabinet and marked as "Emergency Anesthesia Drugs" Staff Education: All RNs will receive an additional copy of updated medication policy and the importance of careful monitoring will be stressed. Monitoring: Quality Care Team members will be assigned tasks of checking expired medication log sheet monthly for documentation of monthly check and monthly check of supplies. Will report to Quality Care Team leader any discrepancies and Health Worker Supervisor of any items that need to be ordered. Clinic Director will perform random quarterly checks on medications and supplies.	09/25/14 09/27/14 10/18/14

State of GA, Healthcare Facility Regulation Division

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U1600	Continued From page 4 patient care use: On the Crash Cart located in the Operating Suite: 1. 1000 ml of Normal Saline fluid bags expired on 9/1/14 x 2. 2. Vial of Solumedrol expired 8/1/14 x 1. 3. Ampoule of Neo-Syneprine HCL (Phenylephrine Hydrochloride) expired on 8/1/14 1 ml x 1. 4. Naloxone hydrochloride 1 mg expired September 1, 2014 x 1. In the anesthesia cart in Operating Room 2 1. Neo-Syneprine HCL (Phenylephrine Hydrochloride) 1 ml X 4 ampoules expired on 8/1/14. 2. Solu-Medrol methylprednisone one 500 mg vial expired 8/14 3. 1 opened 20 ml multiple dose vial of Atropine Sulphate with no indication of opening date per facility policy. In the narcotics cabinet in the recovery area: 1. Fentanyl 5 ml single dose vial of 250 mcg expiration date 8/2015 opened, with no indication of open date, included in narcotic count. 2. Ketamine HCL multiple dose 500 mg/10 ml vial opened marked opened '7/22'. 3. Xanax 1 mg tablets count discrepancy. At the time of discovery of the above items, the Clinic Administrator acknowledged the findings.	U1600	Responsible Persons: All RNs on schedule, CRNA, Quality Care Team Leader, Clinic Director	

State of GA, Healthcare Facility Regulation Division

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

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V 000	Opening Comments At the time of the survey, Atlanta Women's Medical Center was in compliance with Chapter 290-5-32, Rules and Regulations for Performance of Abortions After the First Trimester of Pregnancy and Reporting Requirements For All Abortions.	V 000		

State of GA Inspection Report

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U 000	Initial Comments. AMENDED 2567 A relicensure and complaint investigation (GA00136570) was conducted on 6/12/2014, Atlanta Women's Medical Center was not in compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers, the following deficiencies were cited:	U 000	HEALTHCARE FACILITY REG. JUL 22 2014 RECEIVED	
U1025 SS G	111-8-4-.10(l) Physical Plant and Operational Standards. The center shall be arranged and organized in such a manner as to ensure the comfort, safety, hygiene, privacy, and dignity of patients treated therein. This RULE is not met as evidenced by: Based on observation and staff interview the facility failed to ensure patient safety related to glucometer use. Findings include: The facility was equipped with a glucometer (device to assess blood sugar) and the only test strips available were expired. Interview with the Director of Nursing following the observation confirmed the strips were expired and that the machine was for single patient use and not approved for multi-patient use.	U1025	AWC responded to this deficiency in a plan of corrections submitted on July 7, 2014. A copy of that plan of correction, to which AWC has not yet received a response, is incorporated herein by reference.	July 10, 2014
U2100 SS A	111-8-4-.21 Advertising. Any advertising of the services provided in or by ambulatory surgical treatment center shall include the full name of the center and its Georgia license	U2100	AWC responded to this deficiency in a plan of corrections submitted on July 7, 2014. A copy of that plan of correction, to which AWC has not yet received a response, is incorporated herein by reference.	July 11, 2014

State of GA, Healthcare Facility Regulation Division

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U2100	Continued From page 1 number, as shown on the face of the permit. Authority O.C.G.A. Secs. 31-2-4 et seq. and 31-7-1 et seq. Administrative History. Original Rule entitled "Advertising" was filed on January 22, 1980; effective March 1, 1980, as specified by the Agency, This RULE is not met as evidenced by: Based on observation and staff interview it was the facility failed to include its Georgia license number as shown on the face of the permit, in it's advertising, . Findings include: Review of the facility's online website, which included information about the center and services provided, failed to reveal the center's Georgia license number. During an interview with the administrator on 6/12/2014 at 3:00 p.m., he/she confirmed that the website was the only source of advertising, and that it did not include the Georgia license number.	U2100		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U 000	Initial Comments. AMENDED 2567 A relicensure and complaint investigation (GA00136570) was conducted on 6/12/2014, Atlanta Women's Medical Center was not in compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers, the following deficiencies were cited:	U 000		
U1005 SS G	111-8-4-.10(e) Physical Plant and Operational Standards. Entrances for patients shall be connected to the public right-of-way by a hard-surfaced, unobstructed walkway in good repair. Handicapped patients confined to a wheel chair or otherwise impaired shall be able to access the center building without climbing any stairs or steps. A ramp with handrails over existing stairs or steps may be utilized in meeting this requirement. A hard-surfaced, unobstructed road or driveway for use by ambulances or other emergency fire or police vehicles shall run from at least one entrance of the building to the public right-of-way. The doorway of such entrance shall be immediately adjacent to the road or driveway. This RULE is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide handicapped patients confined to a wheelchair or otherwise impaired access to the facility without climbing any stairs. Findings include: Observation on 06/11/2014 at 9:00 a.m. revealed two (2) parking spaces labeled with the blue handicapped symbols (wheelchair) painted on the pavement. Continued observations revealed a	U1005	The cited rule requires "access to the center building without climbing any stairs or steps." AWC complies with this rule by providing access to its building via a ramp. The cited rule does not appear to address access between the floors of the building, and DCH has not previously indicated that this rule might require an elevator between the floors of AWMC's building. AWC is addressing its lack of an elevator by taking the corrective actions listed below in response to U1006.	July 18, 2014

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	C 06/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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U1005	Continued From page 1 ramp that was level with the pavement and the sidewalk located between the entrance of the facility and another office. The facility was located on the second (2nd) floor, there was a front patient and visitor entrance accessible by climbing 19 stairs. There was no elevator in the facility. Interview on 06/11/14 at 10:20 a.m., the Administrator acknowledged that the facility did not have an elevator. Interview on 06/12/14 at 10:15 a.m., the Clinical Coordinator confirmed that the patient and visitor entrance had 19 stairs and that there was no elevator in the facility. Observation on 06/12/14 at 3:00 p.m., a back staircase which the Administrator confirmed was used by staff or emergency personnel when transferring patients. This staircase also had 19 steps.	U1005		
U1006 SS G	111-8-4-.10(f) Physical Plant and Operational Standards. Ambulatory surgical services provided in multistory buildings shall be accessible by an elevator of adequate size to accommodate date a standard wheeled litter patient and two attendants. A stairway or ramp of adequate dimensions shall be available for transfer of a patient in case of power failure. This RULE is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to provide an elevator for patient transport to the second(2nd)	U1006	First Corrective Action: In order to ensure that AWMC's lack of elevator access does not adversely affect patient safety or care, AWC will comply with the following policies and procedures: • Patients who receive IV sedation will be accompanied to the center by a personal escort. • Following her procedure, a patient receiving IV sedation will be escorted down the stairs by her personal escort and a clinic staff member. • The patient's personal escort will accompany the patient to her transportation. • All staff escorts will document the escorting of patients in the Staff Escort Log. • Patients who have not received IV sedation but who have been determined to need assistance to safely navigate the stairs will also be escorted down the stairs by a clinic staff member.	Immediate (these are ongoing practices already in place prior to the inspection

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U1006	Continued From page 2 floor Ambulatory Surgery Center. Findings include: Observation on 06/11/2014 at 9:00 a.m. revealed two (2) parking spaces labeled with the blue handicapped symbols (wheelchair) painted on the pavement. Continued observations revealed a ramp that was level with the pavement and the sidewalk located between the entrance of the facility and another office. The facility was located on the second (2nd) floor, there was a front patient and visitor entrance accessible by climbing 19 stairs. There was no elevator in the facility. Interview on 06/11/14 at 10:20 a.m., the Administrator acknowledged that the facility did not have an elevator. Interview on 06/12/14 at 10:15 a.m., the Clinical Coordinator confirmed that the patient and visitor entrance had 19 stairs and that there was no elevator in the facility. Observation on 06/12/14 at 3:00 p.m., a back staircase which the Administrator confirmed was used by staff or emergency personnel when transferring patients. This staircase also had 19 steps.	U1006	• If a patient must be transferred to another facility, the clinic administrator or a designee will call the ambulance service to arrange for transfer and alert the operator that the center is on the second floor and that access to the center is via a stairway. • Prospective patients will be notified that AWMC is on the second floor and that access to AWMC is via a stairway. Such notification will be documented in patient appointment notes. • The center will maintain in its file a statement signed by its current medical director that in his/her medical judgment, walking down stairs following surgery presents minimal, if any, risk to the patient. Staff Education: Staff Meeting for review of procedures scheduled on 7/23/14. Monitoring: Administrator will perform periodic quality assurance checks to ensure policies are being followed. Responsible Party: Administrator Second Corrective Action: From the time this facility was first licensed in 1994 until 2012, the Department continuously granted AWC variances from the elevator requirement. The most recent of those variances expired in 2012. AWC made several attempts to renew those variances, but the Department denied our applications. Accordingly, we have undertaken to install an elevator in the building: We have retained an architecture firm, prepared construction drawings, sought permitting and applied for the necessary loan funds. In addition, on March 17, 2014, we applied for a temporary one-year variance to allow us to continue operations while installing the elevator. On July 7, 2014, AWC requested informal review of the Department's initial denial of the March 17th variance application. That matter is still pending. (Also pending is AWC's 3/14/14, request for informal review of the Department's initial denial of AWC's 9/12/13 (variance request to use stairlift in lieu of elevator). AWC is also in the process of seeking a settlement conference with the Department in an attempt to reach a suitable resolution agreeable to all	Unknown as to the administrative proceedings. March 16, 2015 (the date on which AWC's requested one-year variance would expire) as to installation of the elevator.
U1025 SS G	111-8-4-.10(l) Physical Plant and Operational Standards. The center shall be arranged and organized in such a manner as to ensure the comfort, safety, hygiene, privacy, and dignity of patients treated therein.	U1025		

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U1006	Continued From page 2 floor Ambulatory Surgery Center. Findings include: Observation on 06/11/2014 at 9:00 a.m. revealed two (2) parking spaces labeled with the blue handicapped symbols (wheelchair) painted on the pavement. Continued observations revealed a ramp that was level with the pavement and the sidewalk located between the entrance of the facility and another office. The facility was located on the second (2nd) floor, there was a front patient and visitor entrance accessible by climbing 19 stairs. There was no elevator in the facility. Interview on 06/11/14 at 10:20 a.m., the Administrator acknowledged that the facility did not have an elevator. Interview on 06/12/14 at 10:15 a.m., the Clinical Coordinator confirmed that the patient and visitor entrance had 19 stairs and that there was no elevator in the facility. Observation on 06/12/14 at 3:00 p.m., a back staircase which the Administrator confirmed was used by staff or emergency personnel when transferring patients. This staircase also had 19 steps.	U1006	Our plan for compliance is to pursue all of these avenues with the goal of installing an elevator in the building while continuing to provide services. Staff Education: Staff will be appropriately notified of decisions resulting from the pending administrative proceedings and any changes that may be implemented as a result of such decisions. Monitoring: Legal Counsel & Administrator will continue monitoring progress of all administrative proceedings on this matter. Responsible Persons: Legal Counsel & Clinic Administrator	
U1025 SS G	111-8-4-.10(l) Physical Plant and Operational Standards. The center shall be arranged and organized in such a manner as to ensure the comfort, safety, hygiene, privacy, and dignity of patients treated therein.	U1025	AWC responded to this deficiency in a plan of corrections submitted on July 7, 2014. A copy of that plan of correction, to which AWC has not yet received a response, is incorporated herein by reference.	July 10, 2014

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U1025	Continued From page 3 This RULE is not met as evidenced by: Based on observation and staff interview the facility failed to ensure patient safety related to glucometer use. Findings include: The facility was equipped with a glucometer (device to assess blood sugar) and the only test strips available were expired. Interview with the Director of Nursing following the observation confirmed the strips were expired and that the machine was for single patient use and not approved for multi-patient use.	U1025		
U2100 SS A	111-8-4-.21 Advertising. Any advertising of the services provided in or by ambulatory surgical treatment center shall include the full name of the center and its Georgia license number, as shown on the face of the permit. Authority O.C.G.A. Secs. 31-2-4 et seq. and 31-7-1 et seq. Administrative History. Original Rule entitled "Advertising" was filed on January 22, 1980; effective March 1, 1980, as specified by the Agency. This RULE is not met as evidenced by: Based on observation and staff interview it was the facility failed to include its Georgia license number as shown on the face of the permit, in it's advertising, . Findings include:	U2100	AWC responded to this deficiency in a plan of corrections submitted on July 7, 2014. A copy of that plan of correction, to which AWC has not yet received a response, is incorporated herein by reference.	July 11, 2014

State of GA, Healthcare Facility Regulation Division

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V 000	Opening Comments At the time of the survey, Atlanta Women's Medical Center was in compliance with Chapter 290-5-32, Rules and Regulations for Performance of Abortions After the First Trimester of Pregnancy and Reporting Requirements For All Abortions.	V 000		

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

September 29, 2014

Ms. Joline Milord, Administrator
Cliff Valley Clinic
1924 Cliff Valley Way, NE
Atlanta, GA 30329

Dear Ms. Milord:

Enclosed is a annual Report of Licensure Inspection completed at your facility on **September 24, 2014** by surveyor(s) from this office. This report contains one or more violations which must be corrected.

Your plan to correct these violations should be entered in the right hand column entitled "Providers Plan of Correction" with a projected completion date entered in the column "Completion Date". After you have completed the form, sign and date it in the space provided, return the ORIGINAL to our office no later than **October 15, 2014**.

Thank you for the courtesies extended to our representatives during this visit. If I can be of further assistance, please contact me at (404) 657-5440.

Sincerely,

Marsha Fricks

Marsha Fricks, R.N.
Program Director
Acute Care Unit
Department of Community Health
Healthcare Facility Regulation Division

MF:rf

Americans United for Life

State of GA, Healthcare Facility Regulation Division

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V 000	Opening Comments A State re-licensure survey was conducted on May 13, 2015. Atlanta Women's Medical Center was in compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers. No deficiencies were cited.	V 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025-115	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH MEDICAL CLINIC	120 East 34th Street SAVANNAH, GA 31401

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V 000	Opening Comments A re-licensure survey was conducted on 4/16/15, Savannah Medical Clinic was in compliance with Chapter 290-5-32, Rules and Regulations for Performance of Abortions After the First Trimester of Pregnancy and Reporting Requirements For All Abortions.	V 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/08/15

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025-115	A. BUILDING: _____ B. WING _____	04/16/2015

HEALTHCARE FACILITY REGULATION DIVISION
MAY 14 2015
RECEIVED

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U 000	Initial Comments. A re-licensure survey was conducted on April 15, 2015. Savannah Medical Clinic was not in compliance with Chapter 290-5-32, Rules and Regulations for Performance of Abortions After the First Trimester of Pregnancy and Reporting Requirements for All Abortions. The following deficiencies were written as the result of that survey.	U 000		
U1007 SS=D	111-8-4-.10(g) Physical Plant and Operational Standards. All procedure rooms shall be constructed, equipped, and maintained to assure the safety of patients and personnel. This RULE is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to maintain a sanitary enviornment to assure the safety of all patients. Findings include: Oservation on 4/14/2015 between 12:00 p.m. and 12:35 p.m.. revealed the operating room procedure table has stirrups (device used to position a patients legs in place during a procedure) wrapped with thick silver tape, which hinders the possibility to proper cleaning and disinfection. Review of policy entitled, " Policy for physical environment maintenance" no policy number or revision date stipulates in the statement heading, "A physical enviornment maintenace policy is sufficient to keep the center and equipment in clean and tidy condition and in a state of good repair." There is no reference, included in the policy specifically addressing cleaing of the	U1007	The policy for physical environment maintenance will reference the cleaning of the stirrup holders and revision date. Protective barrier film will be used to cover and insure proper cleaning and disinfection of stirrup holders between patients. 5/6/15	

State of GA, Healthcare Facility Regulation Division

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U1007	Continued From page 1 equipment. Interview on 4/14/2015 at 12:35 p.m.with the administrator confirmed the findings, she verbalized that "the tape is intended to hold the stirrups in place because, some patients legs are heavy."	U1007		
U1023 SS=D	111-8-4-.10(j) Physical Plant and Operational Standards. All medical gases shall be stored in accordance with Bulletin 56A of the National Fire Protection Association. This RULE is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure proper storage of four (4) of four (4) medical gas cylinders (oxygen tanks). Findings include: Observation on 4/14/2015 between 1:30 P.M. and 2:45 p.m accompanied by the Adiminstrator and employee # 1 revealed four (4) of four (4) small gas oxygen cylinders located in the administrators office behind an opened door. Review of policy entitled, "Policy for Physical Environment Maintenance" no policy number or revision date, failed to address storage of gas cylinders. Interview on 4/14/2015 at 2:45 P.M. with the Administrator comfirmed the finding.	U1023	(2) 2 cylinder D/E Oxygen Cylinder Cats have been purchased to accommodated and secure 4 gas cylinders. A policy has been written to address storage of all gas cylinders with revision date. 5/15/15	

State of GA, Healthcare Facility Regulation Division

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U1027	Continued From page 2	U1027	All medicines will be stored in a conveniently located cabinett with lock and only licensed personnel has access. All medications observed have been removed from unlocked cabinet and stored in locked cabinets.	5-6-15
U1027 SS=F	111-8-4-.10(n) Physical Plant and Operational Standards. Medicines shall be stored in a conveniently located cabinet with lock, and only licensed persons shall have access. This RULE is not met as evidenced by: Based on observation, record review and interview the facility failed to store medications in a locked cabinet where only lecensed persons can have acccess. Findings include: Observation on 4/14/2015 between 1:30 P.M. and 2:45 P.M. revealed the following medications stored in an unlocled cabinet in the administrators office, where unlicensed personnel had access to. 19 vials - Lidocaine 50 ml, Expiration date 12/1/15, Lot #45-183 EV 20 vials - NS 0.9%, Expiration date 3/1/16, Lot 39-565-DK 10 vials - Midazolam IM injection 50mg/10ml, Expiration 10/1/16, Lot 46-388-DK 1 - 500 tablet bottle of Ibuprofen 800mg, Expiration 06/16, Lot#AF 27414 2 - Bottles Equate Acetaminophen 500 mg 250 tabs, Expiration 1/2017 20 - Medroxyprogesterone 150mg/ml, Expiration 11/15 20 - Misoprostol 200 mcg (8 tabs each bottle), Expiration 6/16 10 - Fentanyl citrate 250mg/5 ml ampules	U1027		

State of GA, Healthcare Facility Regulation Division

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U1236	Continued From page 3	U1236		
U1236 SS=D	111-8-4-.12(6) Records. Patient records shall be current and shall be entitled to the same protection as provided for any medical records under Georgia law. Authority O.C.G.A. Secs. 31-2-4 et seq. and 31-7-1 et seq. Administrative History. Original Rule entitled "Records" was filed on January 22, 1980; effective March 1, 1980, as specified by the Agency. This RULE is not met as evidenced by: Based on observation review of facility policies and procedures and staff interview the facility failed to ensure the privacy and security of patient protected health information. Findings include: Observation on 4/14/2015 at 2:45 P.M. in the administrtors office reveals approximately 75 patient medical records lying on top of a cabinet. Review of policy entilted,"Policy for Medical Records, no policy number, no revision date stipulates,"Medical records are required to be kept by the rules and regulations of the Georgia Department of Human Resources, using HIPPA guidelines." Interview on 4/14/2014 at 2:45 P.M. the Administrator confirmed the records are placed there for next day procedures and confirmed that all staff, including the facility's after hours cleaning crew, had access to these health records.	U1236	There is no after hours cleaning or any other service at the facility. One cleaning woman comes during specific morning hours on days when clients are not present and an office staff member is present. She has no access to any patient records nor does any staff member not immediately working on a particular patient record. 5/6/15	

State of GA, Healthcare Facility Regulation Division

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V 000	Opening Comments A re-licensure survey was conducted on 4/16/15, Savannah Medical Clinic was in compliance with Chapter 290-5-32, Rules and Regulations for Performance of Abortions After the First Trimester of Pregnancy and Reporting Requirements For All Abortions.	V 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Admin/Rep — 5/8/15

State of GA, Healthcare Facility Regulation Division

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U 000	Initial Comments. At the time of the survey, Savannah Medical Clinic was in compliance with Chapter 290-5-32, Rules and Regulations for Performance of Abortions and Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of complaint investigation number GA00153118. No deficiencies were cited.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-287	A. BUILDING: _____ B. WING _____	C 07/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIFF VALLEY CLINIC	1924 CLIFF VALLEY WAY, NE ATLANTA, GA 30329

(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
U 000	Initial Comments. At the time of the survey, Cliff Valley Clinic was in compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of complaint investigation #GA00153117. No deficiencies were cited.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	C 07/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U 000	Initial Comments. At the time of survey, Atlanta Women's Medical Center was in compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers as the result of complaint investigation number GA00153112. No deficiencies were cited.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING: _____ B. WING _____	C 07/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	**1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324**

(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
U 000	Initial Comments. At the time of the survey, Summit Medical Associates was in substantial compliance with Chapter 111-8-4, Rules and Regulations for Ambutory Surgical Treatment Centers, as the result of complaint investigation #GA153119. No deficiencies were cited.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING: _____ B. WING _____	04/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
U 000	Initial Comments. A State licensure survey was conducted on April 14, 2015. Summit Medical Associates is in compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers. No deficiencies were cited.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING: _____ B. WING _____	04/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
V 000	Opening Comments At the time of the survey on 4/14/2015, Summit Medical Associates was in compliance with Chapter 290-5-32, Rules and Regulations for Performance of Abortions as the result of a State licensure survey.	V 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	C 02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U 000	Initial Comments. At the time of survey, Atlanta Women's Medical Center was in compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers as the result of complaint investigation number GA00158266. No deficiencies were cited.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

April 11, 2016

Ms. Stacey Linn, Administrator
Atlanta Women's Medical Center
235 West Wieuca Road
Atlanta, GA 30342-3321

Re: Complaint #GA00158266

Dear Ms. Linn:

Enclosed is a copy of the results of the complaint investigation completed at your facility on **February 11, 2016** by a surveyor(s) from this office. The report indicated that no violations of state regulations that are enforced by this office were noted in the services provided at your facility.

We appreciate the courtesies extended to our representative(s) during the visit. If we may be of assistance at any time, please call me at (404) 657-5440.

Sincerely,

Margaret Kersey, R.N., Program Director
Acute Care Unit
Department of Community Health
Healthcare Facility Regulation Division

MK:rf

Americans United for Life

Accepted
1/9/17 AA

PRINTED: 11/17/2016
FORM APPROVED

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A BUILDING _____ B WING _____	11/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U 000	Initial Comments. At the time of the survey, Atlanta Women's Medical Center was in substantial compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a relicensure survey. The following deficiencies were cited as a result of that survey.	U 000	HEALTHCARE FACILITY REGULATION DIVISION JAN 09 2017 RECEIVED	
U 302 SS=D	111-8-4-.03(3) Organization and Administration. The governing body of the center shall be responsible for appointing the professional staff and shall establish effective mechanisms for quality assurance and to ensure the accountability of the center's medical and/or dental staff and other professional personnel This RULE is not met as evidenced by: Based on credential file review, review of facility's Medical Staff By-Laws and 2015-2016 Quality Improvement Plan, and staff interview, the governing body failed to establish effective mechanisms for quality assurance and to ensure the accountability of the center's medical staff. Findings include: Review of four (4) credential files (#s 1-3 and 10) revealed that three (3- #s 1-3) did not contain evidence that quality reviews had been performed by a peer. Review of the facility's Medical Staff By-Laws, undated, revealed that General Medical Staff Responsibilities included: 3. Each member would cooperate with and participate in the Medical Staff Peer Review and Quality Assurance Program. The Reappointment Process	U 302	CORRECTIVE ACTION: The Administrator has reassigned the chart review process to the Medical Director for at least Quarterly. The Medical Director was notified of change on 11/29/16; therefore, ensuring adherence to established Peer Review & Quality Plan as outlined by the Quality Improvement Plan. The Medical Director will review at least 30 randomly selected physician's charts for appropriate signatures, dates, treatment information, appropriate follow-up, standard-of-care, and complications. EDUCATION: The revision of duties were discussed with the Medical Director and Governing Body on 11/29/16 by the Administrator. MONITORING:Tracking of completion of peer reviewed charts by the Medical Director will be monitored by the Administrator. The results of the reviews will be communicated to the Governing Body at each Quarterly meeting by the Administrator. RESPONSIBLE PERSON(S): Administrator, Medical Director, Governing Body	12/01/16

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A BUILDING _____ B WING _____	11/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U 302	Continued From page 1	U 302		

3. In addition to the information provided by the applicant as previously prescribed, consideration would be given to the following and to other valuable reasonable indicators of the applicant's qualifications for reappointment:
a. Peer recommendation regarding the applicants professional performance, individual judgement, clinical or technical skills, ethics, conduct and ability to communicate.
b. The results of Quality Assurance monitoring and evaluation.

Review of the facility's 2015-2016 Quality Improvement Plan revealed:
3. Physician Performance
Routine performance assessments would be made for each physician regularly contracted. Medical record evaluations would be conducted by the Medical Director to ensure all contracted physicians provide services and documentation consistent with the facility's protocols, procedures, and mission. Records for review would be chosen randomly.
a. Threshold- Compliance/Corrective
b. Monitoring Frequency-Quarterly
c. Reporting Frequency-Quarterly
d. Person Responsible- Medical Director

Interview with the administrator on 11/2/2016 in the break room at 9:45 AM revealed that physician peer reviews were conducted on cases which had complications only, and were not done routinely. The administrator produced evidence that random medical record reviews had been conducted on physicians, stating that they has been completed by him/herself or his/her assistant.

State of GA, Healthcare Facility Regulation Division

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	060-011	A. BUILDING _____ B. WING _____	11/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U1210	Continued From page 2	U1210		
U1210 SS=D	111-8-4-.12(2)(b) Records. Contents of individual medical records shall normally contain the following at least: (b) History and physical examination data: 1. Personal medical history (including all current medication that the patient is taking). 2. Family medical history. 3. Physical examination 4. Psychiatric examination (if applicable). ... This RULE is not met as evidenced by: Based on medical record review, review of facility policies, and staff interview, the facility failed ensure that all patients received a history and physical examination by a physician prior to their procedure, and that it included family histories. Findings include: Review of twenty (20) medical records revealed: A. Two (2-#s 1 and 20) did not contain a history and physical examination by a physician B. Eighteen (#s 2-19) which did contain a history and physical examination, did not include family histories. Review of facility policy, Medical History & Physical, last rev. 06/14, revealed the RN/NP would perform a pre-anesthesia evaluation and physical prior to screening by the MD or CRNA. Any patient with active diagnosis would be reviewed on a case-by-case basis. The RN/NP would review with the patient current medical status, as well as medical history. Any contraindication to an outpatient abortion procedure would be consulted with the physician	U1210	CORRECTIVE ACTION: The Administrator updated the Patient's History form on 11/ 30/16 to incorporate the patient's family history: (1) Cancer, (2) Diabetes, (3) TB, (4) Heart Disease, (5) History of Twins, (6) Kidney Disease, and (7) Malignant Hyperthermia. Also, the Administrator provided a memo on 11/16/17 to all licensed clinical staff (e.g., RN's, MD's and CRNA's) reminding them to ensure completion of the the initial H&P per patient and that the MD must validate the H&P prior to any procedure. This is Atlanta Women's Center's current practice. EDUCATION: The Administrator reviewed the changes on 11/30/16 with all staff during an inservice related to the addition of family history on the Patient's History Form and the memo was given to the licensed clinical staff on 11/16/17 related to the H&P process. MONITORING: Compliance will be monitored by the Administrator or designee as part of the Quarterly chart review process in the Quality Improvement Plan. RESPONSIBLE PERSON(S): Administrator	12/01/16

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING _____ B. WING _____	11/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

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U1210	Continued From page 3 and/or CRNA as appropriate. All findings are documented in the patient's medical record. Review of facility policy, Medical Screening For Patients Receiving Local Anesthesia, rev. 08/14, revealed that through pre-operative medical screening and physical examination, the physician, NP, CRNA, or RN would evaluate the patient's health status and determine [redacted] eligibility for the suction curettage abortion in the outpatient facility. The physician reviews the patient's medical history and performs a physical examination, which includes a pelvic examination. The administrator acknowledged the absence of the physical examinations and documentation of family histories in the medical records on 11/2/2016 during the closing conference.	U1210		
U1214 SS=D	111-8-4-.12(2)(c) Records. Contents of individual medical records shall normally contain the following at least: (c) Treatment data: 1. Practitioner's orders. 2. Progress notes. 3 Nurse notes. 4. Medication. 5. Temperature-Pulse-Respiration (Graphic Chart; surgical purposes only). 6. Special examination(s) and reports (include x-ray and lab reports). 7. Signed informed consent form. 8. Operation record. 9. Anesthesia record (if applicable). 10. Consultation record (if applicable). 11. Tissue findings when performed.	U1214	CORRECTIVE ACTION: The Administrator created a specific Physician Orders Sheet (APPENDIX A) to reflect treatment orders for Pre-Op and General Patient Care on 11/29/16. The current practice and policy is that the Post-Procedure Record (APPENDIX B) reflects the post-operative orders and discharge with the signature of the physician providing care. We will continue to adhere to this practice, which is consistent with the GA Regulations and Atlanta Women's Center's policy.	12/01/16

State of GA, Healthcare Facility Regulation Division

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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U1214	Continued From page 4 12. Where dental services are rendered, a complete dental chart with dental diagnosis, treatment, prescription and progress notes shall be part of the clinical record. ... This RULE is not met as evidenced by: Based on medical record review, staff interview, review of facility's Patient Treatment Guidelines and Doctors' Guidelines, review of facility policies, and review of employee files, the facility failed ensure that medical records contained physician orders for treatment rendered therin. Findings include: Review of twenty (20) medical records revealed: A. None contained pre-operative orders B. Ten (#s 5-8, 10, 12, 15, 16, 18, and 20) did not contain post-operative orders or discharge orders C. All medical records contained a form titled Pre-Procedure Nursing Record, which included areas for documentation of the patient's name, date of birth, surgery date, gestational age, and 1-day or 2nd Day of 2 day in the first section. The second section titled 2nd Day of 2-Day include areas to document: 1. Vital signs, height/weight, BMI (body mass index), time and name of person completing 2. Admission assessment which included pain scale, nausea yes/no, rupture of membranes (ROM) yes/no, and time and name of person completing. The third section titled IV Assessment included areas to document gauge size (24, 22, 20, 18), location, inserted by, number of attempts, date and time, and check boxes for patient tolerated well and IV patent, good blood return, flushes	U1214	STAFF EDUCATION: A new Physician's Order Sheet was created by the Administrator on 11/15/16. The Staff was educated about the new Physician's Order Sheet during an inservice and via memo to the MD's on 11/16/16, by the Administrator. Additionally, the Administrator reinforced the importance of physician orders for both Pre-op and Post-Op phases. MONITORING: The Administrator or Designee will monitor compliance at least weekly. RESPONSIBLE PERSON(S): Administrator	

State of GA, Healthcare Facility Regulation Division

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

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U1214	Continued From page 5	U1214		

well.
The fourth section included a table which contained a column for times, medications, doses, route, and initials. Multiple doses for medications Norco 5/325 mg (hydrocodone-a synthetic opiate made from codeine and Tylenol, Tylenol #3 (with Codeine- a narcotic pain reliever), Tylenol, Misoprostol, and Azithromycin (antibiotic) were listed to choose from. The right side of the fourth section contained an area titled Pre-Operative Notes which was lined for free hand written notes. The bottom of the form contained four (4) lines for RN signatures, one (1) line for MD signature, one (1) line for date, and one (1) line for time.
The forms had been signed by the physician at various times ranging from the time of medication administration to hours later.

Interview with the administrator on 11/1/2016 at 2:00 PM in the breakroom revealed that nurses utilized facility protocols for pre-operative medication administration, and that the physician's signature on the Pre-Procedure Nursing Record served as an order.

Upon surveyor request for facility pre-operative protocols, the administrator provided:

1. Patient Treatment Guidelines
2. Doctors' Guidelines
3. Standing Orders for Post-Operative Medications

Review of facility's Patient Treatment Guidelines, last rev. 03/16, revealed directives for Laminaria and/or Dilapan-S insertion (used to dilate the cervix for abortion)-1 and 2 day procedures, Misoprostol (Cytotec-medical abortion pill), Hemoglobin (protein in red blood cells that carry

State of GA, Healthcare Facility Regulation Division

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	060-011	A BUILDING _____ B WING _____	11/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U1214	Continued From page 6	U1214		

oxygen/Hematocrit (ratio of the volume of red blood cells to the total volume of blood), Medical Conditions, Fasting/NPO (nothing by mouth), and Obesity (over weight).

Review of the facility's Doctors' Guidelines, last rv 05/16, revealed columns for physician first and last names, number of weeks, 1 day with number of week ranges, 2 day with number of week ranges, Cytotec with number of week ranges, Laminaria, Dilapan, and Digoxin with number of week ranges, RN directives, and notes.

Review of facility policies failed to reveal a policy which addressed physician orders.

Review of six (6) employee files revealed that all contained initial applications with references, job discriptions, had received annual trainings which included infection control; had underwent competency testing and evaluations; and, had current BLS and ACLS certification, as appropriate.

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	060-141	A. BUILDING: _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
U 000	Initial Comments. At the time of the survey, Summit Medical Associates was in compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a State relicensure survey. No deficiencies were cited.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

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	060-141	A. BUILDING: _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
V 000	Opening Comments At the time of the survey, Summit Medical Associates was in compliance with Chapter 290-5-31-.01, Rules and Regulations for Abortion Centers, as the result of a relicensure survey. No deficiencies were cited.	V 000		

State of GA Inspection Report

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State of GA, Healthcare Facility Regulation Division

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	025-115	A. BUILDING: _____ B. WING _____	03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH MEDICAL CLINIC	120 East 34th Street SAVANNAH, GA 31401

(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
U 000	Initial Comments. A State Re-licensure survey was conducted on 2/28/2017 through 3/2/2017. Savannah Medical Clinic was in compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers. No deficiencies were cited.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025-115	A. BUILDING: _____ B. WING _____	03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH MEDICAL CLINIC	**120 East 34th Street SAVANNAH, GA 31401**

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V 000	Opening Comments At the time of the survey, Savannah Medical Clinic was in compliance with Chapter 290-5-32, Rules and Regulations for Performance of Abortions After the First Trimester of Pregnancy and Reporting Requirements For All Abortions, as the result of a State licensure survey.	V 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Accepted 5/4/17 aa

PRINTED: 03/30/2017
FORM APPROVED

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-287	A. BUILDING: _____ B. WING _____	03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIFF VALLEY CLINIC	1924 CLIFF VALLEY WAY, NE ATLANTA, GA 30329

(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
U 000	Initial Comments. At the time of the survey, Cliff Valley Clinic was in substantial compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a State re-licensure survey. The following deficiencies were written as the result of that survey.	U 000	HEALTHCARE FACILITY REGULATION DIVISION DEPARTMENT OF COMMUNITY HEALTH MAY 04 2017 RECEIVED	
U 300 SS=D	111-8-4-.03(1) Organization and Administration. Each ambulatory surgical treatment center shall be organized with an identifiable governing body that establishes the objectives, sets the policies and assumes full legal responsibilities for the overall conduct of the center and for compliance with all applicable laws and regulations pertaining to the center. The membership of the governing body shall be identified in the application to the Department for licensure. This RULE is not met as evidenced by: Based on medical record review, review of employee and credential files, review of facility policies, and staff interview, the Governing Body failed to be responsible for the overall conduct of the center. Findings include: Cross reference U tags: 0302 - Organization and Administration 0903- Professional Services 0907 - Professional Services 1027 - Physical Plant and Operational Standards 1103 - Personnel 1104 - Personnel 1105 - Personnel 1210 - Records 1214 - Records	U 300	See next page for plan of correction	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Clinic Administrator 5/3/2017

State of GA, Healthcare Facility Regulation Division

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U 300	Continued From page 1 2001 - Sanitation and Waste Disposal V tags 0030 - Procedure for Filing Certificate of Abortion	U 300	U302 Corrective Action: All records for professional staff were reviewed for completeness. Request was made to professional staff to submit any missing documents. Practitioners were given a time frame to supply missing documentation or have privileges temporarily suspended. All completed charts that are due for reappointment will be forwarded to medical director and then back to medical staff administration at least 30 days prior to reappointment being due. Peer reviews will be conducted and documented quarterly.	5/15/2017
U 302 SS=D	111-8-4-.03(3) Organization and Administration. The governing body of the center shall be responsible for appointing the professional staff and shall establish effective mechanisms for quality assurance and to ensure the accountability of the center's medical and/or dental staff and other professional personnel. This RULE is not met as evidenced by: Based on credential file review, review of facility's Medical Bylaws, and staff interview, the facility failed to ensure that professional staff were appointed, and that quality reviews were conducted. Findings include: Review of four (4) credential files (#s 1-4) revealed: File #3 did not contain requested privileges. Files #3 and 4 did not contain evidence that privileges had been approved. Files #2, 3, and 4 did not contain Medical Staff or Governing Body approval. Files #3 and 4 did not contain re-appointment dates. None of the files contained evidence that peer review had been conducted. File #3 did not contain an agreement to abide by the Governing Body Bylaws. Review of facility's Medical Bylaws, undated,	U 302	Staff Education: In-service has been scheduled for Professional staff as well as clinic administration to review Medical bylaw requirements for appointment. Monitoring: Summary of Medical Bylaws has been created to be distributed to professional staff annually about necessary documentation which is necessary for credentialing at the clinic. A separate document will be forwarded quarterly to professional staff with the status of items that is required for re-appointment. It will also include the status of quarterly peer review. Responsible Persons: Clinic Administrator, Medical director	5/15/2017

State of GA, Healthcare Facility Regulation Division

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U 302	Continued From page 2 revealed that the Medical Director is accountable for the oversight of clinical services provided by the professional staff, clinical policies & procedures and medical quality assurance activities. Duties and Responsibilities include: Assures medical staff are appropriately trained and credentialed. Monitors Physicians, CRNAs, RN cod services and Advanced Practitioners for performance and privileges as required by the medical staff bylaws. Participates actively in peer review and the quality management process. Section 3: Reappointment Process B. All applicants for reappointment would be required to provide the following information: 1. Conformation of admitting privileges. D. Recommendations for the reappointment of Medical Staff member and clinical privileges to be granted upon reappointment will be based upon, but not limited to, the member's: 4. Quarterly medical peer review. Section 1: Peer Review Medical peer review would be conducted on a quarterly basis. The Q-Care Patient Outcome review would be performed on any chart that is entered as a statistic. Additionally, 5 random charts would be evaluated for appropriateness of diagnosis and treatment. The peer review would be conducted either by the Medical Director or by another active physician with comparable skill. Interview on 3/14/17 at 1:00 PM with the Director of Clinical Administration revealed that MD #2	U 302	U302 See previous page for plan of correction	

State of GA, Healthcare Facility Regulation Division

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U 302	Continued From page 3 had been suspended effective January 1, 2017 due to not providing current documentation; and he/she acknowledged the above findings.	U 302		
U 903 SS=D	111-8-4-.09(4) Professional Services. All nursing services shall be under the supervision of a registered nurse (R.N.). Each center shall have a sufficient number of currently licensed nurses present and on duty to attend to patients at all times patients are receiving treatment or recovering from treatment up to and including the time of discharge. Additional staff shall be on duty and available to assist the professional staff to adequately handle routine and emergency patient needs. This RULE is not met as evidenced by: Based on staff interview, employee file review and review of facility policies, the facility failed to have an appointed Director of Nursing (DON) / Nursing supervisor. Findings include: During the entrance interview with Director of Clinical Administration on 3/13/2017, he/she stated that the facility has not had a DON since [redacted] Review of employee files failed to reveal a DON file. Review of facility policies failed to reveal a policy which addressed requirement for a DON / Nursing Supervisor.	U 903	U903 Corrective Action: Nursing Supervisor was hired on [redacted] Staff Education: As part of the on-boarding process, Nurse Supervisor has been educated about the nursing roles and responsibilities of the clinic. Monitoring: Nursing Supervisor will be appointed by Medical director for a renewable two year term. Responsible Persons: Clinic Administrator, Medical Director	3/23/2017 3/23/2017

State of GA, Healthcare Facility Regulation Division

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U 907	Continued From page 4	U 907	U907	
U 907	111-8-4-.09(8) Professional Services. Each center will have effective policies and procedures for handling infection control and for recording complications which occur during or after surgery, which includes a reporting mechanism for patients who develop infections or postoperative complications after discharge. This RULE is not met as evidenced by: Based on review of the Operating Room (OR) Temperature and Humidity (T&H) Logs, Air Exchange and Balance report, observation, and staff interview, it was determined that the facility failed to have effective policies and procedures to ensure that patients remained free from complications of infections. Findings: OR #1's T&H Log was reviewed from 01/15/16 through 3/11/17 and OR #2's T&H Log was reviewed from 03/11/16 through 03/11/17. Both logs revealed that the acceptable humidity range was 30% to 60%. Documentation revealed that the T&H for both ORs was documented as "EE" for the above time frames. Further review of the logs revealed that OR #1 on 11/14/14 "EE" was noted as equipment error and OR #2 on 01/09/15 noted that the monitor was not working. Review of the Air Exchange and Balance report from Medical Equipment Technology, Inc. dated 06/16/14 revealed that the Pathology Room (dirty instruments room) had a positive pressure and 9.53 air exchanges per hour. Observation on 03/14/16 at 9:30 a.m. revealed that the Pathology Room failed the tissue test	U 907	Corrective Action: The OR logs have been updated to have a monthly signature from lead Health Advocate, Nursing Supervisor, or Clinic Administrator. Any abnormalities are to be immediately reported. The Operations manager has been accepting bids from HVAC companies to convert the pathology room to a negative pressure room. Staff Education: In-service was held for the staff reviewing the temperature and humidity logs were to be performed every day the OR was used. Also during the in-service, it was reviewed with staff that abbreviations are not permissible in the logs. Should the equipment not function properly, it is to be immediately reported. Staff will also be trained how to perform the tissue test for the pathology room to ensure that it stays a negative pressure room once converted. Monitoring: O.R. Logs will be reviewed monthly. Should there be any abnormalities on the daily record, they are to be immediately reported by the OR staff. The tissue test will be performed and documented monthly for the pathology room. Responsible Persons: Lead Health Advocate, Clinic Administrator, Nursing Supervisor, Operations Manager	4/14/2017 4/14/2017

State of GA, Healthcare Facility Regulation Division

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U 907	Continued From page 5 (tissue held at bottom of door and if it blows under the closed door the room is negative pressure). During an interview on 03/14/16 at 2:00 p.m. in the Conference Room, the Director of Clinic Administrator confirmed that staff had been documenting the ORs' humidity levels "wrong" for the above timeframe and that the Pathology room was not a negative pressure room.	U 907	U907 See previous page for plan of correction	
U1027	111-8-4-.10(n) Physical Plant and Operational Standards. Medicines shall be stored in a conveniently located cabinet with lock, and only licensed persons shall have access. This RULE is not met as evidenced by: Based on review of facility's policy, observation, and staff interview, the facility failed to ensure that medications were secured with only licensed persons having access. Findings: Review of facility policy entitled Medication Policies and Procedures, last reviewed 11/2013, revealed that upon receipt, all medications must be immediately stored in locked medication cabinets, the narcotics cabinet (if they are a controlled substance), or in the refrigerator (if they are a medication which requires refrigeration). Observation on 03/13/17 at 3:30 p.m., accompanied by the facility's Director of Clinic Administration revealed the following unsecured	U1027	U1027 Corrective Action: A lock was purchased and placed on medication refrigerator with broken lock. Staff Education: In-service was held for nursing staff about which medications need to be stored in a locked unit. Monitoring: All locked units will be checked and documented that they are functioning properly weekly. Any malfunctions must be reported immediately to Nursing Supervisor. Responsible Persons: Nurses, Nursing Supervisor, Clinic Administrator, and Operations Manager	3/14/2017 4/21/2017

State of GA, Healthcare Facility Regulation Division

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U1027	Continued From page 6 medications in an unlocked refrigerator in the Post Anesthesia Care Unit (PACU): a. Five (4) Rhogam (a sterile solution made from human blood plasma that is given to Rh-negative [redacted] in the form of an injection) 300 micrograms (mcg) syringes expiration date 08/20/17; b. One (1) Rhogam 300 mcg syringe expiration date 10/27/17; c. Eight (8) Rhogam 300 mcg syringes expiration date 06/23/17; d. Ten (10) Rhogam 300 mcg syringes expiration date 10/20/18; e. Seven (7) Rhogam 50 mcg syringes expiration date 12/20/17; f. Four (4) Rhogam 50 mcg syringes expiration date 02/20/18; g. A bottle of liquid Trichloroacetic Acid (used to treat genital warts) 80% solution expiration date 12/31/2017. h. Twelve (12) one (1) milliliter vials of Methergan (used to help stop bleeding after childbirth or an abortion) 0.2 milligrams (mg) per ml expiration date 05/20/18; i. One (1) one (1) ml vial of Purified Protein Derivative (PPD used to test for tuberculosis) 5TU/0.1 ml or 50 tests; and j. Five (5) Hepatitis B vaccines 10 mg per one (1) ml vial expiration date 11/20/18. At the time of the discovery the Director of Clinic Administration confirmed that the refrigerator lock had been broken for a "little over a month" and that the PACU door did not lock. In addition, the Director confirmed that unlicensed staff and contracted housekeepers had access to the medications.	U1027	U1027 See previous page for plan of correction	

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U1103	Continued From page 7	U1103	U1103	
U1103 SS=D	111-8-4-.11(4) Personnel. Each center shall require that each employee receives a health examination upon employment and a policy shall provide for follow-up examinations. The examination shall be in sufficient detail, including pertinent laboratory and x-ray data, to assure that the employee is physically and mentally qualified to perform the job to which [redacted] is assigned. This RULE is not met as evidenced by: Based on review of employee files, facility policies, and staff interview, the facility failed to assure that employees received a health examination upon hire, and to have a policy which addressed follow up examinations. Findings include: Review of five (5) employee files (#s 6-10) revealed: None contained an examination by a physician or mid-level provider on hire. Four (4- #s 6, 7, 8, and 9) contained a health questionnaire completed by the employee post hire. Two (2- #s 6 and 8) did not contain evidence of TB testing. Review of four (4) credential files (#s 1-4) revealed: Files #2, 3, and 4 did not contain evidence of current TB testing. Review of facility policy #HR 180, Employment Physical Assessment, effective 01-01-07, revised 10-19-06, revealed that each employee must undergo an employment physical assessment by	U1103	Corrective Action: All employee staff records were reviewed. Request for missing documentation was made to staff. Staff will be given a time frame to supply missing documentation, which may include physical exams. Failure to provide missing documents will result in the staff member not being allowed to work. Request has been submitted to the Directors to have the Human Resources Policy to reflect this change in policy. Staff Education: In-service has been scheduled for staff to review requirements to work in the clinic and the frequency these documents are to be maintained. Monitoring: Summary of requirements to work in the clinic has been created to be distributed to staff annually about necessary documentation which is needed. A separate document will be forwarded to them with status of items that are required for employment. The orientation/ annual check list will be updated and documented at least annually. Once updated, it will be signed by the supervising manager then submitted to the Clinic Administrator to be included in the personnel file. Responsible Persons: Clinic Administrator, Front Office Supervisor, Nursing Supervisor	5/15/2017 5/15/2017

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U1103	Continued From page 8 the end of the first month of employment. The employee must schedule an appointment with the Clinical Director for the employment physical assessment. At the time of the appointment, the employee would be given a FWHC employee health form for completion and then seen by a physician or nurse (NP or RN) for assessment. The employee health form/physical assessment would be kept with the employee's personnel/ medical file. The policy did not address follow up examinations. The Director of Clinical Administration acknowledged the above findings on 3/13/2017.	U1103	U1103 See previous page for plan of correction	
U1104 SS=D	111-8-4-.11(5) Personnel. There shall be a separate personnel folder maintained for each employee. This file shall contain all personnel information concerning the employee, including the application and qualifications for employment, physical examination (including laboratory and x-ray reports, if applicable), job description and attendance record. This RULE is not met as evidenced by: Based on employee file review, review of facility policies, and staff interview, the facility failed to assure that files included evidence of orientation and job descriptions. Findings include: Review of five (5) employee files (#s 6-10) revealed: Four files (4- #s 6, 7, 8, and 9) did not contain	U1104	U1104 Corrective Action: All employee staff records were reviewed. Request for missing documentation was made. Staff will be given a time frame to supply missing documentation, which may include TB test, CPR, physical exams, etc. Failure to have an updated employee file will result in the employee not being allowed to work. Staff Education: In-service has been scheduled for staff to review requirements to work in the clinic and the frequency these documents are to be maintained. Monitoring: Summary of requirements to work in the clinic has been created to be distributed to staff annually about necessary documentation which is needed. A separate document will be forwarded to them with status of items that are required for employment. The orientation/ annual check list will be updated and documented at least annually. Once updated, it will be signed by the supervising manager then submitted to the Clinic Administrator to be included in the personnel file. Responsible Persons: Clinic Administrator, Front Office Supervisor, Nursing Supervisor	5/15/2017 5/15/2017

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U1104	Continued From page 9 orientation check lists signed by the supervisor. Two (2- #s 6 and 8) did not contain a job description. One (1- #9) did not contain current CPR certification as required by job description. Review of facility policy #A01, Orientation policy, effective, revised and approved 10/21/09, revealed: Hiring procedure: All new hires and re-hires must attend an orientation with the HR and Office Manager prior to their start date. The completed portions of the personnel file and the orientation checklist to the employee's supervisor. The supervisor completes tasks on Orientation Checklist under "Job Specific Orientation". The supervisor signs and obtains employee's signature for the Orientation Checklist, and places it in the employee's personnel file. The Director of Clinical Administration acknowledged the above findings on 3/13/2017.	U1104	U1104 See previous page for plan of correction	
U1105	111-8-4-.11(6) Personnel. Fire and internal disaster drills shall be conducted at least quarterly and the results documented. There shall be an ongoing program of continuing education for all personnel concerning aspects of fire safety and the disaster plan for moving personnel and patients to safety, and for handling patient emergencies. Authority O.C.G.A. Secs. 31-2-4 et seq. and 31-7-1 et seq. Administrative History. Original Rule entitled "Personnel" was filed on January 22, 1980; effective March 1, 1980, as specified by the Agency.	U1105	U1105 See next page for plan of correction	

State of GA, Healthcare Facility Regulation Division

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U1105	Continued From page 10 This RULE is not met as evidenced by: Based on review of the facility's Disaster Preparedness Plan, fire and disaster drills, and staff interview, it was determined that the facility failed to conduct quarterly fire and disaster drills and disaster drills. Findings: Review of the facility's Disaster Preparedness Plan, no policy number or date, revealed that fire drills and disaster drills were to be conducted quarterly. Review of the facility's Fire and Disaster Drill manual revealed the facility failed to conducted the following drills: a. Forth (4th) quarter fire drill; b. Third (3rd) quarter disaster drill; and c. Forth (4th) quarter disaster drill. During an interview on 03/14/17 at 2:00 p.m. in the Conference Room, the Director of Clinic Administration confirmed that fire drills and disaster drills had not been conducted quarterly.	U1105	U1105 Corrective Action: Fire and internal disaster drills will be pre-scheduled at the beginning of the calendar year. The first quarter drills was conducted on 3/20/2017. Future drills have been scheduled for June 20, September 26, and December 5, of 2017. Staff Education: In-service has been scheduled for staff to review fire and disaster plans for the clinic. The in-services will be included as part of staff meetings throughout the year. Monitoring: Dates of the last performed drill and upcoming scheduled drills will be documented on the monthly signed, OR log. The dates of the conducted drills will also be documented by the Operations Manager quarterly. Responsible Persons: Clinic Administrator, Health Advocate, Nursing Supervisor, Operations Manager	3/20/2017 5/22/2017
U1210	111-8-4-.12(2)(b) Records. Contents of individual medical records shall normally contain the following at least: (b) History and physical examination data: 1. Personal medical history (including all current medication that the patient is taking). 2. Family medical history. 3. Physical examination 4. Psychiatric examination (if applicable). ...	U1210	U1210 See next page for plan of correction	

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-287	A. BUILDING: _____ B. WING _____	03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIFF VALLEY CLINIC	1924 CLIFF VALLEY WAY, NE ATLANTA, GA 30329

(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
U1210	Continued From page 11 This RULE is not met as evidenced by: Based on review of facility policy, Medical Bylaws, medical records, and staff interview, it was determined that the facility failed to ensure that physical examinations were performed prior to procedures and that discharge orders were written, for three (3) of ten (10) sampled patient records (#6, 7, and 10). Findings: Review of facility policy entitled Medication Abortion Policies and Procedures, no policy number, last updated 05/2014, revealed patients having a medical abortions with Mifepristone and Misoprostol (medications administered to bring about an abortion) were to have a medical history and physical examination. The physical examination was to include the following: a. Pertinent physical examination, including vital signs; b. Determination of gestational age (age of fetus) by clinical assessment; and c. Ultrasonographic (specialized x-ray that determines age of fetus) examination when indicated. Review of Medical Bylaws, no date, revealed in Article VIII: Rules and Regulations, Section 3: Medical Records, B. History and Physical, 1. A complete gynecologic (female reproductive system) history and physical exam shall in all cases be performed and written by a physician, advanced practice nurse, or a Registered Nurse, and be a part of each patient's chart. C. Written, Verbal, and Standing Orders, 1. All orders for treatment shall be in writing.	U1210	U1210 Corrective Action: All professional staff have been instructed that a history and physical, as well as a discharge summary is needed on all patients being seen in the ambulatory surgical center, regardless of the procedure performed. Electronic medical records will be implemented by June 2017 to assist with compliance. History and Physicals are to be performed by the practitioner only. Staff Education: In-service has been scheduled for Professional staff and clinic staff to review Medical bylaws, as well as policies and procedures to determine the components of a complete chart for all patients treated in the ambulatory surgical center. In-service has also been scheduled in May 2017 to train professional staff on using the Electronic Medical Record, Nextgen, to record a complete history, physical and discharge summary. Monitoring: Completion of charts, including the physical exam, will be reviewed as part of the front staff chart audit, as well as by random chart audits by the Clinic Administrator, Nurse Supervisor, or Medical Director. Chart will also be reviewed as part of the quarterly peer review. Responsible Persons: Clinic Administrator, Medical Director, Nurse Supervisor, Front Office Supervisor, Professional Staff	

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-287	A. BUILDING: _____ B. WING _____	03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIFF VALLEY CLINIC	1924 CLIFF VALLEY WAY, NE ATLANTA, GA 30329

(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
U1210	Continued From page 12 Three (3) of ten (10) medical records reviewed (#6, 7, and 10) revealed a physical examination was not completed prior to administering the Mifepristone and/or Misoprostol for medical abortion procedures and that no discharge orders were written. During an interview on 03/14/16 at 2:00 p.m. in the Conference Room, the Director of Clinic Administrator confirmed that the above medical records contained neither discharge orders nor documented evidence of a physical examination.	U1210	U1210 See previous page for plan of correction	
U2001 SS=D	111-8-4-.20(2) Sanitation and Waste Disposal. All garbage, trash and waste shall be stored and disposed of in a manner, by approved methods, that will not permit the transmission of disease, create a nuisance, or provide a breeding place for insects or rodents. This RULE is not met as evidenced by: Based on observation, staff interview, and review of facility policies, the facility failed to store biohazardous waste properly. Findings include: Observation during a tour on 3/13/2017 at 3:30 PM with the Director of Clinical Administration revealed a closet which contained boxed biohazardous waste and full sharp containers, along with clean sharp containers. The Director of Clinical Administration acknowledged the above findings at the time. Review of facility policy titled Waste Disposal,	U2001	U2001 Corrective Actions: All clean containers have been relocated from the biohazard closet. Only containers that contain biohazardous waste will be stored in the biohazard closet. Staff Education: In-service has been scheduled to review how to properly dispose of biohazardous waste. Also, OSHA compliant videos for Infection Control Essentials: Every Action and Infection Control for Ambulatory Care Settings training handbooks by Coastal Training Technologies Corp will be reviewed and the quiz will be taken by everyone in attendance. Monitoring: Quarterly mock inspection will be performed. As part of the mock inspection, disposal methods will be reviewed to determine if the method is appropriate. Responsible persons: Clinic Administrator, Nurse Supervisor, Health Advocates, Nurses	4/15/2017 5/22/2017

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-287	A. BUILDING: _____ B. WING _____	03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIFF VALLEY CLINIC	1924 CLIFF VALLEY WAY, NE ATLANTA, GA 30329

(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
U2001	Continued From page 13 undated, last developed/reviewed 12/13, revealed that regulated medical waste would be handled in accordance with the blood-borne pathogens standards of OSHA (Occupational Safety and Health Administration).	U2001	See previous page for plan of correction	

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor

Frank Berry, Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

January 10, 2017

Ms. Stacey Linn, Administrator
Atlanta Women's Medical Center
235 West Wieuca Road
Atlanta, GA 30342-3321

Dear Ms. Linn:

The Healthcare Facility Regulation Division acknowledges receipt of your plan of correction for the deficiencies that were cited as the result of your **November 2, 2016** survey. The plan of correction has been reviewed and accepted as appropriate to correct the cited deficiencies.

If a follow-up visit is not conducted, please be advised that the implementation of your plan of correction will be monitored at your next on-site visit.

If you have any questions, please contact my office at (404) 657-5440 or write to the address listed above.

Sincerely,

Bola Ansa

Abimbola (Bola) Ansa, RN
Program Director, Acute Care Unit
Department of Community Health
Healthcare Facility Regulation Division

AA:rf

Americans United for Life

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

November 18, 2016

Ms. Stacey Linn, Administrator
Atlanta Women's Medical Center
235 West Wieuca Road
Atlanta, GA 30342-3321

Dear Ms. Linn:

Enclosed is a annual Report of Licensure Inspection completed at your facility on **November 2, 2016** by surveyor(s) from this office. This report contains one or more violations which must be corrected.

Your plan to correct these violations should be entered in the right hand column entitled "Providers Plan of Correction" with a projected completion date entered in the column "Completion Date". After you have completed the form, sign and date it in the space provided, return the ORIGINAL to our office no later than **December 2, 2016**.

Thank you for the courtesies extended to our representatives during this visit. If I can be of further assistance, please contact me at (404) 657-5440.

Sincerely,

for Abimbola (Bola) Ansa, RN
Program Director, Acute Care Unit
Department of Community Health
Healthcare Facility Regulation Division

AA:rf

Americans United for Life

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor | Frank Berry, Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

April 6, 2017

Ms. Joline Milord, Administrator
Cliff Valley Clinic
1924 Cliff Valley Way, NE
Atlanta, GA 30329

Dear Ms. Milord:

Enclosed is a annual Report of Licensure Inspection completed at your facility on **March 14, 2017** by surveyor(s) from this office. This report contains one or more violations which must be corrected.

Your plan to correct these violations should be entered in the right hand column entitled "Providers Plan of Correction" with a projected completion date entered in the column "Completion Date". After you have completed the form, sign and date it in the space provided, return the ORIGINAL to our office no later than **April 20, 2017**.

Thank you for the courtesies extended to our representatives during this visit. If I can be of further assistance, please contact me at (404) 657-5440.

Sincerely,

Abimbola (Bola) Ansa, RN
Program Director, Acute Care Unit
Department of Community Health
Healthcare Facility Regulation Division

AA:rf

Americans United for Life

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
HEALTHCARE FACILITY REGULATION DIVISION	025-115	A. BUILDING: _____ B. WING _____	04/10/2018

JUL 30 2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH MEDICAL CLINIC RECEIVED	120 East 34th Street SAVANNAH, GA 31401

(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
U 000	Initial Comments. At the time of the survey, Savannah Medical Clinic was in substantial compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a relicensure survey. The following deficiency was cited as a result of that survey.	U 000		
U 907 SS=F	111-8-4-.09(8) Professional Services. Each center will have effective policies and procedures for handling infection control and for recording complications which occur during or after surgery, which includes a reporting mechanism for patients who develop infections or postoperative complications after discharge. This RULE is not met as evidenced by: Based on review of policy, patient records and staff interviews it was determined that the facility failed to have an effective mechanism for recording and reporting post-operative complications and/or infections. Findings were: Review of POLICY FOR RECORDING OF INFECTIONS AND POST-PROCEDURE COMPLICATIONS, no policy number or initial or revision date, reveals that the facility will have an effective procedure for recording complications which occur during or post procedure that includes a reporting mechanism for patients who develop infections or post operative complications after discharge Six (6) patient records (#s 1, 2, 3, 4, 8 & 10) out of ten (10) did not have documented follow up after the day of the procedure. No follow up or	U 907		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin. — (X6) DATE: 7/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025-115	A. BUILDING: _____ B. WING _____	04/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH MEDICAL CLINIC	120 East 34th Street SAVANNAH, GA 31401

(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
U 907	Continued From page 1 attempts to follow up were noted in any of the (6) six records. Interview with registered nurse (staff #1)on 04/10/18 at 2:00 p.m. in the counselors office revealed that two (2) patients had experienced complications but there were no infections reported or documented in the past twelve months and that there is no log to follow post operative complications/infections within the facility. It was confirmed by the assistant administrator (staff #7) during the exit conference in the counselors office on 04/10/18 at 4:54 p.m. that there is no log or formal follow-up procedure to follow complications/infections of patients after procedures.	U 907		

Tag # U907

7/30/18

Mechanism for recording and reporting post operative complications and/or infections.

Corrective Action: All patients receive a post operative check up appointment. For all patients that do not return for this check up a follow up telephone call will be placed at 30 days post operative to access their recovery.

Monitoring: Monitoring of this program will be included as part of the biannual post procedure review performed by the Medical Director.

Implementation: All patients have been receiving post procedure check-up appointments since the facilities inception. The follow-up call has been implemented immediately post inspection.

Responsible person: A log has been established and will be reviewed weekly by staff member performing post procedure checkup assessment to follow complications/infections of patients after procedures.

Complete date: 4/17/2018

Americans United for Life

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025-115	A. BUILDING: _____ B. WING _____	04/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH MEDICAL CLINIC	120 East 34th Street SAVANNAH, GA 31401

(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
V 000	Opening Comments At the time of the survey, Savannah Medical Clinic was in compliance with Chapter 290-5-32, Rules and Regulations for Performance of Abortions After the First Trimester of Pregnancy and Reporting Requirements For All Abortions, as the result of a State licensure survey.	V 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
V 000	Opening Comments At the time of the survey, Atlanta Women's Medical Center was in compliance with Chapter 290-5-32, Rules and Regulations for Performance of Abortions After the First Trimester of Pregnancy and Reporting Requirements For All Abortions, as the result of a State licensure survey.	V 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U 000	Initial Comments. At the time of the survey, Atlanta Women's Medical Center was in compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a relicensure survey.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING: _____ B. WING _____	03/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
U 000	Initial Comments. At the time of the survey, Summit Medical Associates was in compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a relicensure survey. No deficiencies were cited.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING: _____ B. WING _____	03/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
V 000	Opening Comments At the time of the survey, Summit Medical Associates was in compliance with Chapter 290-5-32, Rules and Regulations for Performance of Abortions After the First Trimester of Pregnancy and Reporting Requirements For All Abortions, as the result of a relicensure survey. No deficiencies were cited.	V 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
V 000	Opening Comments At the time of the survey, Atlanta Women's Medical Center was in compliance with Chapter 290-5-32, Rules and Regulations for Performance of Abortions After the First Trimester of Pregnancy and Reporting Requirements For All Abortions, as the result of investigation of complaint #GA00190010 and #GA00190237. No deficiencies were cited.	V 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-287	A. BUILDING: _____ B. WING _____	R 08/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIFF VALLEY CLINIC	1924 CLIFF VALLEY WAY, NE ATLANTA, GA 30329

(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
{V 000}	Opening Comments	{V 000}		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-287	A. BUILDING: _____ B. WING _____	R 08/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIFF VALLEY CLINIC	1924 CLIFF VALLEY WAY, NE ATLANTA, GA 30329

(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
{U 000}	Initial Comments.	{U 000}		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-287	A. BUILDING:_____ B.WING	05/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIFF VALLEY CLINIC	1924 CLIFF VALLEY WAY, NE ATLANTA, GA 30329

(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)	(XS) COMPLETE DATE
U 000	Initial Comments. At the time of the survey, Cliff Valley Clinic was not in compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a relicensure survey. The following deficiencies were cited as a result of that survey.	U 000	HEALTHCARE FACILITY REGULATION DIVISION JUN 06 2018 RECEIVED	
U 300 SS=E	111-8-4-.03(1) Organization and Administration. Each ambulatory surgical treatment center shall be organized with an identifiable governing body that establishes the objectives, sets the policies and assumes full legal responsibilities for the overall conduct of the center and for compliance with all applicable laws and regulations pertaining to the center. The membership of the governing body shall be identified in the application to the Department for licensure. This RULE is not met as evidenced by: Based on review of the facility's policies and procedures, QAPI (quality assurance performance improvement) meeting minutes and data, Infection Control meeting minutes and data, and staff interview, it was determined that the facility failed to establish an ongoing QAPI or Infection Control program. Findings: A review of the Medical Staff Bylaws revealed that the Medical Staff is responsible for the quality of medical care in the facility and must accept and discharge that responsibility, subject to the ultimate authority of the facility governing body. A review of the facility policy, no policy number, "Quality Assessment and Improvement Plan",	U 300		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-287	A BUILDING:_____ B.WING	05/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIFF VALLEY CLINIC	1924 CLIFF VALLEY WAY, NE ATLANTA, GA 30329

(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)	(XS) COMPLETE DATE
u 300	Continued From page 1	U 300		

last revised 2013, revealed that the facilty would have a quality plan in place to provide a systemic process to organize and direct quality assessment and improvement activities provided by the physicians, registered nurses, nurse practitioners, health workers, health educators, and medical records staff. A further review revealed that QAPI summary data would be submitted and evaluated by the Quality Committee. The policy revealed that the QAPI Program would fall under the responsibility of the Nursing Supervisor, in collaboration with the Medical Director, and the committee would meet no less than quarterly. A continued review revealed that the Quality Assessment and Improvement Data would be initially be discussed with the board.

A review of the facility policy, no policy number, "Quality Assurance: Infection Control", last reviewed 12/2013, revealed that the Quality Improvement Committee would monitor and evaluate the overall quality of the infection control program, and the committee would meet monthly. A further review revealed that statistical data would be complied based on surveillance and studies and reviewed quarterly during the Quality Assurance meetings.

A review of the facility Meeting Minutes for 2017 revealed that QAPI plan was not discussed or reviewed. There were no meeting minutes for 2018.

A review of the Nursing Supervisor's (Employee #10) Job Description revealed that the Nursing Supervisor would monitor the development and quality monitoring methods for the QAPI program.

During an interview with the Administrator

Toni P. Hawkins Clinic Administrator 6-5-18

State of GA - Healtm:are Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-287	A BUILDING:_____ B.WING	05/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIFF VALLEY CLINIC	1924 CLIFF VALLEY WAY, NE ATLANTA, GA 30329

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U 300	U 300 Continued From page 2 (Employee #2) on 05/02/18 at 8:00 a.m. in the Conference Room, the Administrator stated that the facility had no current QAPI or Infection Control committees or plans in place. The Administrator acknowledged that the facilty policy stated the committees would meet at least quarterly and would have ongoing plans, studies, and surveillance review.	U 300	**Corrective Action:** Effective 2nd Quarter 2018 QAPI meetings will resume being held on a Quarterly basis to ensure a systematic process to organize and direct quality assessment. The Nursing Supervisor/Manager has assumed the task of re-organizing and implementing the QAPI program. The Nurse Manager has received and signed a Job Description outlining [redacted] duties and responsibilities as QAPI Care Program Supervisor. June 30, 2018 QAPI program will be in place and up to date for the 2nd Quarter of 2018. Corrective Action will include the reinstitution of regular QA Meetings to facilitate ongoing plans and studies as deemed necessary to maintain both the program and the Quality of the facilities services. **Responsible Person:** Nurse Manager	
U 302 SS=E	111-8-4-.03(3) Organization and Administration. The governing body of the center shall be responsible for appointing the professional staff and shall establish effective mechanisms for quality assurance and to ensure the accountability of the center's medical and/or dental staff and other professional personnel. This RULE is not met as evidenced by: Based on review of the facilities policies and procedures, QAPI (Quality Assurance Performance Improvement) meeting minutes and data, and staff interviews, it was determined that the facility failed to establish an ongoing QAPI program that included quality indicators that measured, analyzed, and tracked patient care and indicated the setting of priorities for performance improvement activities. A review of the facility policy, no policy number, "Quality Assessment and Improvement Plan", last revised 2013, revealed that the facility would have a quality plan in place to provide a systemic process to organize and direct quality assessment and improvement activities provided by the physicians, registered nurses, nurse practitioners, health workers, health educators, and medical records staff. A further review	U 302		

Connie P. Hawkins

Clinic Administrator

State of GA, Healthcare Facility Regulation Division

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U 302	Continued From page 3 revealed that QAPI summary data would be submitted and evaluated by the Quality Committee. The policy revealed that the QAPI Program would fall under the responsibility of the Nursing Supervisor, in collaboration with the Medical Director, and the committee would meet no less than quarterly. A continued review revealed that the Quality Assessment and Improvement Data would be initially be discussed with the board. A review of the facility Meeting Minutes for 2017 revealed that a QAPI plan was not discussed or reviewed. There were no meeting minutes for 2018. A review of the Nursing Supervisor's (Employee #10) Job Description revealed that there were no specific duties or information listed, as it related to the management of the QAPI program. During an interview with the Administrator (Employee #2) on 05/02/18 at 8:00 a.m. in the Conference Room, the Administrator stated that the facility had no current QAPI committee or plan. The Administrator acknowledged that the facility policy stated the committee would meet at least quarterly and would have ongoing plans and srud s.	U 302		
U 906 SS=D	111-8-4-.09(7) Professional Services. Each center shall have a hospital affiliation agreement and/or the medical staff must have admitting privileges or other acceptable documented arrangements to insure the necessary backup for medical complications. The center must have the capability to transfer a patient immediately to a hospital with adequate	U 906		

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U 906	Continued From page 4 emergency room services. This RULE is not met as evidenced by: Based on review of facility's records and interview, the facility failed to maintain hospital affiliation agreements, admitting privileges of medical staff to ensure the necessary backup for medical complications. Findings: A review of the facility's Medical Staff Bylaws policy (not dated), "Feminist Women's Health Center's Cliff Valley Clinic Medical Staff Bylaws", Article V: Procedure for Appointment and Reappointment, Section 1: Application for Appointment, required physicians to provide: 3. Information as to whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced or not renewed at any other hospital or institution; involvement in any professional liability actions; Review of credentialed files #16, #17, revealed no documentation of a hospital privileges agreements. During an interview with the Clinic Administrator (Employee #2) on 5/1/18 at 11:45 a.m., in the facility's conference room, the Administrator stated he/she could not locate #16 or#17's hospital privileges agreements.	U 906	**Corrective Action:** All Physician files in accordance with 111-8-4-09(7) Professional Services have undergone complete review by the Clinic Administrator. Those Physician files lacking or missing the required information have been updated in compliance with the facilities Medical Staff ByLaws, as have all Physician files. This process shall be completed by June 8, 2018. **Responsible Person:** Clinic Administrator	
U 907 SS=E	111-8-4-.09(8) Professional Services. Each center will have effective policies and procedures for handling infection control and for	U 907		

Corie P. Hawkins Clinic Administrator

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U 907	Continued From page 5	U 907		

recording complications which occur during or after surgery, which includes a reporting mechanism for patients who develop infections or postoperative complications after discharge.

This RULE is not met as evidenced by:
Based on review of the facility's policies and procedures, Infection Control meeting minutes and data, and staff interview, it was determined that the facility failed to establish an ongoing Infection Control program that included a plan to report reportable communicable disease, statistical data, facility infection rates or trends, and surveillance review or studies .

Finding

A review of the facility policy, no policy number, "Quality Assurance: Infection Control", last reviewed 12/2013, revealed that the Quality Improvement Committee would monitor and evaluate the overall quality of the infection control program, and the committee would meet monthly. A further review revealed that statistical data would be complied based on surveillance and studies and reviewed quarterly during the Quality Assurance meetings.

A review of the facility Meeting Minutes for 2017 revealed that Infection Control was not discussed or reviewed. There were no documented meeting minutes for 2018.

.A review of the Nursing Supervisor's (Employee #10) Job Description revealed that there were no responsibilities or tasks listed that related to infection control.

During an interview with the Administrator

Corrective Action:

The Clinic Administrator as per her responsibilities has credentialed and assigned the INFECTION CONTROL oversight to the Nurse Manager & Medical Director as prescribed by FWHC P&P.
In addition, an OR Supervisor has recently been employed to maintain all Logs pertinent to Infection Control in the OR Suite.
Quality Control Meetings will be held Quarterly as prescribed to enhance and complete the requirement for an effective and data driven review of surveillance at FWHC.

Responsible Persons: Nurse Manager and Operating Room Supervisor

Anne P. Hawkins Clinic Administrator

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u 907'	Continued From page 6 (Employee #2) on 05/02/18 at 8:00 a.m. in the Conference Room, the Administrator stated that the facility had no current Infection Control committee or plan in place. The Administrator acknowledged that the facility policy stated the Infection Control committee would meet at least quarterly and would have ongoing plans, studies, and surveillance review. The Administrator stated that Employee #10 would be i responsible for the Infection Control Program moving forward.	U 907		
U1007 SS=D	111-8-4-.1 0(g) Physical Plant and Operational Standards. All procedure rooms shall be constructed, equipped, and maintained to assure the safety of patients and personnel. This RULE is not met as evidenced by: Based on review of the facility's policy and staff interview, the facility failed to ensure all procedure rooms were maintained to assure the safety of patients and personnel. Findings: A review of the facility's policies showed revealed no documentation of an Operating Room Temperature Humidity tracking policy or protocol. A review of the Operating Room (OR) Daily Dusting and Cleaning Log & Temperature & Humidity for OR #1, revealed that the facility last checked the temperature and humidity of operating room (OR) #1 on 3/11/17. **No** further checks of the temperature and humidity for operating room #1 were provided.	U1007		

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U1007	Continued From page 7 A review of the facility's OR #1 Daily Log Temperature & Humidity, Dusting & Cleaning log revealed that the facility last checked the temperature and humidity of operating room (OR) #2. on 5/6/17. No further checks of the temperature and humidity for operating room #2 were provided. During an interview on 4/30/18 at 12:50 p.m. in the Clinic Administrator's office, the Clinic Administrator stated the facility had not checked the operating rooms' temperature and humidity logs since the facility's last inspection dated 3/14/17.	U1007	Per Rule 111-8-4-10(g) Physical Plant and Operational Standards: **Corrective Action:** As of 5/5/2018 Logs were re-constructed to maintain record of 1. Operating Room Dusting & Cleaning: OR's will be terminally cleaned every Wednesday. 2. Temp and Humidity Logs are notated every day surgery is performed. 3. OR Supervisor will assign Health Advocates on a daily basis after surgery to clean and sanitize the OR and set-up for next day's surgery. Note: OR 1 is presently not being used. Equipment Repairs are in progress and until the OR Table is repaired will remain closed until repairs are completed. Deep Cleaning of the OR suite was conducted on May 23, 2018 by Service Master **Responsible Persons: Nurse Manager, OR Supervisor and Clinic Administrator**	
U1103 SS=E	111-8-4-.11(4) Personnel. Each center shall require that each employee receives a health examination upon employment and a policy shall provide for follow-up examinations. The examination shall be in sufficient detail, including pertinent laboratory and x-ray data, to assure that the employee is physically and mentally qualified to perform the job to which he is assigned. This RULE is not met as evidenced by: Based on a review of employee health records, facility policy, and staff interview, the facility failed	U1103	**Corrective Action:** All facility personnel Health & Physical Requirements will be completed by June 9, 2018. Credentialed employee files have been completed to meet this requirement. **Responsible Person:** Clinic Administrator	

Toni P. Hawkins Clinic Administrator

State of GA, Healthcare Facility Regulation Division

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U1103	Continued From page 8 examination upon employment. Review of employee files #1, 2, 3, 4, 5, 6, 7, 13, 15, and 18, revealed no documentation of a physical exam. Review of credentialed file #14 and #15 revealed no documentation of a physical exam. Review of credentialed file #18 revealed the last physical exam was dated 6/16/16. During an interview with the Administrative Personnel Assistant (Employee #19) on 5/1/18 at 9:05 a.m. in the facility's conference room, the Administrative Personnel Assistant stated he/she could not locate any of the employee's physical exams, and he/she had not seen any physical exams for the employees upon hire. During an interview with the Clinic Administrator (Employee #2) on 5/1/18 at 11:45 a.m. in the facility's conference room, the Clinic Administrator stated he/she could not locate Employee #18's most recent health attestation.	U1103		
U1105 SS=E	111-8-4-.11(6) Personnel. Fire and internal disaster drills shall be conducted at least quarterly and the results documented. There shall be an ongoing program of continuing education for all personnel concerning aspects of fire safety and the disaster plan for moving personnel and patients to safety, and for handling patient emergencies. Authority O.C.G.A. Secs. 31-2-4 et seq. and 31-7-1 et seq. Administrative History. Original Rule entitled "Personnel" was filed on January 22, ;;	U1105		

Toni P. Hawkins Clinic Administrator 6-28-18

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	U1105, Continued From page 9	U1105		

1980; effective March 1, 1980, as specified by the Agency.

, This RULE is not met as evidenced by:
Based on record review and interview, the facility failed to conduct fire and internal disaster drills at least quarterly and document the results.

Findings:

A review of records revealed no documentation for fire or disaster drills in 2017 or 2018.

During an interview with the Clinic Administrator (Employee #2) on 5/1/18 at 2:11 p.m., in the facility's conference room, the Administrator stated he/she could not find the facility's 2017 fire and disaster drills. The employee stated there had been no drills conducted for 2018. Employee #2 further stated, he/she knew the fire and disaster drills needed to be completed quarterly, and did not know whether the drills were conducted.

U1500 111-8-4-.15(1) Housekeeping, Laundry, Maint, SS=D Sterile Supply — U1500

Each center shall provide sufficient space and equipment and ensure that housekeeping and maintenance is sufficient to keep the center and equipment in a clean and tidy condition and state of good repair. Proper maintenance shall be provided as necessary to correct, prevent, or adjust faulty equipment and/or correct other undesirable conditions.

This RULE is not met as evidenced by:
Based on review of facility policy, observation,

Corrective Action:
To meet the Compliance Requirements for 111-8-4-11(6) Personnel as it relates to Fire/Disaster Drills FWHC is in the process of hiring a new **Facilities & IT Coordinator** who will schedule Fire/Disaster Drills, record same as well as complete and record for QA documentation of same.

Drills will be conducted on a Quarterly basis. Completion of 2nd Quarter 2018 drill will be completed by June 30, 2018.

Monitoring is the responsibility of the Facilities/IT Coordinator.

The Executive Director has made an offer to a candidate who the facility has determined a start day of 6/25/2018.

Responsible Persons: Facilities IT Coordinator and Executive Director

Cori P. Hawkins — Clinic Administrator

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U1500	Continued From page 10	U1500		

and staff interview, the facility failed to ensure that maintenance to keep the equipment rooms clean and in good repair.

Findings:

Review of the facility policy, no policy number, "Specific Terminal Cleaning", reviewed on 12/2013, revealed that terminal cleaning will take place at the end of each surgical day by the health workers and the housekeeping crew. A further review revealed that each Operating Room (OR) suite will be terminally cleaned daily. A continued review revealed that terminal cleaning would be completed to reduce the amount of dust, organic debris and microorganisms (germs) present in the surgical environment. Terminal cleaning by the staff will include daily cleaning of furniture and equipment. ,

Review of the facility policy, no policy number, "Disinfection", revised on 5/2005, revealed that in order to destroy and prevent the spread of pathogenic (harmful) microorganisms, the following items must be disinfected or cleaned with a certain solution. The following items and/or spills require disinfecting: furniture, equipment and light fixtures in the exam rooms.

During a tour of Operating Room (OR) *lr2.* on 05/01/2018 at 1:45 p.m. the following observations were made:

a. One (1) ventilator has dust and a waxy build-up around knobs;

b. An angular tear, approximately 2 x 1 inches, in the vinyl on the side of the OR table.

During an interview on 05/01/2018 at 2:02 p.m. in

Corrective Action:
Effective 5/14/2018 with the hiring of a Operating Room Supervisor the following protocols were set and Health Advocate assignments given:

1. OR will be terminally cleaned after each surgery day to include disinfection, dusting, floor scrub as prescribed in the FWHC policy.
2. Terminal Cleaning of the entire OR Suite was conducted by Service Master on 5/24/2018 and will be maintained.
3. OR Supervisor is preparing **"standing orders"** for the proper cleaning of the OR Suite. These orders will be completed by June 18, 2018.

As regards the tear in the OR Table in use, Staff is covering the tear with proper materials to avoid any patient contact with the angular tear until the arrival of a new OR Table which should be in-house and operational no later than July 30, 2018.

Staff Education: OR Supervisor will be conducting an In Service for all Health Advocates working in the OR Suite. This In Service will be completed by June 15, 2018.

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u1soo	Continued From page 11	U1500		
	OR #1, the Nursing Supervisor (Employee #10) confirmed that the ventilator had dust and a waxy substance around the door knob. The employee also confirmed a tear was present on the OR table.			
U1600 SS=E	111-8-4-.16 Drug Storage and Dispensing. Each center shall provide adequate space and equipment and staff to assure that drugs are stored and administered in compliance with State and Federal laws and regulations. Authority O.C.G.A. Secs. 31-2-4 et seq. and 31-7-1 et seq.. Administrative History. Original Rule entitled "Drug Storage and Dispensing" was , filed on January 22, 1980; effective March 1, 1980, as specified by the Agency. This RULE is not met as evidenced by: Based on review of facility policy, observation, and staff interview, the facility failed to ensure that expired medications were not available for patient use and multidose medications were discarded per facility policy. Findings: A review of the facility policy, no policy number, "Medication Policies and Procedures", last revised 11/2013, revealed that any medication remaining in a multi-dose vial must be labeled with the date opened and the initials of the person opening the vial. All medications would be checked for expiration dates on a monthly basis. All expired medications would be discarded. Review of the facility policy, no policy number, "Equipment and Supplies", last revised on	U1600	**Corrective Action:** The Nurse Manager or RN (per assignment) will be responsible for monthly check of sterile supplies for expiration date and wasting as needed per the FWHC facility protocol for Equipment and Supplies. Responsible Person: Nurse Manager Correction: Immediate The CRNA Staff will undergo an In Service refresher with the Medical Director regarding the storage of vials and labeling as well as the disposal of expired anesthesia drugs and equipment in accordance with the facilities policies and procedures. This process shall be completed by June 30, 2018 with the proper notation provided in the QAIP program. Responsible Person: Medical Director, Nurse Manager	

Jori P. Hawkins Clinic Administrator 6-5-18

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U1600	Continued From page 12	U1600		

12/2013, revealed that sterile patient supplies are to be checked prior to use for their expiration date during monthly inventory.

During a tour of Operating Room (OR) #2 on 05/01/2018 at 1:45 p.m. the following observations were made in the locked anesthesia cart:

a. One (1) Flumazenil (to treat drowsiness caused by medications used to produce a state of sleep) 1 mg/10 ml vial expired 3/2018;

b. Four (4) pre-filled syringes with no name of solution, date, time solution was drawn up into syringe, or initials of the person opening the vial;

c. One(1) Xylocaine 1% 30 ml vial spiked with a "mini-spiked" connector with only month/day with no year or initials of the person opening the vial;

d. One (1) Lidocaine HCl 1% 20 ml vial opened with no date or initials of the person opening the vial;

e. One (1) 0.9% Normal Saline (NS) 30 ml vial with no date or initials of the person opening the vial.

A continued tour of OR #2 revealed the following expired supplies:

a. Four (4) winged infusion sets with no date, but "yellowed" tubing;

b. One (1) CO_2 detector expired 112017;

c. One (1) cuffed tracheal tube expired 10/2014;

d. One (1) laryngeal mask airway expired 2/28/16;

Toni P. Hawkins Clinic Administrator

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U1600	Continued From page 13	U1600		

e. One (1) nasopharyngeal airway expired 12/2015.

During a tour of Operating Room (OR) #1 on 05/01/2018 at 2:00 p.m. the locked anesthesia cart was observed to contain one (1) 30 ml multi-dose vial of 0.9% Normal Saline was found to be opened with only the month/day labeled on the vial. The year and initials of the staff member that opened the medication were not documented on the vial. The following expired supplies were observed during the tour of OR #1:

a. Four (4) winged infusion sets with no date, but "yellowed" tubing;

b. One (1) CO2 detector expired 1/2017.

During an interview on 05/01/2018 at 2:15 p.m. in OR #1, the Nursing Supervisor (Employee #10) confirmed that the medications and supplies were expired, and the multi-dose vials were not labeled in accordance with the facility's policies and procedures.

Toni P. Hawkins Clinic Administrator

State of GA, Heal_thc,.rEe Facility Requlation Division

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Accepted 6/6/18 SSS

(X4)1D 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)	(XS) COMPLETE DATE
V ooo	Opening Comments At the time of the survey, Cliff Valley Clinic was not in compliance with Chapter 290-5-32, Rules and Regulations for Performance of Abortions After the First Trimester of Pregnancy and Reporting Requirements For All Abortions, as the result of a State licensure survey. The following deficiency was cited.	V 000	**Corrective Action:** The Clinic Administrator instituted a new protocol for the completion of ITOPS as per Code Section 16-12-141 of the Official Code of Georgia Annotated, **effective on May 3, 2018 at the end of each surgery day the patient charts and Encounter Sheets are** forwarded to the Front Office. The charts undergo "Chart Review" for missed signatures etc and the ITOPS form is completed and certified. This new protocol will eliminate the concern for ITOPS completion in a timely manner. Additionally, ITOPS completion for 2018 will be completed and up to date by June 5, 2018. **Staff Education:** This protocol was reviewed and explained in a Staff Meeting conducted on May 5, 2018. **Responsible Person:** Clinic Administrator	
v 030 SS=E	290-5-32-.03(1) Procedure for Filing Certificate of Abortion In addition to the medical records requirements of Chapters 290-5-6 and 290-5-33 of the Rules and Regulations of the Georgia Department of Human Resources, the physician who performs the abortion shall file with the Commissioner of Human Resources or his designee, within ten (10) days after an abortion procedure is performed, a Certificate of Abortion. It is expressly intended that the privacy of the patient shall be preserved and, to that end, the Certificate of Abortion shall not reflect the name of the patient but shall carry the same facility number, or other identifying number reflected on the patient's medical records. A duplicate of the Certificate of Abortion will he made a part of the patient's Medical record and neither the aforesaid duplicate certificate nor the Certificate of Abortion which is filed with the Commissioner or his designee shall be revealed to the public unless the patient executes a proper authorization which permits such a release or unless the records must be made available to the District Attorney of the Judicial Circuit in which the hospital or health facility is located as provided by Code Section 16-12-141 (d) of the Official Code of Georgia Annotated. Repealed: F. Dec. 18, 2012; elf. Jan. 7, 2013.	v 030		

State of GA Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-287	A. BUILDING: _____ B.WING	05/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIFF VALLEY CLINIC	1924 CLIFF VALLEY WAY, NE ATLANTA, GA 30329

(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)	(XS) COMPLETE DATE
V 030	Continued From page 1	V030		

This REQUIREMENT is not met as evidenced by:
Based on facility policy, medical record review, and staff interview, it was determined that the facility failed to ensure that Certificates of Abortion were filed with the commissioner of Human Resources within ten (10) days following a termination of pregnancy for seven (7) of twelve (12) sampled patient records (#3, 5, 6, 7, 8, 9, and#11.)

Finding

Review of the facilty policy, B23, "VEIS/ITOPS", last revised 03/2011, revealed that all Induced Terminiation of Pregnancies (ITOPs) performed by the facility would be filed with the State within ten (10) days of the procedure, as required by law.

Review of seven (7) of twelve (12) medical records reviewed (#3, 5, 6, 7, 8, 9, and 11) revealed that the Certificates of Abortion were filed after the ten (10) day requirement as follows: .

a. A review of medical record #3 revealed that the abortion procedure was performed on [redacted] however, the Certificate of Abortion was not filed until [redacted] twenty-six (26) days after the procedure;

b. A review of medical record #5 revealed that the abortion procedure was performed on [redacted] however, the Certificate of Abortion was ' not filed until [redacted] thirty-eight (38) days after the procedure;

c. A review of medical record #6 revealed that

Toni P. Hawkins Clinic Administrator 6-5-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-287	A. BUILDING: _____ B. WING	05/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIFF VALLEY CLINIC	1924 CLIFF VALLEY WAY, NE ATLANTA, GA 30329

(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
V 030	Continued From page 2	V030		

the abortion procedure was performed on [redacted] however, the Certificate of Abortion was not filed until [redacted] thirty-three (33) days after the procedure;

d. A review of medical record #7 revealed that the abortion procedure was performed on [redacted] however, the Certificate of Abortion was not filed until [redacted] sixty-four (64) days after the procedure;

e. A review of medical record #8 revealed that the abortion procedure was performed on [redacted] however, the Certificate of Abortion was not filed until [redacted] thirty-one (31) days after the procedure;

f. A review of medical record #9 revealed that the abortion procedure was performed on [redacted] however, the Certificate of Abortion was not filed until [redacted] twenty-four (24) days after the procedure;

g. A review of medical record #9 revealed that the abortion procedure was performed on [redacted] however, the Certificate of Abortion was not filed until [redacted] twenty-four (24) days after the procedure;

During an interview with the Administrator (Employee #2) on 04/30/18 at 9::47 a.m. in the Administrator's office, the Administrator revealed that he/she is new to the position and stated that the facility was not in compliance in numerous areas. The Administrator revealed that many of the ITOPs had not been filed with the State within the required ten (10) days.

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
V 000	Opening Comments At the time of the survey, Atlanta Women's Medical Center was in compliance with Chapter 290-5-32, Rules and Regulations for Performance of Abortions After the First Trimester of Pregnancy and Reporting Requirements For All Abortions, as the result of a State Re-licensure survey. No deficiencies were cited.	V 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-011	A. BUILDING: _____ B. WING _____	02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTA WOMEN'S MEDICAL CENTER	235 WEST WIEUCA ROAD ATLANTA, GA 30342

(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
U 000	Initial Comments. At the time of the survey, Atlanta Women's Medical Center, was in compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical Treatment Centers, as the result of a Re-licensure survey. No deficiencies were cited.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-141	A. BUILDING: _____ B. WING _____	02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL ASSOCIATES	1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324

(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
U 000	Initial Comments. At the time of the relicensure survey on 02/18/19, Summit Medical Associates was in substantial compliance with Requirements with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgery Centers. No deficiencies were cited.	U 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE