PRINTED: 10/24/2019

State of	GA, Healthcare Faci	ility Regulation Division			FORW APPROVE	ΞĐ
STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		060-141	B. WING		02/17/2010	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SUMMIT	MEDICAL ASSOCIA	2 I F S	DMONT RD, A, GA 30324	NE, SUITE 500-E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET	Ë
U 000	INITIAL COMMENT	 ГЅ	U 000			
	Associates was not 290-5-33, Rules an Surgical Treatment State licensure surv	urvey, Summit Medical in compliance with Chapter and Regulations for Ambulatory Centers, as the result of a vey. The following deficiencies result of that survey.				
	290-5-3310(c) PH OPERATIONAL ST		U 069			
	elevators, heating a rooms and special sconstructed so as to occupants. It shall governing body to a safe condition at all inspection record is	cal appliances, wiring, and cooling systems, surgery service areas shall be o assure the safety of all be the responsibility of the assure that the center is in a times and that a fire a maintained on equipment, is that may present a hazard to				
	This Rule is not me	et as evidenced by:				
	interview, it was det body failed to assur	facility records and staff termined that the governing re that the center was in a safe es and that a fire inspection ned.				
	Findings:					
	of a fire inspection r 02/17/10 at 5:00 p. the administrator (e he/she had been er	cords failed to reveal evidence report. During an interview on .m. in the consultation room, employee #8) stated that mployed at the facility for not recall a fire inspection ever			mericans Inited	

State of GA Inspection Report

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

State of	GA, Healthcare Facil	ity Regulation Division				
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		060-141	B. WING		02/1	7/2010
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SUMMIT	MEDICAL ASSOCIA	I E S	OMONT RD, A, GA 30324	NE, SUITE 500-E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
U 069	Continued From pa	ge 1	U 069			
	having been conduc	cted in the facility.				
U 075 SS=D		PHYSICAL PLANT & ANDARDS	U 075			
		in procedure rooms shall be permit frequent washing and				
	This Rule is not me	et as evidenced by:				
	was determined that that the walls and flowere in a condition	ons during the facility tour, it t the facility failed to ensure poring in the procedure room that would permit effective ecting of the surgical area.				
	Findings were:					
	on 02/17/2010 and administrator (emploregistered nurse an #5), observations receiling of the room, (damage) on three esparation of the seprocedure table as flooring. These con	procedure room at 1:30 p.m. accompanied by the facility's oyee #8) and the certified esthetist (CRNA-credential file evealed peeling paint on the deep gouged out areas (3) of the four (4) walls, and tams of the floor around the well as at the edges of the ditions decreased the facility's clean and disinfect the				
	thus increasing the	fore and between procedures, risk of infections. The facility's wledged the condition of the finfections.			S	3
SS=D			U 091	J	Jnit	cans ted
State of GA I STATE FOR!	nspection Report VI		6899 7	WB911 f	Of continua	tion sheet 23 8

State of	GA, Healthcare Facil	ity Regulation Division				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		060-141	B. WING		02/17/2010	
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
SUMMIT	MEDICAL ASSOCIA	1 = 5	MONT RD, ., GA 30324	NE, SUITE 500-E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTION (PROVIDENCY)	D BE COMPLET	Ē
U 091	The center shall be such a manner as to hygiene, privacy, and therein. This Rule is not me. Based on observation pre-operative and printerview, it was det not arranged to ensure and dignity of the presentation of the present	arranged and organized in organized in organized the comfort, safety, and dignity of patients treated of as evidenced by: Ons during tour of the ost-operative areas and staff ermined that the center was ure and respect the privacy atients. On a tour of the pre-operative areas at 1:30 p.m. on organied by the administrator aregistered nurse revealed the following: The area contained twelve (12) hother that the patients used. The patients used area contained six (6) where patients would be resonce sufficiently recovered. The patients in the patients would be the patients in the patients would be the patients in the patients waited that the patients waited	U 091			
	area and were recovilocated in the post-of-that no screens or continuous	rs provided in the pre-operative vered together in the chairs operative area. The RN stated curtains were available to be			meri <mark>can</mark> Initec	5
State of GA STATE FOR	Inspection Report M		6899 7		of continuation sheet	3 8

PRINTED: 10/24/2019

State of	CA Healthcare Facil	lity Regulation Division			FORM A	PPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
		060-141	B. WING		02/17	//2010
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
SUMMIT	MEDICAL ASSOCIA	1 = 5	DIVION I RD, I 4, GA 30324	NE, SUITE 500-E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
U 091	Continued From pa	ge 3	U 091			
	placed between the	chairs in these areas.				
U 093 SS=D	290-5-3310(n) PH OPERATIONAL ST		U 093			
		stored in a conveniently lock, and only licensed access.				
	This Rule is not me	et as evidenced by:				
	staff interview, it was failed to ensure that	ons during a facility tour and solutions determined that the facility the drugs were stored in a locked cessible by licensed				
	Findings were:					
	approximately 1:30 accompanied by the and the certified nu (CRNA-credential fi observed on the top accessible to a non was cleaning the ro on top of the anestha) An opened vial o single use only. Thonly used a small a so the contents of tho one patient;	le #5), medications were o of the anesthesia cart and -licensed staff member who om. The medications located			Sol	3
	cup that was unlabe	eled. The CRNA stated that toxan (an antineoplastic drug		A	meri	cans
		l of Robinul (anesthetic) and		J	Jnit	ed
State of GA STATE FOR	Inspection Report M		6899 7 V		O f continuation	

State of	GA, Healthcare Facil	lity Regulation Division			TORWATTROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		060-141	B. WING		02/17/2010
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE	
summi	MEDICAL ASSOCIA	11-5	OMONT RD, A, GA 30324	NE, SUITE 500-E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
U 093	an unopened vial of and d) Two (2) opened veach labeled for sin as to when the vials. The administrator a non-licensed person medications located.	f Succinylcholine (anesthetic); vials of Propofol (anesthetic), gle use only, were not labeled	U 093		
	(1) Each center shadequipment and ensimal maintenance is suff equipment in a clear of good repair. Proprovided as necess		U 119		
	Based on review of procedures, facility determined that the	facility policies and tour, and staff interview, it was facility failed to ensure that ment was sanitary, free of dust			
	During a tour of the on 02/17/2010 and administrator (empl registered nurse an #5), observations receiling of the room,	procedure room at 1:30 p.m. accompanied by the facility's oyee #8) and the certified esthetist (CRNA-credential file evealed peeling paint on the deep gouged out areas		J	mericans Inited
State of GA I STATE FOR	nspection Report M		6899 7	WB911 f	Of continuation sheet 63 8

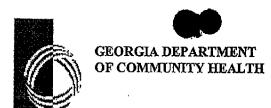
State of	GA, Healthcare Facil	lity Regulation Division				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE : COMP	
		060-141	B. WING		02/1	7/2010
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
SUMMIT	MEDICAL ASSOCIA	11-5	OMONT RD, A, GA 30324	NE, SUITE 500-E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
U 119	(damage) on three is separation of the separation. These con ability to effectively of procedure room befithus increasing the administrator acknown of facility por For The Procedure NURS 10082-D, revealed that acceptive were to be used by possibility of infection. The policy required of the day all horizo equipment, overhead wall mounted equipment, agricultured of the following were of a) The ventilation vesterilizer was covered b) A visible gap was back exit door and to the control of the following were of a) The ventilation vesterilizer was covered b) A visible gap was back exit door and to the following were of a) The ventilation vesterilizer was covered by A visible gap was back exit door and the control of the facility of the f	(3) of the four (4) walls, and cams of the floor around the well as at the edges of the iditions decreased the facility's clean and disinfect the fore and between procedures, risk of infections. The facility's weldinged the condition of the finfections. licy, entitled Sanitation Policy Room Suite, Policy Number vision date August 13, 2002, table sanitation techniques all personnel to reduce the on of both patients and staff. that prior to the first procedure intal surfaces of tables, and lights, and other ceiling and ment was to be damp-dusted the facility conducted at p.m. on 2/17/10 and the administrator (employee #8), abserved: the first procedure with dust; around the top of the facility's the door frame; and ceiling tiles were observed ity; the noted in the florescent light addrer room; on all the flat surfaces in the in the surgical light, and other	U 119	A	se meri Jnii	cans
State of GA I	nspection Report	, ,	J.			· C -
STATE FORI	М		6899 7	WB911	f continuat	ion sheet 33 8

State of	GA, Healthcare Facil	ity Regulation Division			
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		060-141	B. WING		02/17/2010
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE	
SUMMIT	MEDICAL ASSOCIA	1 = 5	MONT RD, , GA 30324	NE, SUITE 500-E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTY)	D BE COMPLETE
U 119	the intubation set-uply a towel. The tray surgical gloves with 12/31/2009; and g) A ceiling tile was pushed open in the Per the administrate to the heating and a above the ceiling.	he suction machine, and on p tray, which was covered only also contained a pair of an expiration date of observed to have been pre-operative area hallway. For this was for workmen access air conditioning area, located administrator acknowledged	U 119		
U 129 SS=D	provide an emerger controlled, that, afte electric power supple power source is avant brought into use with voltage and frequent in-house services at equipment needed	e general anesthesia shall acy electrical system so ar interruption of the normal by, an acceptable auxiliary illable and capable of being thin ten seconds with sufficient acy to reestablish essential and other emergency to effect a prompt and efficient to an appropriate licensed	U 129		
Ctata of CA	interview, it was det used general anestl facility's generator, t was capable of bein	·		Ţ	mericans Inited
State of GA I STATE FOR	nspection Report M		⁶⁸⁹⁹ 7	WB911 f (of continuation sheet 2 8

State of	GA, Healthcare Facil	ity Regulation Division			TORWALL	OVLD
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		060-141	B. WING		02/17/201	10
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SUMMIT	MEDICAL ASSOCIA	I E S	DMONT RD, A, GA 30324	NE, SUITE 500-E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COM	X5) IPLETE ATE
	Findings were: Review of facility po Power, Policy Numb January 27, 1997, r generator was operafailure and that recofile in the administrative Review of the generevidence of testing was capable of being seconds of interrupt supply. During an interview the consultation roo (employee #8) state anesthesia; however unaware that the genere in the seconds of interview the consultation roo (employee #8) state anesthesia; however unaware that the genere in the seconds of interview the consultation roo (employee #8) state anesthesia; however unaware that the genere in the second in the seco	rator log failed to reveal to ensure that the generator g brought into use within tention of the normal power at 4:30 p.m. on 02/16/2010 in m, the facility's administrator d that the facility used general or, the administrator was enerator's capability of use,				
	had to be tested.	of interruption of normal power,	Senn	J	merica Jnite	d
STATE FORI			6899 7	WB911 1	f continuation she	t 2 8

TAG REGULATORY OR .SC IDENTIFYING INFORMATION) 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 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. Americans	State of	GA, Healthcare Facil	lity Regulation Division			
MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMIT MEDICAL ASSOCIATES 1974 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324 (XA) ID PREPIX (EACH DEPICIENCY MUST SE PRECEDED 8 YOUL) PREPIX TAG 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 Preparachess Plans, as the result of a State licensure survey. M 001 Opening Comments ATLANTA (A) 30324 M 001 Opening Comments 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 Preparachess Plans, as the result of a State licensure survey. Americans	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1		
MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMIT MEDICAL ASSOCIATES 1974 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324 (XA) ID PREPIX (EACH DEPICIENCY MUST SE PRECEDED 8 YOUL) PREPIX TAG 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 Preparachess Plans, as the result of a State licensure survey. M 001 Opening Comments ATLANTA (A) 30324 M 001 Opening Comments 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 Preparachess Plans, as the result of a State licensure survey. Americans			000 444			40/04/0040
SUMMIT MEDICAL ASSOCIATES 1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, CA 30324			060-141	1 5. 171110		12/21/2010
X4 D PROVIDER'S PLAN OF CORRECTION PRETEX TAGS PROPERTY TAGS PROVIDER'S PLAN OF CORRECTION PRETEX TAGS PRETEX T	NAME OF F	ROVIDER OR SUPPLIER				
PREFIX TAG REGULATORY OR SC IDENTIFYING INFORMATION) 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	SUMMIT	MEDICAL ASSOCIA	\ - \			
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.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLETE
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	Opening Comment	s	M 001		
		At the time of the su Associates was in o 290-5-45, Rules an Preparedness Plans	urvey, Summit Medical compliance with Chapter nd Regulations for Disaster		A	SS
l l Unite(1					I	Inited

State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



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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:



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DATE

State of GA, Healthcare Facility Requiation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 060-141 HEALTHCARE FACILITY REG12/21/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1874 PIEDMONT RD, NE, SUITE 500-E **SUMMIT MEDICAL ASSOCIATES** MAR 01 2011 ATLANTA, GA 30324 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX (EACH CORRECTIVE ACTION SYNDIDED BE TAG OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) U 000 INITIAL COMMENTS U 000 INITIAL COMMENTS Summit Medical Associates, P.C. has always placed a high priority on Patient Safety and At the time of the survey, Summit Medical Infection Control, and will continue to do so. Associates was not in compliance with Chapter Pursuant to the State Inspection conducted on 290-5-33, Rules and Regulations for Ambulatory December 21, 2010, Summit has responded by Surgical Treatment Centers, as the result of a State implementing the following corrective actions: licensure survey. The following deficiencies were written as the result of that survey. U 028 290-5-33-.03(3) ORGANIZATION & U 028 290-5-33-.03(3) SS=D ADMINISTRATION, AMENDED 2/24/11 ORGANIZATION & ADMINISTRATION. AMENDED The governing body of the center shall be responsible for appointing the professional staff and CORRECTIVE ACTION shall establish effective mechanisms for quality Summit Medical Associates, P.C. respectfully assurance and to ensure the accountability of the disagrees with the Anesthesia Peer Review portion of this deficiency. One of the Facility's center's medical and/or dental staff and other doctors performs anesthesia peer reviews for professional personnel. each anesthetist. The review and summary forms are kept in a separate file folder, which was given to the Surveyors for review at the This Rule is not met as evidenced by: time of the Inspection. Peer review data (which is also kept in a Based on review of facility quality assurance data. separate file folder) is also kept on all medical facility credential files, and staff interview, it was and professional staff; however, this data file was not available at the time of the Inspection. It had determined that the facility lacked effective quality been inadvertently placed in a box headed for assurance mechanisms to ensure accountability of storage. A new form has been developed that the medical and professional staff for five (5) of five will become a part of each medical and professional (5) sampled credential files (#s 1, 2, 3, 4, and 5). staff member's personnel file, which will ensure that the documentation is always on site and available for review. Findings were: MONITORING Review of the facility's Quality Assurance Copies of completed Peer Review forms for all Management Report, dated January 25, 2010, medical and professional staff will be kept in indicated that peer review (quality review) would be their personnel files, and a copy will be sent to a member of the Governing Body on a quarterly conducted on a random number of charts and that

tate of GA Inspection Report

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TATE FORM

peer review for anesthesia would be conducted on

Five (5) of five (5) credential files reviewed (#s 1, 2, 3, 4, and 5) lacked evidence that peer review

random charts on a monthly basis.

basis for review, and to ensure compliance.





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	State of GA.	Healthcare	Facility Re	equiation	Division
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STATEMENT	OF	DEFIC	IENCIES
AND PLAN OF	FC	ORREC	TION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

(X3) DATE SURVEY COMPLETED

060-141

B. WING_

12/21/2010

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

			DMONT RD, J. GA 30324	NE, SUITE 500-E	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REC OR LSC IDENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
U 028	Continued From page 1 had been conducted. During an interview at 5:30 p.m. on 12/21/one of the facility's offices, the Administrat (employee # 1) stated that peer review wa conducted on unexpected outcomes and t physician #3 compiled the peer review dat however, the Administrator was unable to documentation that peer review on random had been completed. The Administrator a that physician #3 completed the peer review certified registered nurse anesthetist (CRNA-credential file #5), but that there we peer review data on the CRNA for review.	or s hat a; provide n cases so stated w on the	U 028		
55-10	290-5-3309(8) PROFESSIONAL SERVICE Each center will have effective policies and procedures for handling infection control ar recording complications which occur during surgery, which includes a reporting mechan patients who develop infections or postope complications after discharge. This Rule is not met as evidenced by: Based on review of facility policies and procedures and staff interview, it was deter that the facility lacked effective infection compositions and procedures by ensuring that act standards regarding temperature and huminate operating room (OR) were followed. Findings were: Review of facility policies and procedures far reveal evidence of a policy/procedure regar acceptable ranges for temperature and huminate OR, and for the recording and tracking of	nd for y or after hism for rative cedures, mined htrol cceptable dity in	U 062	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 lnspection in the event they have been temporary moved or are in use.	
ate of GA Insi	pection Report	<u>_</u>		- fael	11/2

State of GA Inspection Report

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If continuation sheet 2 of 8

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EXHIBIT 'B' PRINTED: 02/10/2011 FORM APPROVED State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 060-141 12/21/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1874 PIEDMONT RD, NE, SUITE 500-E SUMMIT MEDICAL ASSOCIATES ATLANTA, GA 30324 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) U 062 Continued From page 2 U 062 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 093 290-5-33-.10(n) PHYSICAL PLANT & 290-5-33-.10(n) U 093 SS=E OPERATIONAL STANDARDS PHYSICAL PLANT & OPERATIONAL STANDARDS Medicines shall be stored in a conveniently located 2/15/11 cabinet with lock, and only licensed persons shall CORRECTIVE ACTION have access. Patient safety is of utmost importance to Summit Medical Associates. The Medical Director has warned the CRNA that all medications This Rule is not met as evidenced by: 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 Based on observations and staff interview, it was ensure that he understands that non-licensed personnel determined that the facility failed to ensure that should never have access to either medications or drugs were stored in a locked cabinet and only controlled drugs. He acknowledged his understanding accessible by licensed individuals. that further instances of non-compliance would not be tolerated, and would lead to more stringent disciplinary action, which could include dismissal. Findings were: MONITORING During a tour of the facility's operating room (OR) at The Medical Director and Administrator will conduct 3:30 p.m. on 12/21/2010 with the director of nursing random inspections/observations of the operating room (DON-employee #2) and the certified registered to observe the CRNA's compliance. nurse anesthetist (CRNA-credential file #5),

included:

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

of pre-drawn Propofol (anesthetic

a. Twenty (20) 25 cubic centimeter (cc) syringes

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRE		·			
SUMMIT	MEDICAL ASSOCIATE	is	ATLANTA,		NE, SUITE 500-E			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REINTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
U 093	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-ficensed 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.		awn idocaine ialed. At at al blood vials; and ovine contain eft ed that enesthesia only	U 093				
SS=D	Contents of individua normally contain the to the treatment data: 1. Practitioner's order 2. Progress notes. 3. Nurse notes. 4. Medication. 5. Temperature-pulse surgical purposes onli	I medical records sha following at least: s. e-respiration (Graphic y). ns(s) and reports (inc.	chart;	J 106	290-5-3312(2) (c) RECORDS CORRECTIVE ACTION The Pre-op/Post op orders form has be to include date and time next to the pl signature. All physicians have been no begin using the revised form, and to did date and time along with their signature. MONITORING The signature, date and time will be compart of normal Quality Assurance cheef the Administrator and the Medical Directions.	nysician's otified to ocument re. hecked as cks by both	3/1/11 Cans	



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
. 060-141			B. WING		12/21/2010		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	TATE, ZIP CODE		
SUMMIT	MEDICAL ASSOCIATE	:s		MONT RD, 1 GA 30324	NE, SUITE 500-E	:	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE	
U 106	8. Operation record. 9. Anesthesia record. 10 Consultation record. 11. Tissue findings v 12. Where dental se dental chart with der prescription and prog clinical record. This Rule is not met . Based on review of r interview, it was dete ensure that practitior timed for six (6) of six (#s 1, 2, 3, 4, 5, and Findings were: Six (6) of six (6) med 3, 4, 5, and 6) reveal lacked a date or time During an interview a	d (if applicable). ord (if applicable). when performed. rvices are rendered, a ntal diagnosis, treatme gress notes shall be p t as evidenced by: medical records and s ermined that the facilit ner orders were dated x (6) sampled patient 6). lical records reviewed ed that the practitione when signed.	taff y failed to and records (#s 1, 2, ers' orders	U 106			
U ⁻ 110 SS=D	one of the facility's of (employee #1) stated record indicated the of the orders, even thou another staff member that the practitioner's time next to the physical the orders were writted.	ffices, the Administrate that the date on the date that the physicial ugh the date was writter. The Administrator of orders did not have a lician's signature, as to en. ORDS be current and shall be a sprovided for any	top of the in signed en by confirmed a date or o when	U 110 -	290-5-3312(6) RECORDS CORRECTIVE ACTION Medical records that are boxed and reastorage will be kept in a secure, locked picked up by the off-site storage compastaff members have been in-serviced reproper method of staging and securing records for storage pick-up. MONITORING The Administrator will monitor annual records staging for off-site storage to compliance.	area until my. Al garding the medical medical	



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

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
SUMMIT MEDICAL ASSOCIATES			MONT RD, N , GA 30324	IE, SUITE 500-E			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE		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		U 110	DEPICIENCE			
U 119 SS=E	and needed to be picked up for off-site storage He/she also confirmed that the housekeeping did access the area in the evenings while performing their duties. During an interview at 5:30 p.m. on 12/21/201 administrator (employee #1) acknowledged the medical records were unprotected, and stated the records could be moved into another area await pick up. U 119 290-5-3315(1) SS=E HOUSEKEEPING,LAUNDRY,MAINTENANCE		U 119	290-5-3315(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 his company's medical maintenance company to repair.	ans ed		
	(+) ⊏ach center sna⊩ provide suπicient sp	ace		fall	fa		

State of GA Inspection Report

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ND PLAN OF CORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

060-141

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY

OR LSC IDENTIFYING INFORMATION)

B. WING

12/21/2010

(X5) COMPLETE DATE

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STREET ADDRESS, CITY, STATE, ZIP CODE

PREFIX

TAG

U 119

SUMMIT MEDICAL ASSOCIATES

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

A. BUILDING

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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.

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.

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY

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.

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

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SUMMIT MEDICAL ASSOCIATES 18		1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324					
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U 119	Continued From page 7		U 119				
	This rule was previously cited on 02/17/2	010.					
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State of	GA, Healthcare Faci	lity Regulation Division				
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		025-115	B. WING		06/24/2010	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
SAVANN	IAH MEDICAL CLINIC	<u>n.</u>	34th Street AH, GA 3140	11		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
	was in compliance of Performance of About of Pregnancy and F	urvey, Savannah Medical Clinic with Chapter 290-5-32, ortions After the First Trimester Reporting Requirements for Allesult of a State licensure	V 0000	A	SS mericans Inited	
LABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	or Life	

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		025-115	B. WING		06/24/2010	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	FATE, ZIP CODE		
SAVANN	IAH MEDICAL CLINIC		34th Street AH, GA 3140	1		
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U 000	INITIAL COMMENT	S	U 000			
	was in substantial c 290-5-33, Rules an Surgical Treatment	urvey, Savannah Medical Clinic ompliance with Chapter d Regulations for Ambulatory Centers, as the result of a rey. The following deficiency esult of that survey.				
	290-5-3310(I) PH' OPERATIONAL ST		U 091			
	such a manner as t	arranged and organized in o ensure the comfort, safety, and dignity of patients treated				
	pre-operative and p interview, it was det	ons during tour of the ost-operative areas and staff ermined that the center was ure and respect the privacy				
	Findings were:					
State of GA L	and post-operative a p.m. on 06/23/2010 administrator (emplourse (RN-employe 1. The pre-operseats (sofas for two patients before their screens were in playerivacy and dignity 2. The post-operchairs, three (3) charther oom facing each	g a tour of the pre-operative areas at approximately 4:30 and accompanied by the oyee #9) and a registered e #3) revealed the following: ative area contained three love (2) people) for the use of the procedure. No curtains or ce to ensure the individual of the patients in the area; and erative area contained six (6) airs each on opposite sides of the other. No curtains or ce to ensure the individual		L	SS mericans Inited	
		ER/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	or Life	

State of GA, Healthcare Facility Regulation Division							
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
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SAVANN	IAH MEDICAL CLINIC	7.	34th Street AH, GA 314	34			
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				DEFICIENCY)			
U 091	Continued From pa	ae 1	U 091				
	privacy and dignity	of the patients in the area.					
	During an interview	at approximately 5:00 p.m. on					
	_	lity's post-operative area, the					
		stated that the patients waited					
		e seats (sofas) provided in the					
	, 0	and then were recovered					
	together in the recli	ner chairs located in the					
		The RN added that patients					
		he procedure room into the					
		etchers. The stretcher was					
	· -	n the two rows of chairs where					
		d until sufficiently recovered					
		d to a recliner. The RN no screens or curtains were in					
	_	sofas in the pre-op area and					
		n the post-op areas. The RN					
		he patient's condition require					
		be taken to the other side of					
	the room.						
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State of CA. Healtheare Eacility Degulation Division

State of	GA, Healthcare Facil	ity Regulation Division			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		060-011	B. WING		06/16/2010
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	TATE, ZIP CODE	
ATLANT	A WOMEN'S MEDICA	71 CENTER	T WIEUCA R A, GA 30342	OAD	
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V 000	Opening Comments	s	V 000		
V 000	At the time of the su Medical Center was 290-5-32, Performa Trimester of Pregna	urvey, Atlanta Women's in compliance with Chapter ance of Abortions After the First ancy and Reporting Il Abortions, as the result of a	V 000	A	SS mericans
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State of GA I	 Inspection Report		I		TICU
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State of	GA, Healthcare Facil	lity Regulation Division				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		060-011	B. WING		06/1	6/2010
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, ST	TATE, ZIP CODE		
ATLANT	A WOMEN'S MEDICA	AL CENTER	T WIEUCA RO A, GA 30342	OAD		
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U 000	INITIAL COMMENT	īS .	U 000			
U 000	At the time of the si Medical Center was 290-5-33, Rules an	urvey, Atlanta Women's in compliance with Chapter id Regulations for Ambulatory Centers, as the result of a	U 000		S. Ameri Unit	
State of GA	Inspection Report				OIII	LCU
LABORATOR	Y DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	for I	(XPTE

PRINTED: 10/24/2019

FORM APPROVED State of GA, Healthcare Facility Regulation Division

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

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SUMMIT	MIELLICIAL ASSOCIALES	IEDMONT RD, N ITA, GA 30324	E, SUITE 500-E	
(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) COMPLET DATE
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STATE FORM 6899 O4DB12 If continuation sheet 1 of 1

State of	<u>GA, Healthcare Faci</u>	lity Regulation Division			
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		060-141	B. WING		R 03/15/2011
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
SUMMIT	MEDICAL ASSOCIA	. I = \	DMONT RD, A, GA 30324	NE, SUITE 500-E	
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03/15/2011

FORM APPROVED State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING:

NAME OF PROVIDER OR SUPPLIER

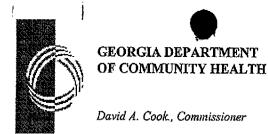
060-141

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING _

SUMMIT MEDICAL ASSOCIATES 1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324					
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) COMPLET DATE		
Opening Comments	{M 001}				
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STATE FORM 6899 O4DB12 If continuation sheet 1 of 1



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

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State of	<u>GA, Healthcare Faci</u>	lity Regulation Division			
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		060-011	B. WING		03/17/2011
NAME OF I	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, S	TATE, ZIP CODE	
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M 001	Medical Center was 290-5-45, Rules an	survey, Atlanta Women's in compliance with Chapte in Regulations for Disasters, as the result of a State	M 001		SS Americans United
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

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03/17/2011

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

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See Attachment A-V 030.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
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STREET ADDRESS, CITY, STATE, ZIP CODE

235 WEST WIEUCA ROAD ATLANTA WOMEN'S MEDICAL CENTER ATLANTA, GA 30342

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION))	-
∨ 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 State licensure survey. The following deficie was written as the result of that survey.	of a	
V 030 SS=D	290-5-3203(1) Procedure for Filing Certifica Abortion	ate of	
	In addition to the medical records requirement Chapters 290-5-6 and 290-5-33 of the Rules Regulations of the Georgia Department of Human Resources, the physician who perfor the abortion shall file with the Commissioner Human Resources or designee, within ter (10) days after an abortion procedure is performed, a Certificate of Abortion. It is expressly intended that the privacy of the patishall be preserved and, to that end, the Certificate of Abortion shall not reflect the nail of the patient but shall carry the same facility number, or other identifying number reflected the patient's medical records. A duplicate of the Certificate of Abortion will made a part of the patient's Medical record and neither the afored duplicate certificate nor the Certificate of Abortion is filed with the Commissioner or designee shall be revealed to the public unless that the publ	and ms of n tient me I on the esaid ortion	

State of GA Inspection Report

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Code Section 16-12-141 (d) of the Official Code

This REQUIREMENT is not met as evidenced

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

of Georgia Annotated.

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PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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STREET ADDRESS, CITY, STATE, ZIP CODE

ATLANTA WOMEN'S MEDICAL CENTER

235 WEST WIEUCA ROAD ATLANTA, GA 30342

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V 030	Continued From page 1	V 030		
	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			C
	(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		S	B
	provide documented evidence of the date each certificate was filed, the Administrator explained			ricans
4212 24 04	that the person responsible for filing the		Uni	ted
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03/17/2011

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

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ATLANTA WOMEN'S MEDICAL CENTER

235 WEST WIEUCA ROAD

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V 030	Continued From page 2		V 030		
	certificates had gone home for the day, expected to return the next day, and the was the only staff member with access program. As of noon on 03/21/2011, no information had been provided by the fa	at he/she to that o further			
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03/17/2011

State of GA, Healthcare Facility Regulation Division

STATEMENT	ΩE	DEFIC	DENCIES
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235 WEST WIEUCA ROAD

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U 000	INITIAL COMMENTS	U 000	APR 28 2011	
	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.		· RECEIVED	
U 028 SS=D	290-5-3303(3) ORGANIZATION & ADMINISTRATION. AMENDED	U 028	See Attachment B - U 028.	4/28/11
1	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,		Amer	sicans
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STATEMENT OF DEFICIENCIES	
AND PLAN OF CORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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STREET ADDRESS, CITY, STATE, ZIP CODE

ATLANTA WOMEN'S MEDICAL CENTER

235 WEST WIEUCA ROAD

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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	U 028		
U 062 SS=D	found any deficient practices on his/her reviews, so, he/she did not do any follow up reviews/monitoring. 290-5-3309(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	U 062	See Attachment C - U 062.	4/26/11
	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:		S Ame Uni	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPL

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(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

ATLANT.	A WOMEN'S MEDICAL CENTER ATL	ANTA, GA 3034		
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U 062	Continued From page 2	U 062		
	Review of the facility's policies and procedure failed to reveal a policy/procedure for the recording of infections or complications which occurred during or after surgery.	ı	·	
;	This information was requested from the facil Administrator (employee #8) on 3/17/2011 at a.m., 12:00 p.m., 2:00 p.m., and 4:00 p.m., b was never received.	9:00		
U 065 SS=D	290-5-3309(11) PROFESSIONAL SERVICE	ES U 065	See Attachment D - U 065.	4/25/11
	Each center shall establish policies for patien care and procedures for maintaining these policies. This Rule is not met as evidenced by:	t		
	Based on review of facility policies, medical records, and staff interview, it was determined that the facility failed to establish procedures maintaining patient care policies related to surgical time-out.	d for		
	Findings were:			
	Review of facility Policies and Procedures faito reveal a policy addressing performance and ocumentation of a surgical time-out (a pause before surgical incision to verify the correct patient, correct surgical site/side, and correct procedure).	d e		
	Six (6) of six (6) medical records reviewed (#4, 5, 7, 9, 11) lacked evidence that a surgical time-out had been conducted.	s 1,	S	S
	During an interview on 3/17/2011 at 12:00 p.r the administrator's office, the administrator (employee #8) confirmed that the facility did n		Ame	ricans
tate of GA I	have a Time Out policy, and did not document have a Time Out policy, and did not document has pection Report	t	Uni	ted

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

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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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U 065	Continued From page 3	U 065		**
	such in the patient's medical record.			
U 068 SS=D	290-5-3310(b) PHYSICAL PLANT & OPERATIONAL STANDARS	U 068	See Attachment E - U 068.	4/22/11
	The physical plant of the center shall mee Federal, State and local laws, codes, ordinand regulations which apply to its location construction, maintenance and operation.	nances		
	This Rule is not met as evidenced by:		-14/11- Driaman POCNOT	
	Based on observations during a facility too staff interview, it was determined that the failed to ensure that temperature, humidity air pressures in the surgery center were monitored.	facility	5/8/11-Original POC Not occeptable e udo8, See nesission need 5/5/11, which is occepted.	
ļ	Findings were:			
	Upon arrival to the facility at 9:00 a.m. on 03/17/2011, surveyors provided the facility Administrator (employee #8) with a list of documents for review that included documentation related to the facility's mon and maintenance of the temperature and humidity of the two (2) procedure rooms at the air pressures in the instrument process and sterilizing rooms. Requests for the documents were made at 12:00 p.m., 2:00 and 4:00 p.m., and as of the close of the s	itoring nd of sing p.m.		
	at 6:00 p.m. on 03/17/2011, the documents not been provided.	s had	C.	G
	Observations during a tour of the facility wifacility's Administrator (employee #8) at 5:3 on 03/17/2011 revealed that the facility's divisions of the facility of the facility is divisional to the facility in the facility is divisional to the facility in the facility in the facility is divisional to the facility in the facility in the facility is divisional to the facility with the facil	30 p.m. irty	Ame	かっ ricans
	instrument cleaning area and clean instrun sterilizing and storage area were located in	nent nside a	Uni	<u>.</u>
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ATLANTA	WOMEN'S MEDICA	AL CENTER	235 WEST ATLANTA,	WIEUÇA RO GA 30342	AD		
(X4) ID		ATEMENT OF DEFICIENCIES		[D	PROVIDER'S PLAN OF C	ORRECTION	(X5)

U 068 Continued From page 4 room which was partitioned by a floor-to-celling 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, the facility was unable to maintain the required air pressures in each area, negative air pressures 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 room's door was supposed to be kept closed, and that he room's door was supposed to be kept closed, and that he room's door was supposed to be kept closed, and that he room's door was supposed to be kept closed, and that he room's door was supposed to be kept closed, and that he room's door was supposed to be kept closed, and that he room's door was supposed to be kept closed, and that he room's door was supposed to be kept closed, and that he room's door was supposed to be kept closed, and that he room's door was supposed to be kept closed, and that he room's door was supposed to be kept closed, and that he room's door was supposed to be kept closed, and that he room's door was supposed to be kept closed, the facility areas and solled instrument areas. U 101 See Attachment F = U 101. 4/ See Attachment F = U 101. 5/ See Attachment F = U 101.	AILANI.	ATLANTA	A, GA 30342		
room which was partitioned by a floor-to-ceiling wail, 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 of the air pressures required in the clean/sterilizing areas and soiled instrument areas. U 101 290-5-33-11(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.	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
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 068	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			
	SS=D	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.		Ame	4/26/11
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State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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(X3) DATE SURVEY COMPLETED

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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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U 101	Continued From page 5	U 101		
	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 106 SS≃D	290-5-3312(2)(c) RECORDS	U 106	See Attachment G - U 106.	4/26/
	Contents of individual medical records shall normally contain the following at least:			
	Treatment data:		8	35
	1. Practitioner's orders.		A	
	2. Progress notes.		Ame	nican
	Nurse notes. Medication.		T I	4 -

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State of GA, Healthcare Facility Regulation Division

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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

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U 106	Continued From page 6		U 106		
	 Temperature-pulse-respiration (Graph surgical purposes only). Special examinations(s) and reports (in x-ray and lab reports). Signed informed consent form. Operation record. Anesthesia record (if applicable). Consultation record (if applicable). Tissue findings when performed. Where dental services are rendered, complete dental chart with dental diagnot treatment, prescription and progress not be part of the clinical record. This Rule is not met as evidenced by:	a sis,			
	Based on review of facility policies and procedures, medical records and staff in was determined that the facility failed to that each patient undergoing an abortion procedure certified in writing that, 24 hou advance of the procedure, provided all information required to make informed consent for ten (10) of ten (10) patient records (#1, 2, 4, 5, 6, 7, 8, 9, 10)	ensure irs in a fully sampled			
	Findings were:				
	Review of current Georgia Code, O.C.G. 31-9A-3, revealed that, in order to ensure female considering an abortion makes a informed decision regarding whether to use the procedure, facilities provide the female certain information at least 24 hours in an of the procedure, and that the female certain that she received the information. Code required that, as part of the information provided, the female be given information regarding how to obtain a list of health care.	e that a fully indergo le with dvance tify in The ation			S ricans
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State of GA, Healthcare Facility Regulation Division

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

060-011

B. WING

03/17/2011

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ATLANT.		235 WEST ATLANTA,		OAD	
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U 106	Continued From page 7		U 106		
	providers, facilities and clinics that offer to perform ultrasounds free of charge, arran geographically, and which included the na address, hours of operation, and telephor number of each listed entity.	iged ame,			
	Ten (10) of ten (10) medical records revie (#1, 2, 4, 5, 6, 7, 8, 9, 10 and 11) included document entitled Client Certification Ford delineated the information that was required to be given to each prospective abopatient. Each form also included a patient signature certifying that had been prothe information required by the Code. Ho closer review of the Certification form revethat information regarding how to obtain a health care providers, facilities and clinics offer to perform ultrasounds free of chargenot included.	d a m, which red by ortion t's ovided wever, ealed t list of			
	During an interview in his/her office at 4:1 on 03/17/2011, the facility's Administrator (employee #8) related that the Certificatio had been amended to include the required information related to obtaining free ultras but that the facility had not implemented it	n form d ounds,			
U 118 SS=A	290-5-3314(5) CLINICAL LABORATOR' SERVICES	Y	U 118	See Attachment H - U 118.	4/26/11
	The center shall report to the Department communicable diseases detected or report patients.			S	SSS
	This Rule is not met as evidenced by:				13-
	Based on review of facility policies and procedures, facility logs, and staff interview	w it		Amer	icans
State of GA	was determined that the facility lacked a	vv, IL		Uni	ted
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State of GA, Healthcare Facility Regulation Division

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(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

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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

ILANIA	A WOMEN'S MEDICAL CENTER	ATLANTA,	GA 30342	OAD	
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	policy/procedure and log for the reportin communicable diseases to the Departm	g of ent.			
	Findings were:				
	Review of the facility's policies and proc failed to reveal evidence of a policy/proc the reporting of communicable diseases of facility logs failed to reveal a log for R Diseases.	edure for . Review		~	
	This information was requested on 3/17/9:00 a.m., 12:00 p.m., 2:00 p.m., and 4:0 but was never received.	/2011 at 00 p.m.,			
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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

Americans United for Life

ATTACHMENT A - V 030

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.

Americans United for Life

ATTACHMENT B - U 028

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.



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 5/5/1/ Jonemail

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

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.

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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.

Americans United for Life

ATTACHMENT E - U068

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



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.

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ATTACHMENT G - U 106

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.



PRINTED: 10/15/2019

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State of GA Inspection Report

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ATLANT	A WOMEN'S MEDICA		ATLANTA	, GA 30342			
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	Continued From page Condition #1 of Wai (requirement for an surgical services progranted by the Depage 08/31/12 required the patient's condition adetermine the type of escorts needed to the stairs. The facility evidence of this assist be provided to the Eleast one escort will down the stairs upoon At 10:00 a.m. a patifacility post procedu (employee #1) talke waiting room prior to building. The patient eighteen (18) stairs driver, unaccompaning patient and the comexited the building with the parking lot to An interview was consupervisor (employed Administrator's privated that he/she of down the stairs at dit was his/her under discharge the patien patient to walk down	ge 4 iver of Rule 2: elevator for a ovided in mul- artment 08/30 hat the facility at the time of a of assistance of help the patity will be requiressment of p Department un accompany of n discharge. ient was observe. The PAC and with the patient's not walked downwith a companied by facility mpanion/design without staff entire private with their private with the patient's and ucted with the effice. The did not routine ischarge. He estanding that at the door	90-5-3310(f) mbulatory tistory buildings) 0/2005 until vill assess the discharge and and the number tient safely down uired to maintain atients, which will pon request. At each patient served leaving the EU supervisor tient in the sexit from the vin a flight of anion/designated staff escort. The gnated driver scort and walked vehicle. the PACU 00 p.m. in the e interviewee ely escort patients elyshe stated that it was alright to and allow the	U 135			
	The interviewee con aware of the waiver escort to accompan upon discharge fron	firmed that he requirement to y each patier	e/she was not for facility staff				cans
							ted
State of GA I STATE FORI	nspection Report M			6899 (tion sheet 23 6

State of CA Healtheare Eacility Degulation Division

	GA, Healthcare Facil IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	I	E	COMPLETED	
					С	
		060-011	B. WING		11/22/2011	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
ATLANT	A WOMEN'S MEDICA	M CENTER	TWIEUCA F ., GA 30342			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
U 135	Continued From pa	ge 5	U 135			
U 135	An interview was co at 3:30 p.m. in his/h interviewee stated the staff not to escort the at discharge. The co	onducted with the Administrator her private office. The hat he/she had instructed the he patients out of the building decision was made for staff nember became involved in a	U 135			
				A	mericans Inited	
L State of GA I	nspection Report				TITCU	
STATE FOR		ı	6899	C3EF11	of continuation sheet 6 6	

State of	<u>GA, Healthcare Faci</u>	lity Regulation Division			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		060-011	B. WING		05/03/2012
		0.775.57.48	DDEGG OUTL	T.T. TID 0005	
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE	
ATLANT	A WOMEN'S MEDICA	ALCENIER	T WIEUCA R A, GA 30342		
	OUR MADY OT		.		211
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION SHOUL	(*)
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	
				DEFICIENCY)	
U 000	INITIAL COMMENT	rs.	U 000		
5 555	I III I I I I I I I I I I I I I I I I				
	At the time of the si	urvey, Atlanta Women's			
		in compliance with Chapter			
		d Regulations for Ambulatory			
		Centers, as the result of a			
	State licensure surv	/ey.			
					SK
					mericans
				T	Inited
					mittu
	Inspection Report	ER/SUPPLIER REPRESENTATIVE'S SIGN.	ATURE	TITLE f	or Ivifo
-ADUKATUK'	I DIVECTOR 9 OK PROVID	EMBOFFLIER REFRESENTATIVES SIGN.	TIUNE	IIILE	or Laife

State of	GA, Healthcare Facil	lity Regulation Division				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COWIFLETED	
		060-011	B. WING		10/15/2012	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
ATLANT	A WOMEN'S MEDICA	AL CENTER 235 WES	T WIEUCA R	ROAD		
0/40 15	CHMMADV CTA	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	ON OVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE	
U 000	INITIAL COMMENT	-S	U 000			
	AMENDED					
	Medical Center was Chapter 290-5-33, Ambulatory Surgica result of a State lice	urvey, Atlanta Women's not in compliance with Rules and Regulations for al Treatment Centers, as the ensure monitoring visit. The is being written as a result of				
U 072 SS=D	290-5-3310(f) PH OPERATIONAL ST		U 072			
	multistory buildings elevator of adequate standard wheeled li attendants. A stain	way or ramp of adequate e available for transfer of a				
	This Rule is not me	et as evidenced by:				
	staff interviews, it was failed to provide an	cumentation, observation, and as determined that the facility elevator of adequate size to dard wheeled litter patient and				
	Findings were:				CC	
	at 9:00 a.m. on 10/ the premises throug up the stairs to the was observed in use a locked door that re	nonitoring visit was conducted 15/2012. Surveyors entered gh an open door and walked entrance. No operable elevator e. At the top of the stairs was equired a button to be pressed		L	mericans Inited	
	Inspection Report Y DIRECTOR'S OR PROVIDI	ER/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE f	or Life	

State of	GA, Healthcare Faci	lity Regulation Division			I ORIVI	AFFROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
7415 1 2741	o, 00,111,12011011	IBENTI TO THOU TO MEET.	A. BUILDING:			
		060-011	B. WING		10/1	5/2012
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	FATE, ZIP CODE		
ATLANT	A WOMEN'S MEDICA	AL CENTER	T WIEUCA R A, GA 30342	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
U 072	to allow entry from to The Surgical log for Review of the facility surgical procedures Thirteen (13) procedures 10/10/12, twelve (1: on 10/11/12, eighte performed on 10/12 procedures were performed to docum seventy-eight (78) surveyors also revied during the survey. During an interview the facility's break re (personnel file #1- in Nursing (personnel Business Office Mainterview only) confirmer still being performed to allow the survey.	the staff that was inside. the year 2012 was requested. y's surgical log revealed that were performed as follows: dures were performed on 2) procedures were performed en (18) procedures were 2/12 and thirty-five (35) erformed on 10/13/12.	U 072		Ameri	
					Ini	tod



State of	GA, Healthcare Facil	ity Regulation	n Division				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER	X/SUPPLIER/CLIA ATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		060-011	I	B. WING		10/1	5/2012
NAME OF I	PROVIDER OR SUPPLIER		CTDEET AD	DESS CITY S	TATE, ZIP CODE		
NAME OF	-NOVIDEN ON SOFFLIEN			T WIEUCA R			
ATLANTA WOMEN'S MEDICAL CENTER			ATLANTA	A, GA 30342			ı
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
	290-5-3310(f) PH' OPERATIONAL ST	ANDARDS		U 072			
	Ambulatory surgical multistory buildings elevator of adequate standard wheeled litattendants. A stairy dimensions shall be patient in case of po	shall be acce e size to acco tter patient ar way or ramp o e available for	essible by an mmodate a nd two of adequate				
	This Rule is not me AMENDED	et as evidence	ed by:				
	Based on facility do staff interviews, it was failed to provide an accomodate a stand two attendants.	as determined elevator of ad	d that the facility lequate size to				
	Findings were:						
	An unannounced m at 9:00 a.m. on 10/the premises througup the stairs to the was observed in use a locked door that re to allow entry from t	15/2012. Sulgh an open do entrance. No e. At the top equired a but	rveyors entered foor and walked operable elevator of the stairs was ton to be pressed				
04-40 - 5 0 2 2	The Surgical log for Review of the facility surgical procedures Thirteen (13) proced 10/10/12, twelve (12 on 10/11/12, eighte performed on 10/12 procedures were performed to docum seventy-eight (78) sevential Band 100 for Reverting Report 100 for	y's surgical log were perform dures were pe 2) procedures en (18) proce 1/12 and thirty rformed on 1 nentation in th	g revealed that ned as follows: erformed on swere performed edures were y-five (35) 0/13/12. ne log,		Ţ	lni ₁	S cans ted
	nspection Report ORECTOR'S OR PROVIDE	ER/SUPPLIER REI	PRESENTATIVE'S SIGNA	TURE	TITLE	orI	(XETATE

State of	<u>GA, Healthcare Facil</u>	lity Regulation Division			
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		060-011	B. WING		C 10/15/2012
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
ATLANT	A WOMEN'S MEDICA	ALCENIER	T WIEUCA R A, GA 30342		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE
U 072	performed 10/10/20 Surveyors also revied during the survey. During an interview the facility's break re (personnel file #1- in Nursing (personnel Business Office Mainterview only) confiwere still being perfe	ige 1 012 through 10/13/2012. ewed six (6) medical records on 10/15/12 at 10:15 a.m. in com, the facility's Administrator nterview only), Director of file #2- interview only), and nager (personnel file #3-irmed that surgical procedures formed and were also reek of the on-site monitoring	U 072	A	SS mericans Jnited
State of GA I STATE FORI	nspection Report ผ		6899 c	OUTC11	Of continuation sheet 2012
O IAI E I OIN	¥Ι		h	P0TG11	

State of CA. Healtheare Eacility Population Division

State of	GA, Healthcare Facil	lity Regulation Division			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		060-011	B. WING		10/15/2012
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
ATLANT	A WOMEN'S MEDICA	ALCENTER	T WIEUCA R A, GA 30342		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
	Medical Center was 290-5-32, Rules an the result of a State	urvey, Atlanta Women's in compliance with Chapter d Regulations for Abortions, as e licensure monitoring visit.	V 000	A	SS mericans Jnited
LABORATOR'	Inspection Report Y DIRECTOR'S OR PROVIDI	ER/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	TITLE	or Life

State of	GA, Healthcare Faci	lity Regulation Division				
		(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		060-141	B. WING		03/1	2/2012
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
CLIBABALT	MEDICAL ACCOCIA	1874 PIEI	OMONT RD,	NE, SUITE 500-E		
SUMMIN	MEDICAL ASSOCIA	ATLANTA	A, GA 30324			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG	\	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
		·		DEFICIENCY)		
11,000	INITIAL COMMENT	-c	U 000			
0 000	INTTIAL COMMENT	3	0 000			
	At the time of the su	urvey, Summit Medical				
		in compliance with chapter				
		d Regulations for Ambulatory				
		Centers, as a result of				
		tion #GA00105953. Allegation				
		The following deficiency was				
	written as a result o	f the survey process.				
LLAGE	000 5 00 00 4/4/1	(ED OF DIE E	I LAOF			
SS=D	290-5-3322 WAIV	ER OF RULE	U 135			
00-5	The Department ma	ay waive any rule for a stated				
		it is shown that the specific				
	rule is not	The original trial the opening				
	applicable or when	a waiver is needed to permit				
	experimentation and	d demonstration of new and				
	innovative					
		delivery of services which will				
		nealth and safety of the ners utilizing the center.				
	Results of such exp					
		ects shall be submitted to the				
		scribed by the plan under				
	which the waiver is	approved. The Department				
		ord of and make available to				
		information on all waivers				
	granted under this					
	This Rule is not me	conditions required by the				
		ver of Rule 290-5-3309 (4),				
		cy and procedure, call log, and				
		s determined that the facility			-C(
		n one of seven (#2) conditions			God	2
		g and continuation of the			رب	77
	waiver.			_		
	Findings were:			\mathbf{A}	meri	cans
	_	. #O		T	Init	ted
	Review of Condition	#2 revealed that the facility				

State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

State of	GA, Healthcare Facil	lity Regulation Division				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE : COMP	
		060-141	B. WING		03/1:	2/2012
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SUMMIT	MEDICAL ASSOCIA	1 = 5	DMONT RD, A, GA 30324	NE, SUITE 500-E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
U 135			U 135			
	three (3) months (Jafter hours calls rec responded to by a r the calls was in rega	cility's call log for the past anuary-March) revealed that eived from patients were being medical assistant. One (1) of ard to a patient (#9) seeking mptoms related to a two (2)				3
	revealed that the pa	cal record for patient #9 atient had a two (2) day ed an after hours call (1:25 for advise regarding symptoms			_	cans t ed

State of	GA, Healthcare Facil	ity Regulation Division				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		060-141	B. WING		03/1	2/2012
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
SUMMIT	MEDICAL ASSOCIA	1 = \	OMONT RD, A, GA 30324	NE, SUITE 500-E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
U 135	the patient talked wassistant (MA), who pain medication. The to the documentation physician and the patient not return to experienced contract patient's caregiver winstructions. An interview was compatient's caregiver winstructions. An interview was compatient's caregiver winstructions. An interview was compatient's caregiver was accelled a concerns/compliced procedure. Patients answering service particles then contact with patient's concerns with a contact pernarse and also confit the facility had not be confident with the contact pernarse and also confit the facility will have to all after hours cal receiving two (2) da Director will conductive to all after hours cal receiving two (2) da Director will conductive to all after hours cal receiving two (2) da Director will conductive to all after hours cal receiving two (2) da Director will conductive to all after hours cal receiving two (2) da Director will conductive to all after hours cal receiving two (2) da Director will conductive to all after hours cal receiving two (2) da Director will conductive to all after hours cal receiving two (2) da Director will conductive the contact pernare t	dure. The record indicated that ith employee #2, a medical instructed the patient to take the medical assistant, according on, spoke with the patient's hysician suggested that the other facility unless the patient etions. The MA called the with the physician's Inducted at 1:55 p.m. on your call center with the interviewee related that assigned to receive after hours argency calls and calls related eations with the two (2) day were instructed to call the shone number. The answering ted employee #2 to follow up rns. The Administrator stated as a medical assistant. In ministrator related that he/she hours calls if the medical vailable. In a later interview at 2, the Administrator confirmed son for patient #9 was not a firmed that after hours calls for been assigned to a nurse. Decived from the facility 1/12/12: Effective immediately, a Registered Nurse to respond that from patients who were your conducts. The Medical training on 03/13/12 to	U 135	A		cans
State of GA	Inspection Report	ity protocols were followed				LLU
STATE FOR			6899	S25011 f) f continua	ted tion here 4

PRINTED: 10/24/2019

FORM APPROVED

State of	GA, Healthcare Facil	lity Regulation Division				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		OOM LETED	
		060-141	B. WING		03/12/2012	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, S	TATE, ZIP CODE		
SUMMIT	MEDICAL ASSOCIA	. I – ×	EDMONT RD, 'A, GA 30324	NE, SUITE 500-E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIEMENCY)	ULD BE COMPLETE	
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	nspection Report		6800	225044	orLife	
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State of	GA, Healthcare Faci	lity Regulation Division			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		060-141	B. WING		04/19/2012
NAME OF I	PROVIDER OR SUPPLIER	PTREET AD	DBECC CITY C	TATE ZID CODE	•
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE	
SUMMIT	MEDICAL ASSOCIA	\ I E \	A, GA 30324	NE, SUITE 500-E	
	CUINANA DV CT		<u> </u>		DN
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL	f x
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	
				DEFICIENCY)	
U 000	INITIAL COMMENT	-S	U 000		
5 555	THE COMMENT				
	At the time of the si	urvey, Summit Medical			
		compliance with Chapter			
		d Regulations for Ambulatory			
	Surgical Treatment				
					Clyu
					San
					mericans
				T	Initad
					Inited
State of GA	Inspection Report		1	C	I C
_ABORATOR`	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	TITLE	or Life

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SUMMIT MEDICAL ASSOCIATES

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

SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION מו (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) U 000 Initial Comments. U 000 U 000 INITIAL COMMENTS At the time of the survey, Summit Medical Summit Medical Associates strives to provide quality, Associates was not in compliance with Chapter compassionate care to our patients. The care and safety 111-8-4, Rules and Regulations for Ambulatory of our patients is of utmost priority and as such, Summit Surgical Treatment Centers, as the result of a Medical Associates endeavors to meet all standards set forth by the Georgia Department of Community Health. State licensure survey. The following deficiencies Summit Medical Associates welcomes the opportunity to were written as the result of that survey. address these deficiencies by implementing the following corrective actions: U1007 111-8-4-.10(g) Physical Plant and Operational U1007 U1007 SS C Standards. PHYSICAL PLANT AND OPERATIONAL STANDARDS All procedure rooms shall be constructed. CORRECTIVE ACTION equipped, and maintained to assure the safety of Maintaining a clean and safe environment has always been a patients and personnel. 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 This RULE is not met as evidenced by: new surgical center was built out upstairs. Plumbers have Based on the facility policy and procedures. had to make numerous visits, removing ceiling tile to access observation and staff interview, it was determined the plumbing pipes overhead. In some instances, the ceiling that the facility failed to maintain construction and tiles were chipped in the process. The building management equipment to assure the safety of patients and was notified and was working closely with the facility to replace the tiles. personnel. A meeting was held with the janitorial service representative to stress that a higher level of overall cleaning Findings were: must be delivered per contract. The janitorial closet was better organized to reduce clutter. A new ultrasound machine will be ordered. Review of the facility policy entitled Title: The small section of chair rail on the wall outside of exam Sanitation Policy For The Procedure Room Suite. room #2 has been caulked and repainted. Policy Number: Nurs 10082-D, reviewed 1/4/2013 The staff has been in-serviced to properly cover all opened revealed that acceptable sanitation techniques supplies, and to discard any stained linen. The cardboard covering the vent in the biohazard was would be used by all personnel to reduce the immediately removed. possibility of infection to patients and staff. The intubation set up tray has been placed in a covered Further review of the policy reveled that horizontal container. surfaces of tables, equipment, overhead lights Going forward, the Administrator and DON or OR and other ceiling and wall mounted equipment Supervisor will conduct a weekly facility inspection and would be damp dusted with germicide. complete a newly developed Facility Inspection checklist that will cover all areas. The Administrator and During a tour of the facility's surgical suite Medical Director will conduct monthly Facility Inspections 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:

State of GA Inspection Report

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

STATE FORM

If continuation sheet 1 of 6

COMPLETED

07/18/2013

State of GA, Healthcare Facility Regulation Division

TITLE OF GIRL FIGURE	<u>.</u>
STATEMENT OF DEFICIENCIES	
AND PLAN OF CORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION	
A. BUILDING:	

(X3) DATE SURVEY COMPLETED

060-141

B. WING

07/18/2013

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

		1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FI REGULATORY OR LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
U1007	Broken ceiling tiles and cracks in the patie bathroom Dust in the pre-op room, the Janitorial close cluttered with soiled mops and pails TTe sonogram machine in the sono room cracked with large openings and chipped the keyboard The wall outside of exam room #2 was a lichair molding with exposed sharp wood. An uncovered cart with exposed sanitary in the vent in the Biohazard room was taped with cardboard The operating room supply cart was cover soiled/stained linen The intubation tray set up on the counter in patient's bay was covered with a chuck (laused to place under patients to absorb fluids/secretions) 1 rusted, dirty silver looking food tray wrap with aluminum foil Damaged ceiling tiles in the Recovery room The Assistant Administrator confirmed all findings.	was along broken napkins d off red with n a arge pad	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.	
SS C	111-8-415(2) Housekeeping, Laundry, M Sterile Supply. Laundry service shall be provided. Separa space and facilities shall be provided for receiving, sorting, and storing soiled laund 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	te ry, and	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 or 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 use 1 in 1 is facility. A copy of the in-service has been placed in the employee	3
; ;	observation, and staff interview, it was determined that the facility failed to mainta			training manual.	ted

State of GA Inspection Report

TO continuation sheet of 6





State of GA, Healthcare Fac	ility Regulation Divis	SION		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURV COMPLETED
	060-141		B. WING	07/18/20
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
		1874 PIE	DMONT RD. NE. SUITE 500-E	

NAME OF PROVIDER OR SUPPLIER SUMMIT MEDICAL ASSOCIATES SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 1874 PIEDMONT RD, NE, SUITE 500-E ATLANTA, GA 30324 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)			060-141		B. WING		07/18	3/2013
ATLANTA, GA 30324 (M4) ID SUMMARY STATEMENT OF DEFICIENCIES BY POLITION (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 Sulte, 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 facility's surgical sulte between 10:40 a.m. and 12:30 p.m. on 7/18/2013 with the facility Assistant Administrator (employee file #3), the surveyor observed laundry supplies in the laundry room revealed uncovered clean linen positioned max 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 stated that he/she stated 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	NAME OF	PROVIDER OR SUPPLIER		STREET AD				
### CACH BEFORENCY MUST SE PRECEDED BY FULL TAG TAG	SUMMIT	MEDICAL ASSOCIAT	ES					
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 a garbage can and soiled linen was positioned next to a garbage can and soiled linen was positioned next to a garbage can and soiled linen was positioned next to a garbage can end soiled linen was positioned next to a garbage can end soiled linen was positioned next to a garbage can end 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	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
asked if it was necessary to do so. The AMERICANS	U1501	Findings were: Review of the facility Sanitation Policy For Policy Number: Nurrevealed that accept would be used by all possibility of infection Further review of the linens, soiled or not bags and closed. During a tour of the between 10:40 a.m. with the facility Assistile #8), the surveyor the laundry room. The laundry room and Hammer detergy Assistant Administration products were used contaminated linens at the products used. I laundry room reveal positioned next to a was positioned next	y policy entitled Title: or The Procedure Roc is 10082-D, reviewed itable sanitation techn il personnel to reduce on to patients and sta e policy reveled that would be placed in la facility's surgical sult and 12:30 p.m. on 7 stant Administrator (er r observed laundry-si hose supplies include gent and Clorox liquic ator was asked if tho to wash the facility's and he/she stated the Further observation i ed uncovered clean garbage can and so to dirty linen. at 2:45 p.m. on 7/18/e Administrator (empl yas asked if the facilit linen, and he/she sta ered on site. The sked if he/she used aundry cleaning produ the facility's linens. that he/she did not,	om Suite, in 1/4/2013 niques e the aff. reusable aundry te repolies in ed Arm di. The se in the linen iled linen iled linen ty atted that ucts (for The	U1501	MONITORING The Administrator and DON will conduct week spot checks of the linen used in the facility. Any fails inspection will not be used. The Administ document results on the weekly Inspection Reprinclude any adverse findings in the Monthly Ad-	laundry that rator will ort and ministrator's	3
	j	Administrator was as	sked if he/she knew			I	nit	ed

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State of	GA, Healthcare Faci	ility Regulation Divisi	on				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		} ` '	FIPLE CONSTRUCTION (X3) DATI COM		'E SURVEY IPLETED		
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SUMMIT	MEDICAL ASSOCIAT	ES		DMONT RD, A, GA 30324	NE, SUITE 500-E		
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U1501	Continued From pa	ge 3	·	U1501			1
	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 of	confirmed all findings	i .				
U1503 SS C	111-8-415(4) Hou Sterile Supply.	sekeeping, Laundry,	Maint,	U1503	U1503 HOUSEKEEPING, LAUNDRY, MAINTEN STERILE SUPPLY	ANCE,	8/13/18
	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				CORRECTIVE ACTION A traffic cone (used by one the building worker inadvertently placed on the floor just inside the supply area. All staff has been in-serviced to be items out of place, and to keep such items out o room.	door of the	y
	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.			MONITORING Continued educational in-services on infection of staff will be conducted and results documented training logbook. Weekly and monthly inspect conducted by the Administrator and Medical Diffue Physical Plant Inspection Checklist complet compliance. Results will be documented in the Administrator's monthly report and sent to the Gody each month.	in the staff ions will be rector, and ed to ensure		
	Findings were:				-	•	•
a california	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.				ÇV.	C	
	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				Ar	neri neri	cans

area.
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State of GA, Healthcare Facility Regulation Division

STATEMENT OF	DEFICIENCIES
AND PLAN OF C	ORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION	
A. BUILDING:	

(X3) DATE SURVEY COMPLETED

060-141

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

Sommit Himbioan Accounting		ATLANTA, GA 30324			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
U1503	Continued From page 4		U1503		
	The Assistant Administrator confirmed the findings.	ne l			
U1600 SS C	111-8-416 Drug Storage and Dispensir	ıg.	01000 - 1	U1600 DRUG STORAGE AND DISPENSING	9/8/13

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 seg. and 31-7-1 et seg., 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.

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,

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State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY | COMPLETED | (X3) DATE SURVEY | (X4) DATE SURVEY | (X5) DATE SURVEY | (X6) DATE SURVEY | (X6) DATE SURVEY | (X7) DATE SURVEY | (X8) DAT

B. WING ______ 07/18/2013

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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

TIMMU	MEDICAL ASSOCIATES		A, GA 30324	NE, 5011E 500-E	
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U1600	Continued From page 5		U1600		1
	During an interview at 2:30 p.m. on the facility office, the facility Adminis (personnel file #7-interview only) stanurses should have disposed of the fluids at the end of the work day. The Administrator and the Assistant confirmed the findings.	trator ted that the bag of IV			
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PRINTED: 09/09/2013 FORM APPROVED State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 060-011 08/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 235 WEST WIEUCA ROAD ATLANTA WOMEN'S MEDICAL CENTER ATLANTA, GA 30342 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 000 Opening Comments V 000 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. Corrective Action: 8/28/13 The internal process for filing the Certificate of V 030 290-5-32-,03(1) Procedure for Filing Certificate of V 030 Abortion has been updated to include defined SS=A Abortion roles and responsibilities of staff members that will be held accountable for filing the certificates In addition to the medical records requirements of of abortion. Additional documentation has been added to ensure all abortion procedures have Chapters 290-5-6 and 290-5-33 of the Rules and been filed, including: Regulations of the Georgia Department of · An "ITOP Worksheet" to be used internally Human Resources, the physician who performs has been instituted and will be used by staff to the abortion shall file with the Commissioner of complete filing. Human Resources or designee, within ten · A column has been added to the Postanesthesia Care Unit (PACU) Log for staff to (10) days after an abortion procedure is indicate a completed submission/filing of each performed, a Certificate of Abortion. It is abortion procedure performed each day. expressly intended that the privacy of the patient shall be preserved and, to that end, the Staff Education: Certificate of Abortion shall not reflect the name Staff members responsible for filing the of the patient but shall carry the same facility certificates of abortion have been assigned number, or other identifying number reflected on responsibility for specific days of service (i.e. Wed. Thurs. Fri. Sat) and were trained on the the patient's medical records. A duplicate of the updated procedures and documents to ensure Certificate of Abortion will he made a part of the that all records are filed within the required 10 patient's Medical record and neither the aforesaid day time period. duplicate certificate nor the Certificate of Abortion which is filed with the Commissioner or his Monitoring: Daily PACU Logs will be reviewed under designee shall be revealed to the public unless supervision of Clinic Administrator within 10 the patient executes a proper authorization which days. Random chart reviews will continue to be permits such a release or unless the records conducted as part of the Quality Assurance must be made available to the District Attorney of process to ensure that "Proof of Filing" form is the Judicial Circuit in which the hospital or health included in medical chart. Staff members will be facility is located as provided by held accountable for any violations of the Policy for Filing Certificate of Abortion, including Code Section 16-12-141 (d) of the Official Code termination of duties, and possible termination of Georgia Annotated. of employment.

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

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Administrator



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PRINTED: 09/09/2013 FORM APPROVED State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 060-011 08/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 235 WEST WIEUCA ROAD ATLANTA WOMEN'S MEDICAL CENTER ATLANTA, GA 30342 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) V 030 Continued From page 1 V 030 Responsible Persons: Repealed: F. Dec. 18, 2012; eff. Jan. 7, 2013. Assigned Staff Members and Clinic Administrator This REQUIREMENT is not met as evidenced 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 the Commissioner of Community Health notification was 2. Patient #8, abortion was completed on the Commissioner of Community Health notification was

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Interview on 8/9/2013 at 6:30 p.m., the Administrator confirmed the findings.

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STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
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U 000	Initial Comments.	,	U 000		,	
	at Atlanta Women's compliance with Ch Regulations for Am Centers, as the res	survey conducted on 8/9/2013 s Medical Center, was not in napter 111-8-4, Rules and bulatory Surgical Treatment ult of a State licensure survey, encies were written as the	•			
U1005 SS=G	Entrances for patie public right-of-way unobstructed walky Handicapped patiel or otherwise impair center building with steps. A ramp with or steps may be uti requirement. A hard or driveway for use emergency fire or pleast one entrance right-of-way. The dibe immediately adjusted in the steps of the continuation of the contin	nts shall be connected to the by a hard-surfaced, vay in good repair. Ints confined to a wheel chair red shall be able to access the out climbing any stairs or handralls over existing stairs lized in meeting this d-surfaced, unobstructed road by ambulances or other colice vehicles shall run from at of the building to the public borway of such entrance shall accent to the road or driveway. The as evidenced by: Interior of the public portion, it was determined that the vide for handicapped patients lichair or otherwise impaired to without climbing any stairs or	U1005	Corrective Action: On Sept. 16, 2013, Administrator conta the property owner to notify it of the pa violation and request purchase of "No Parking" signage. On Sept. 17, 2013, a property owner representative sent rec purchase of signage to AWMC Clinic Administrator with expected delivery da Sept. 27, 2013. "No Parking" signage v installed, visible to the public, prohibitir parking that would block access to the In the event a vehicle parks illegally in spot, a towing company will be called t remove the vehicle. Staff Education: AWMC staff and contractors and first fl building tenants were notified of this pa enforcement regarding the striped area of the sidewalk ramp on Sept. 18, 2013 were informed that signage prohibiting in this area will soon be posted. Monitoring: AWMC Security Officer will report any parking violations to AWMC Clinic Administrator, who will notify property of to handle appropriately. Responsible Persons: AWMC Security Officer and AWMC Cli	rking a eipt of ate of vill be ng any ramp. that o oor arking a in front B. All parking	10/4/13
	two (2) parking spa	08/2013 at 9:00 a.m. revealed ces labeled with the blue ols (wheelchair) painted on the		Administrator .		Sis

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

Administrator WP1P11

TITLE



PRINTED: 09/09/2013 FORM APPROVED

State of GA, Healthcare Fac	ility Regulation vision	·	I ONW AFFINOVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING:	(X3) DATE SURVEY COMPLETED
	060-011	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

- ATLANT	A WOMEN'S MEDICAL CENTER 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	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		U1006	First Corrective Action: In order to ensure that AVVMC's lack of elevator access does not adversely affect patient safety or care, AVVMC 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.	(these are ongoing practices already in place prior to the inspection)
	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.	,	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.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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(X3) DATE SURVEY COMPLETED

060-011

B, WING

08/09/2013

NAME OF PROVIDER OR SUPPLIER

ATLANTA WOMEN'S MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

235 WEST WIEUCA ROAD ATLANTA, GA 30342

	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
U1006 U1502 SS=G	Interview on 08/09/2013 at 6:00 p.m., the Administrator acknowledged that there was not an elevator in the facility. 111-8-415(3) Housekeeping, Laundry, Maint.	U1006 U1502	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.	
	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.	•	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.	Unknown
	Interview on 8/8/2013 at 5:00 p.m., the Administrator confirmed the findings.		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.	

State of GA Inspection Report STATE FORM

Americans frontionalist sheet 3 of 5 United for Life

State of GA,	Healthcare	Facility	Regulation	Division
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION	
A. BUILDING:	

(X3) DATE SURVEY COMPLETED

060-011

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

	ATLANTA	, GA 30342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DÉFICIENCIES (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
U1502 SS=G	Interview on 08/09/2013 at 6:00 p.m., the Administrator acknowledged that there was not an elevator in the facility. 111-8-415(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	Monitoring: Legal Counsel & Administrator will continue monitoring progress of all administrative proceedings on this matter. Responsible Persons: Legal Counsel & Clinic Administrator 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
5	1	1	411	

State of GA Inspection Report

STATE FORM



PRINTED: 09/09/2013

FORM APPROVED State of GA, Healthcare Facility Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 060-011 08/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 235 WEST WIEUCA ROAD ATLANTA WOMEN'S MEDICAL CENTER ATLANTA, GA 30342 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) U1902 Continued From page 3 U1902 U1902 111-8-4-.19(3) Electrical Power. U1902 10/9/13 Corrective Action: SS=G AWMC will not provide (and do not currently Centers which utilize general anesthesia shall provide) general anesthesia, making the provide an emergency electrical system so generator rule inapplicable to the facility. controlled, that, after interruption of the normal AWMC has never provided general anesthesia. electric power supply, an acceptable auxiliary Staff Education: power source is available and capable of being Staff in-service scheduled for 10/9 to review brought into use within ten seconds with sufficient the proper terminology for the level/type of voltage and frequency to reestablish essential . anesthesia/sedation provided at the center, in-house services and other emergency which is IV sedation/MAC (monitored equipment needed to effect a prompt and anesthesia care) and/or local anesthesia. efficient transfer of patients to an appropriate Monitoring: licensed hospital, when needed. Clinic administrator will ensure that all policies and chart paperwork reflect the appropriate Authority O.C.G.A. Secs. 31-2-4 et seq. and terminology regarding type of anesthesia provided at the center. 31-7-1 et seq. Administrative History, Original Rule entitled "Electrical Power" was filed on Responsible Persons: January 22, 1980; effective March 1, 1980, as Administrator 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

State of GA Inspection Report

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.

STATE FORM



FORM APPROVED

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		060-011	B, WING		08/09/2013
	PROVIDER OR SUPPLIER A WOMEN'S MEDICA	A CENTER 235 WES	DDRESS, CITY, S T WIEUCA RO A, GA 30342	OAD .	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLETE
U1902	Continued From pa	age 4	U1902		·
	On 08/08/13 at 1:0 confirmed the finding	00 p.m., the Administrator ngs.			
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State of GA Inspection Report STATE FORM

State of GA, Healthcare Facility Regulation

689





Nathan Deal, Governor

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, Interim Program Director

Maisha Luchs

Acute Care Programs

Department of Community Health

Healthcare Facility Regulation Division

MF:rf







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, Maisha Suchs

Marsha Fricks, Interim Program Director

Acute Care Programs

Department of Community Health

Healthcare Facility Regulation Division

MF:rf



	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDING	7/41 1/411	TE SURVEY MPLETED
		044-287	B. WING	AFAID IT REG	8/07/2013
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY	STATE, ZIP CODE	90712013
CLIFF V	ALLEY CLINIC		F VALLEY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE AC ROALSHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
U 000	Initial Comments.		U 000		
Liveon	substantial compliar Rules and Regulation Treatment Centers, licensure survey. The written as the result			Corrective Action: Drug expiration removal and logging. The responsibility of checking all medications that is shared between all Registered Nurses on staff shall be included the shall be shall be included the shall be i	
	Each center shall prequipment and staff stored and administrated and Federal laws and Authority O.C.G.A. S 31-7-1 et seq Admi Rule entitled "Drug S filed on January 22, 1980, as specified by This RULE is not me Based on review of t procedures, observainterview, it was determined and staff and	Secs. 31-2-4 et seq. and nistrative History. Original Storage and Dispensing" was 1980; effective March 1, y the Agency. et as evidenced by: he facility's policies and tions during facility tour and ermined that the facility failed d medications were not	U1600	All Nurses are expected to check the area that they are assigned to (Presop (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.	
E	entitled Equipment and Policy to Prevent Transevised 09/2009, revenued to the checked for expiration by a full time register A tour of the facility was 16/2013 at 3:30 p.m.	s policies and procedures nd Supplies, and General nsmission of Infections, last ealed all medications were n dates on a monthly basis ed nurse. rith the Clinical Director on , revealed the following bired and available for		Amer	Sicans
of GA Ins	spection Report	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE CALL	(X6) DATE

Štate of	GA, Healthcare Fac	cility Real tion Division				: ub/28/20 APPROVE
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	LE CONSTRUCTION S:	(X3) DATE	SURVEY
		044-287	B. WING		08/0	7/2013
	PROVIDER OR SUPPLIER	1924 CLI	DDRESS, CITY, FF VALLEY A, GA 30329	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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	patient care use: 1) Exam room #2 is a. One (1) full box one Step test fecal to identify hidden b January 2013; and	n a locked wall cabinet: and one (1) partially full box of l occult blood packages (used lood in the stool), expired	U1600	Staff Education: Each Nurs return to clinic will receive a refresher inservice on	-	Started 81911 Comple 8116

to prevent surgical wound infections) expired

2) Operating room cart drawer, located in the

a. Three (3) boxes each containing Junior strength acetaminophen 160 mg tab (

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

b. Two (2) Normal Saline IV bags 500 ml (fluid

An interview was conducted in the facility's post-operative area between on 8/6/2013 at 3:10

given in the vein to prevent dehydration and/or to administer medication) expired on 04/1/2013.

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

pain reliever) expired on 8/5/2013; and

08/2002.

04/2013; and

post-operative area:

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



procedures.

)18 EC

_ State o	GA, Healthcare Fac	ility Reseation Division			PRINTED: FORM	: 08/28/20 APPROVE
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G:	(X3) DATE COMP	SURVEY
 .		044-287	B. WING		08/0	7/2013
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CLIFF V	ALLEY CLINIC	1924 CLIF	F VALLEY	WAY, NE		
			, GA 30329	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICIENCY)	DBE	(X5) COMPLETE DATE
V 000	Opening Comments	3	V 000	Upon further internal investig	ation,	8/10/
	At the time of the cu	rvey,Cliff Valley Clinic was		it was found that the comput	• •	
	not in compliance w	ith 290-5-32 Rules and		system used to file the Certif	i	
	Regulations for Per	formance of Abortion After the		of Abortion (ITOP forms) was	1	
		regnancy and Reporting		experiencing technical difficu		
	State licensure surv	ey. The following deficiency		due to system upgrades		
	was written as a res	ult of that survey.		intermittently between the da	ates	
V 030	290-5-32- 03(1) Pro	cedure for Filing Certificate of	V 030	of 1/25/13 to 3/27/13.		
SS=A	Abortion	cedure for Fining Certificate of	V 030	01 1/20/10 to 0/21/10.		914/1
	In addition to the me	dical records requirements of		Corrective Action: To ensure	е	יוריור
	Chapters 290-5-6 ar	nd 290-5-33 of the Rules and		compliance all employees		
	Regulations of the G	eorgia Department of		trained to submit ITOP forms	s shall	
	the abortion shall file	the physician who performs with the Commissioner of		cross reference all chart nun	nbers	
	Human Resources of	or his designee, within ten		with the pathology log and a	li i	
	(10) days after an al	portion procedure is		appointments listed as "kept	" in	
	performed, a Certific expressly intended to	hat the privacy of the patient		the computer system for eac	:h	
	shall be preserved a	nd, to that end, the		clinic day to be sure no char	t has	
	of the patient but sha	n shall not reflect the name		been left out for reporting.	£:	
	number, or other ide	ntifying number reflected on		Any patient's chart that need	s	
	the patient's medical	records. A duplicate of the		medical follow up shall have	the	
	patient's Medical rec	n will he made a part of the ord and neither the aforesaid		ITOP form submitted before	being	
	duplicate certificate r	nor the Certificate of Abortion		placed in the follow up area	for	
		Commissioner or his vealed to the public unless		Nurse or Physician.		
	the patient executes	a proper authorization which		Monitoring: For each clinic d	ay a	
	permits such a release	se or unless the records		form shall be completed to	CO	
	the Judicial Circuit in	ble to the District Attorney of which the hospital or health		document which charts have	had 4	2
Ī	facility is located as p	provided by		ITOP forms completed and a	(20)	ノ
	of Georgia Annotated	141 (d) of the Official Code		reason why a chart has not		

Repealed: F. Dec. 18, 2012; eff. Jan. 7, 2013.

TITLE

been reported.

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If continuation sheet 1 of 2

⁻State ŏ	f GA, Healthcare Fac	ility Remation Division				D: 08/28/2013 I APPROVE
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3:		E SURVEY PLETED
		044-287	B. WING_		08/	07/2013
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CLIFF V	ALLEY CLINIC		F VALLEY J. GA 30329	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED (CROSS-REFERENCED)	D BE	(X5) COMPLETE DATE
V 030	Continued From page	ge 1	V 030			
	by: Based on review of reviews, and staff in the facility failed to e Abortion was filed w of ten (10) patients. Findings: No Policy was identified to require of ten (10) safe ten (10) safe ten (10) safe ten (10) days. Medical Findings: Department within the (10) days. Medical Findings and was filed on date of abortion was Certificate of Abortio. The Clinical Manage	policy and procedure, medical terview it was determined that ensure that the Certificate of ith the Department for two (2) fied during the survey. ampled medical records (#'s 9 and 10) revealed that MR reveal evidence that the of Abortion was filed with the re regulatory timeframe of ten Record # 5's date of abortion the Certificate of Abortion Medical Record #7's and the n was filed on the control of the regulatory timeframe of ten Record # 5's date of abortion the Certificate of Abortion for the Cert		A quarterly inspection of daily shall be conducted by Admissions Supervisor to ensall Certificates of Abortion harfiled. Staff Education: All admission that are trained to submit ITO shall receive an inservice to rathe form to be filled out for eaclinic day and how to cross rethe chart numbers with the pathology log. Responsible Persons: Admissions Supervisor, and Odirector	sure ve beer ns staff P form: eview ach eference	9/4/
					Sin	3

State of GA Inspection Report STATE FORM

23OU11



13





Nathan Deal, Governor

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.

Marsha Fricks, Interim Program Director

tag- Chitan

Acute Care Programs

Department of Community Health

Healthcare Facility Regulation Division

MF:rf



Nathan Deal, Governor

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, R.N., Program Director

Acute Care Unit

Department of Community Health

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Healthcare Facility Regulation Division

MF:rf



PRINTED: 10/24/2019 FORM APPROVED

State of GA. Healthcare Facility Regulation Division

State of	GA, Healthcale Laci	ity Regulation Division				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		060-141			04/0	
		1			j 01/0	3/2013
	PROVIDER OR SUPPLIER	1874 PII	DDRESS, CITY, ST. EDMONT RD. N	ATE, ZIP CODE NE, SUITE 500-E		
SUMMIT	MEDICAL ASSOCIA	\	EDMONT RD, 1 FA, GA 30324	1E, 3011E 300-E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
U 000	INITIAL COMMENT	rs	U 000			
	At the time of the si Associates was in o 290-5-33, Rules an Surgical Treatment	urvey, Summit Medical compliance with Chapter and Regulations for Ambulatory Centers, as the result of tion #GA00119494.			S. Ameri Unit	
State of GA	 Inspection Report DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	MATURE	TITLE		
LADUKATUK	I DIVECTOR 9 OK EKOND	ENJOUFFLIER REFREDENTATIVE'S SIG	NATURE	IIILE	for I	

STATE FORM 6699 4FD411 If continuation sheet 1 of 1

PRINTED: 10/24/2019 FORM APPROVED

State of	GA, Healthcare Facil	lity Regulation Division			
AND DIAN OF CORRECTION INDESTRUCTION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		
		025-115	B. WING		02/14/2013
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE	
SAVANN	IAH MEDICAL CLINIC	CL	34th Street AH, GA 3140	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE COMPLETE
U 000	INITIAL COMMENT	-S	U 000		
U 000	At the time of the si was in compliance vand Regulations for	urvey, Savannah Medical Clinic with Chapter 290-5-33, Rules Ambulatory Surgical as the result of a State	U 000	A	SS mericans Inited
State of GA I	 Inspection Report 	ED/CLIDDLIED DEDDECENTATIVE'S CLONA	! TI IDE	TITLE £	or Life
LABURATUR	ו שואבטוטא א טא אמטעוטו	ER/SUPPLIER REPRESENTATIVE'S SIGNA	IURE	TITLE	UI L'ITE





Nathan Deal, Governor

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.

Marsha Fricks, Interim Program Director

tag- Chitan

Acute Care Programs

Department of Community Health

Healthcare Facility Regulation Division

MF:rf



PRINTED: 10/15/2019 FORM APPROVED

State of	State of GA, Healthcare Facility Regulation Division					
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		060-011	B. WING		C 04/16/2013	
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
ATLANT	A WOMEN'S MEDICA	AL CENTER	EST WIEUCA R NTA, GA 30342	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE	
U 000	Medical Center was 290-5-33, Rules an Surgical Treatment	urvey, Atlanta Women's in compliance with Chapter and Regulations for Ambulator Centers, as the result of tion #GA00123252.			SS mericans Jnited	
State of GA I	 nspection Report					
_ABORATOR\	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	or Lafe	

PRINTED: 10/07/2014

HEALTHCARE FACILITY REGULATION APPROVED DIVISION

<u>State of GA, Healthcare Fac</u>	<u>ility Regulation Division</u>
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER

AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING: _

OCT 1 0 2014

(X3) DATE SURVEY COMPLETED

044-287

B. WING

RECEIVED

09/24/2014

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CLIFF VALLEY CLINIC

1924 CLIFF VALLEY WAY, NE

CLIFF W	ATLANT	ra, 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
∨ 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.		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	09/25/14
V 030 SS=F	290-5-3203(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 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 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 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.	of d	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.	SS
	Repealed: F. Dec. 18, 2012; eff. Jan. 7, 2013.			400

State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDEN SUPPLIER REPRESENTATIVES SIGNATURE

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State of	GA Healthcare Faci	lity Regulation Division			FORM	APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		044-287	B. WING		09/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CLIEEV	ALLEY CLINIC	1924 CLI	FF VALLEY V	WAY, NE		
OLII I V	ALLEI GLINIG	ATLANTA	, GA 30329			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 030	This REQUIREMENT by: Based on record refacility failed to ensive Abortion was filed with the policy evidence of a Policy evidence of a Policy evidence of a Policy evidence of Abortion as evidence that the Cowith the Department imeframe of ten (1). Review of patient # abortion as evidence of that the filed with the Department imeframe of ten (1). Review of patient # abortion as evidence of that the filed with the Department imeframe of ten (1). Interview conducted Manager on 9/23/20 certificate was a two second page which	NT is not met as evidenced view and staff interview the ure that the Certificate of vith the Department for two (2) of ten (10) patients. y manual revealed no y addressing filing of on. 4, revealed the date of however there was no erificate of Abortion was filed at within the regulatory 0) days. 7, revealed the date of however there was no e Certificate of Abortion was the control of the co	V 030	Responsible Persons: Lead Health Educator, Quality Care Team Leader, and Clinic Director.		

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State of GA. Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLÉTED A. BUILDING: B. WING 044-287 09/24/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1924 CLIFF VALLEY WAY, NE **CLIFF VALLEY CLINIC** ATLANTA, GA 30329 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) U 000 U oool Initial Comments. Corrective Action: A State re-licensure survey was conducted on Each sterilized instrument found to be out 09/25/2014 September 22, 2014. Cliff Valley Clinic was not in dated was removed from the container. substantial compliance with Chapter 111-8-4, Rules and Regulations for Ambulatory Surgical recleaned and sterilized in the autoclave. Treatment Centers. The following deficiencies All instruments are to be checked every were cited. Tuesday for expirations. Any instrument that is found to be due to expire that week U1026 U1026 111-8-4-.10(m) Physical Plant and Operational will be pulled, cleaned, sterilized and SS=D Standards. correctly marked with date completed. date of expiration, initials of person Equipment for sterilizing instruments and supplies shall be conveniently located and of adequate completing and autoclave machine used. capacity for the workload. Records shall be Documentation will also be recorded on maintained to assure quality control, including instrument cleaning log. date, time and temperature of each batch of Staff Education: sterilized supplies and equipment. All Health workers will be retrained on 10/18/2014 This RULE is not met as evidenced by: weekly duties and reminded of Based on record review and interview the facility importance of checking all instruments failed to ensure sterilized speculum instruments especially those instruments that are not were not expired, and that expired sterilized in regular use. instruments were not stored with unexpired sterilized instruments. Monitoring: Findings include: Quality Care Team member will be Observation on 9/23/14 at 12:00 p.m., with the assigned to check all instruments monthly Clinical Director and Health Advocate of the clean for compliance and will report any issues sterile room revealed fifteen (15) sterile wrapped of noncompliance to Team Leader and instruments in a sterilized container of which three (3) speculum instruments, dated 6/19/14. Health Worker Supervisor. 8/1/14 and 9/16/14 respectively were expired. Responsible Persons: Review of the facility's Central Log revealed Health Worker Supervisor. three (3) expired speculum instruments. Quality Care Team Leader and Clinic Interview on 9/23/14 at 12:30 p.m. in the Director sterilization clean room with the Health Advocate who confirmed the above findings. U1027 111-8-4-.10(n) Physical Plant and Operational U1027 SS=C Standards.

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LABORATORY DIRECTOR'S OR PERFORMANDER REPRESENTATIVE'S SIGNATURE

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State of	GA. Healthcare Faci	lity Regulation Division			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l , .	E CONSTRUCTION	(X3) DATE COMPI	
		044-287	B. WING		09/2	4/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CLIFE V	ALLEY CLINIC		F VALLEY V	VAY, NE		
OLII (7	ELL! OLINO	ATLANTA	, GA 30329			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
U1027	Continued From pa	ge 1	U1027	Corrective Action:		
	Medicines shall be located cabinet with persons shall have	stored in a conveniently I lock, and only licensed		Bin containing normal saline IV fluoremoved from medical suite storage closet and locked cabinet in aftercare until nufor storage closet can be obtained Facilities.	placed in ew key	09/25/14
	Based on interview failed to ensure me only licensed perso Findings include:	and observation, the facility dications were secured with		Once replacement key is obtained fluids will be returned to medical storage closet, closet will be locked key will be placed on key ring for medication access and placed in locker with Nurse access only.	suite ed and	, 10/11/14
	entitled 'Medication reviewed 11/2013, t medications must b locked medication of (if they are a contro	Policies and Procedures', last revealed that upon receipt, all be immediately stored in cabinets, the narcotics cabinet fled substance), or in the are a medication which		Staff Education: All nurses will be instructed on whe key opens medical suite storage and instructed to open and lock cas they do with all medication sto areas and return key to secure lo	closet, loset rage	10/18/14
	accompanied by the revealed the followi an unlocked storag Room Suite:	3/2014 at 12:20 p.m., e facility's Administrator ng unsecured medications in e cabinet in the Operating	·	the end of shift. Monitoring: Upon closing at end of day, RN o will assure that all cabinets and c are locked. Quality Care team monitoring.	losets ember	
	(Normal Saline) 100 At the time of the di acknowledged that	nultiple bags of 0.9 NaCL. 00 ml (intravenous fluid). scovery the Administrator the storage cabinet was kept ensed staff had access to it.		will be assigned task of checking suite for compliance and report to Director any discrepancies or unle areas. Responsible Persons:	Clinic	C
U1104	111-8-411(5) Pers		U1104	All Registered Nurses on schedul Care Team, and Clinic Director.	e, Qualit	3

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There shall be a separate personnel folder maintained for each employee. This file shall





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NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE, ZIP CODE	
	044-287	B. WING	09/24/2014
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING;	(X3) DATE SURVEY COMPLETED
<u> </u>	IIIY Regulation Division		

	ALLEY CLINIC 1924 CLIN	FF VALLEY 1 , GA 30329	STATE, ZIP CODE WAY, NE	
(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
U1104	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	09/29/201
U1600 SS=F	111-8-416 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	Director	Sican

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		044-287	B. WING		09/24/2014		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CUEE V	ALLEY CLIMIC	1924 CLIF	F VALLEY V	VAY, NE			
CLIFF VA	ALLEY CLINIC	ATLANTA	GA 30329				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO- DEFICIENCY)	D BE	(X5) COMPLETE DATE	
U1600	Continued From pa	ge 3	U1600	Corrective Actions:		09/25/14	
	1980, as specified b			All expired medications removed	s removed and		
	1300, as specified t	by the Agency.		discarded according to DEA regul			
		net as evidenced by:		Medication expiration log reviewe			
		the facility's policies and		RN that signed off as checking all	s checking all		
		servations the facility failed to medications were not		medications on September 18th, 2	-		
		t's use; multidose medications		been relieved of duties and will no longer			
		facility policy; single dose		be working at clinic.			
	medication was discarded per medication label,			Policy for checking medications ha	s has been nedications		
		were accurate per facility					
	policy. Findings include:			at least 30 days before they are d	re due to		
				expire and all medications that are	e on		
	9			anesthesia cart but not in regular use will			
	Review of the facility's policies and procedures			be removed from carts and stored in			
		Policies and Procedures', last revealed the following:		aftercare cabinet and	ercare cabinet and		
	Tevieweu 11/2013, i	evealed life following.		marked as "Emergency Anesthes	as "Emergency Anesthesia Drugs"		
	All medications are checked for expiration			Staff Education:			
		basis by the full time RN or a nic Administrator, with the		All RNs will receive an additional	copy of		
				updated medication policy and the	•		
	checked by a Nurse	lied drugs, which must be		importance of careful monitoring v	vill be		
	Chocked by a Harst	. .		stressed.			
		medications must be		Monitoring:			
		in locked medication cabinets.		Quality Care Team members will			
	the narcotics cabinet (if they are a controlled substance), or in the refrigerator (if they are a			assigned tasks of checking expire	d		
		equires refrigeration).		medication log sheet monthly for			
				documentation of monthly check a			
		emaining in a multi-dose vial		monthly check of supplies. Will report to			
	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.			Quality Care Team leader any			
				discrepancies and Health Worker			
				Supervisor of any items that need	to be	8	
				ordered.		2)	

State of GA Inspection Report

Observation on 9/23/14 at 12:30 p.m. with the Clinic Administrator revealed the following

medications were expired and available for

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supplies.

Clinic Director will perform random

quarterly checks on medications and

State of GA, Healthcare Facility Regulation Division						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
044-2		044-287	B. WING		09/24/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, (STATE, ZIP CODE	_	-
CLIFF V	ALLEY CLINIC		F VALLEY V , GA 30329	NAY, NE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
U1600	Continued From pa	ige 4	U1600			
	patient care use:			Responsible Persons:		
	•	!	All RNs on schedule, CRNA, Qu Team Leader, Clinic Director		ality Care	
	On the Crash Can i	located in the Operating Suite:				
		al Saline fluid bags expired				
	on 9/1/14 x 2. 2. Vial of Solumedr	ol expired 8/1/14 x 1.				
	3. Ampoule of Neo-	-Syneprine HCL				
	(Phenylephrine Hyd 1 ml x 1.	drochloride) expired on 8/1/14				
		chloride 1 mg expired				
	September 1, 2014 x 1.					
	In the anesthesia ca	art in Operating Room 2				
	1. Neo-Syneprine H Hydrochloride) 1 ml	HCL (Phenylephrine I X 4 ampoules expired on				
	8/1/14.					
	expired 8/14	hylprednisone one 500 mg vial				
		multiple dose vial of Atropine dication of opening date per	:			
	In the narcotics cab	oinet in the recovery area:				
	expiration date 8/20	ngle dose vial of 250 mcg 115 opened, with no indication ded in narcotic count.				
	2. Ketamine HCL m opened marked open	oultiple dose 500 mg/10 ml vial ened '7/22'.			-0	<u>C</u>
	3. Xanax 1 mg table	ets count discrepancy.			S	S
		very of the above items, the acknowledged the findings.		Δ	mei	icane

State of GA Inspection Report STATE FORM

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State of	GA, Healthcare Facil	lity Regulation Division			_	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		060-011	B. WING		06/12/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
ATLANT	ATLANTA WOMEN'S MEDICAL CENTER 235 WEST WIEUCA ROAD ATLANTA, GA 30342					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
V 000	Opening Comments	s	V 000			
V 000	At the time of the si Medical Center was 290-5-32, Rules an of Abortions After the	urvey, Atlanta Women's in compliance with Chapter d Regulations for Performance he First Trimester of Pregnancy uirements For All Abortions.	V 000			
					mericans Inited	
State of GA	nspection Report					
_ABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	or Life	

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		060-011	B. WING		06/12/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET AN	DRESS CITY	STATE, ZIP CODE		
		235 WEST	WIEUCA R			
ATLANT	A WOMEN'S MEDICA	L CENTER .	, GA 30342			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
U 000	Initial Comments.	•	U 000	HEALTHCARE FACILITY RI	G.	
	AMENDED 2567			,		
	(GA00136570) was	complaint investigation conducted on 6/12/2014, ledical Center was not in		JUL .2 2 2014		
:	compliance with Ch Regulations for Am	napter 111-8-4, Rules and ibulatory Surgical Treatment ing deficiencies were cited:		RECEIVED		
U1025 SS G	111-8-410(I) Phys Standards.	ical Plant and Operational	U1025	AWC responded to this deficiency in a pla corrections submitted on July 7, 2014. A c plan of correction, to which AWC has not	opy of that	
	such a manner as	e arranged and organized in to ensure the comfort, safety, nd dignity of patients treated	1	a response, is incorporated herein by refe	rence.	
	Based on observat	net as evidenced by: ion and staff interview the ure patient safety related to			, 	
	Findings include:		• • • • • • • • • • • • • • • • • • •			
		uipped with a glucometer blood sugar) and the only test re expired.				
	the observation con and that the machi	Director of Nursing following nfirmed the strips were expired ne was for single patient use for multi-patient use.			-CC	
U2100 111-8-421 Advertising. SS A		ising.	U2100	AWC responded to this deficiency in a plate corrections submitted on July 7, 2014. A corrections submitted on July 7, 2014.	copy of thet	
	ambulatory surgical the full name of the	the services provided in or by al treatment center shall include e center and its Georgia license		plan of correction, to which AWC has not a response, is incorporated herein by refe		
State of GA Inspection Report LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE						
Vtoc	es C. Y	ATTACON LINE WELLESEN IN HIVE S SIC		Administrato	Or/hife	
SIAJEFOR	91 //	•	6899	JYCZ11	If continuation sheet 1 of 2	

PRINTED: 07/08/2014 FORM APPROVED State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: **B. WING** 060-011 06/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 235 WEST WIEUCA ROAD ATLANTA WOMEN'S MEDICAL CENTER ATLANTA, GA 30342 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) U2100 Continued From page 1 U2100 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.

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State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C 060-011 B. WING 06/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 235 WEST WIEUCA ROAD ATLANTA WOMEN'S MEDICAL CENTER ATLANTA, GA 30342 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) U 000 Initial Comments. U opa **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: July 18, 2014 U1005 111-8-4-.10(e) Physical Plant and Operational The cited rule requires "access to the center building U1005 SS G Standards. 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 Entrances for patients shall be connected to the access between the floors of the building, and DCH public right-of-way by a hard-surfaced, has not previously indicated that this rule might require unobstructed walkway in good repair. an elevator between the floors of AWMC's building. Handicapped patients confined to a wheel chair AWC is addressing its lack of an elevator by taking the or otherwise impaired shall be able to access the corrective actions listed below in response to U1006. 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 State of GA Inspection Report LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 060-011 06/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 235 WEST WIEUCA ROAD ATLANTA WOMEN'S MEDICAL CENTER ATLANTA, GA 30342 PROVIDER'S PLAN OF CORRECTION **SUMMARY STATEMENT OF DEFICIENCIES** (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY U1005 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. **Immediate** First Corrective Action: U1006 111-8-4-.10(f) Physical Plant and Operational U1006 (these are In order to ensure that AWMC's lack of elevator SS G Standards. ongoing access does not adversely affect patient safety or practices care, AWC will comply with the following policies Ambulatory surgical services provided in aiready in and procedures: place prior to multistory buildings shall be accessible by an Patients who receive IV sedation will be the inspection l elevator of adequate size to accommodate date a accompanied to the center by a personal escort. standard wheeled litter patient and two Following her procedure, a patient receiving IV attendants. A stairway or ramp of adequate sedation will be escorted down the stairs by her dimensions shall be available for transfer of a personal escort and a clinic staff member. patient in case of power failure. 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. This RULE is not met as evidenced by: Patients who have not received IV sedation but who Based on observations and staff interview, it was have been determined to need assistance to safe'v determined that the facility failed to provide an navigate the stairs will also be escorted down the stairs elevator for patient transport to the second(2nd) by a clinic staff member.

State of GA Inspection Report

State of GA, Healthcare Facility Regulation Division

If continuation sheet, 2 of 5

State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING 060-011 06/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 235 WEST WIEUCA ROAD ATLANTA WOMEN'S MEDICAL CENTER ATLANTA, GA 30342 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY If a patient must be transferred to another facility, the U1006 | Continued From page 2 U1006 clinic administrator or a designee will call the ambulance floor Ambulatory Surgery Center. 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 Findings include: the second floor and that access to AWMC is via a stairway. Such notification will be documented in Observation on 06/11/2014 at 9:00 a.m. revealed patient appointment notes. two (2) parking spaces labeled with the blue The center will maintain in its file a statement signed i handicapped symbols (wheelchair) painted on the by its current medical director that in his/her medical : pavement. Continued observations revealed a judgment, walking down stairs following surgery ramp that was level with the pavement and the presents minimal, if any, risk to the patient. sidewalk located between the entrance of the Staff Education: facility and another office. The facility was Staff Meeting for review of procedures scheduled on located on the second (2nd) floor, there was a 7/23/14. Monitoring: front patient and visitor entrance accessible by climbing 19 stairs. There was no elevator in the Administrator will perform periodic quality assurance checks to ensure policies are being followed. facility. Responsible Party: Administrator Interview on 06/11/14 at 10:20 a.m., the Second Corrective Action: Jnknown as to Administrator acknowledged that the facility did From the time this facility was first licensed in 1994 the administrative not have an elevator. until 2012, the Department continuously granted AWC proceedings. variances from the elevator requirement. The most March 16, 201 Interview on 06/12/14 at 10:15 a.m., the Clinical recent of those variances expired in 2012. AWC made the date on Coordinator confirmed that the patient and visitor several attempts to renew those variances, but the which AWC's entrance had 19 stairs and that there was no requested Department denied our applications. Accordingly, we elevator in the facility. have undertaken to install an elevator in the building: one-year We have retained an architecture firm, prepared variance would construction drawings, sought permitting and applied expire) as to Observation on 06/12/14 at 3:00 p.m., a back for the necessary loan funds. In addition, on installation of staircase which the Administrator confirmed was March 17, 2014, we applied for a temporary one-year the elevator. used by staff or emergency personnel when variance to allow us to continue operations while transferring patients. This staircase also had 19 installing the elevator. On July 7, 2014, AWC requested steps. 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 U1025 111-8-4- 10(I) Physical Plant and Operational U1025 SS G Standards. 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 The center shall be arranged and organized in settlement conference with the Department in an such a manner as to ensure the comfort, safety, attempt to reach a suitable resolution agreeable to all hygiene, privacy, and dignity of patients treated

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therein.

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State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING: COMPLETED C 060-011 B. WING 06/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 235 WEST WIEUCA ROAD ATLANTA WOMEN'S MEDICAL CENTER ATLANTA, GA 30342 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) U1006 Continued From page 2 U1006 Our plan for compliance is to pursue all of these avenues with the goal of installing an elevator in the floor Ambulatory Surgery Center. building while continuing to provide services. Staff Education: Findings include: Staff will be appropriately notified of decisions resulting from the pending administrative proceedings and any Observation on 06/11/2014 at 9:00 a.m. revealed changes that may be implemented as a result of such two (2) parking spaces labeled with the blue decisions. handicapped symbols (wheelchair) painted on the Monitoring: pavement. Continued observations revealed a Legal Counsel & Administrator will continue ramp that was level with the pavement and the monitoring progress of all administrative proceedings sidewalk located between the entrance of the on this matter. Responsible Persons: facility and another office. The facility was Legal Counsel & Clinic Administrator 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. U1025 111-8-4-.10(I) Physical Plant and Operational July 10, 2014 AWC responded to this deficiency in a plan of U1025 SS G corrections submitted on July 7, 2014. A copy of that Standards. plan of correction, to which AWC has not yet received a response, is incorporated herein by reference 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. State of GA Inspection Report

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PRINTED: 07/08/2014 FORM APPROVED State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B WING 060-011 06/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 235 WEST WIEUCA ROAD ATLANTA WOMEN'S MEDICAL CENTER ATLANTA, GA 30342 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) U1025 Continued From page 3 U1025 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. ່ວົນໄຈ 11, 2014 U2100 111-8-4-.21 Advertising. AWC responded to this deficiency in a plan of U2100 SS A corrections submitted on July 7, 2014. A copy of that plan of correction, to which AWC has not yet received Any advertising of the services provided in or by a response, is incorporated herein by reference. 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 seg. 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, .

State of GA Inspection Report

Findings include:

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State of	GA, Healthcare Faci	ility Regulation Division			1 ORMAN I NOVED
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	: At the time of the si Medical Center was 290-5-32, Rules an	urvey, Atlanta Women's in compliance with Chapter d Regulations for ortions After the First ancy and Reporting			
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tate of GA I	en ("	ER/SUPPLIER REPRESENTATIVE'S SIG		TITLE Administratos	fortalist
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Nathan Deal, Governor

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, R.N.

Program Director Acute Care Unit

Department of Community Health

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Healthcare Facility Regulation Division

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State of GA. Healthcare Facility Regulation Division.

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	A State re-licensure	STILVEN MAS C	onducted on May					
	13, 2015. Atlanta V							
	compliance with Ch							
	Regulations for Aml							
	Centers. No deficier	ncies were cite	ed.					
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State of	GA, Healthcare Facil	lity Regulation Division				
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	Δ re-licensure surve	ey was conducted on 4/16/15,				
		Clinic was in compliance with				
		Rules and Regulations for				
		ortions After the First Trimester				
		Reporting Requirements For All				
	Abortions.					
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State of GA I	nspection Report		<u> </u>			
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State of GA, Healthcare Facility Regulation Division (X2) MULTIPLE CONSTRUC (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING 025-115 04/16/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER RECEIVED 120 East 34th Street SAVANNAH MEDICAL CLINIC SAVANNAH, GA 31401 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4):ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) U 000 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. U1007 111-8-4-.10(g) Physical Plant and Operational U1007 SS=D 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 State of GA Inspection Report LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 6666

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State of	GA, Healthcare Fac	ility Regulation Division			
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		025-115	B. WING		04/16/2015
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	equipment.				
	equipment.	y			
	administrator confir verbalized that "the	015 at 12:35 p.m.with the med the findings, she tape is intended to hold the			
	heavy."	cause, some patients legs are	10 (c)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
U1023 SS=D	111-8-410(j) Phys Standards.	ical Plant and Operational	U1023	and look	15 5/15/15
		hall be stored in accordance the National Fire Protection		(2) & cylinder D/ have been purchase	Cats Cats
	Based on observati interview the facility	net as evidenced by: ion, record review and refailed to ensure proper of four (4) medical gas anks).	Q	(2) 2 cylinder D/ axygen Cylinder have been purchase accommodated and 4 gas cylinders. policy has been i	secure A- written
	Findings include:			to addicess stotage	= 여
¥	2:45 p.m accompar employee # 1 revea	4/2015 between 1:30 P.M. and nied by the Adiminstrator and aled four (4) of four (4) small rs located in the administrators ened door.	Sp. 18p,	all gascylindess i Revision date.	
	Environment Mainte revision date, failed cylinders.	titled, "Policy for Physical enance" no policy number or to address storage of gas			83
		015 at 2:45 P.M. with the			
	Administrator comfi	rmed the finding.		Λ :	nericans
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FORM APPROVED State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 025-115 04/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 East 34th Street SAVANNAH MEDICAL CLINIC SAVANNAH, GA 31401 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) U1027 U1027 Continued From page 2 All medicines will be U1027 111-8-4-.10(n) Physical Plant and Operational U1027 SS=F Standards. the second second second 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 access. 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

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State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 025-115 04/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 East 34th Street SAVANNAH MEDICAL CLINIC SAVANNAH, GA 31401 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) U1236 Continued From page 3 U1236 U1236 111-8-4-.12(6) Records. U1236 SS=D 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.

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	lity Regulation Division (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025-115		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/16/2015
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V 000	Savannah Medical Chapter 290-5-32, Performance of Abo	s ey was conducted on 4/16/15, Clinic was in compliance with Rules and Regulations for ortions After the First Trimester Reporting Requirements For All	V 000		
	Abortions				
	1		ing nggappagan nggapang nggapang nggapang		SS Americans
State of GA In ABORATORY	nffer_	ER/SUPPLIER REPRESENTATIVE'S SIGN		TITLE REPLE	If continuation sheet 1 of 1

State of	<u>GA, Healthcare Faci</u>	lity Regulation Division			
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		025-115	B. WING		C 07/21/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE	
SAVANN	IAH MEDICAL CLINIC	6.	34th Street AH, GA 3140	01	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
U 000	was in compliance of and Regulations for Chapter 111-8-4, R Ambulatory Surgica result of complaint i	urvey, Savannah Medical Clinic with Chapter 290-5-32, Rules Performance of Abortions and ules and Regulations for al Treatment Centers, as the investigation number deficiencies were cited.	U 000	A	\$3 mericans Inited
State of GA I	nspection Report	ER/SUPPLIER REPRESENTATIVE'S SIGNA'	TURF	TITLE	or Lxpfe
	DIVEGLOUS ON ENOUD	E.VOO. FEIER REFREDENTATIVE O SIGNA	IONE	IIILL	UI LIIT

State of	GA, Healthcare Fac	ility Regulation Division				
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:			
		044 297	B. WING		07/2	
		044-287	<u> </u>		0712	21/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CLIFF VA	ALLEY CLINIC		F VALLEY V , GA 30329	VAY, NE		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
		,		DEFICIENCY)		
U 000	Initial Comments.		U 000			
		urvey, Cliff Valley Clinic was in napter 111-8-4, Rules and				
		ibulatory Surgical Treatment				
	Centers, as the res	sult of complaint investigation				
	#GA00153117. No	deficiencies were cited.				
					Cli	Ó
					Con	D
					-U.	
				A	meri	cans
				¥.	T •	1

State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

State of	<u>GA, Healthcare Fa</u> cil	lity Regulation Division			
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER	s. I	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		060-011	B. WING		C 07/21/2015
NAME OF F	PROVIDER OR SUPPLIER	STF	REET ADDRESS, CITY, S	STATE, ZIP CODE	
ATLANT	A WOMEN'S MEDICA	AT CENTER	5 WEST WIEUCA F LANTA, GA 30342		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
U 000	Center was in comp Rules and Regulation Treatment Centers	ey, Atlanta Women's Med bliance with Chapter 111- ons for Ambulatory Surgi as the result of complain er GA00153112. No ted.	·8-4, cal		\$3 Americans United
State of GA I _ABORATOR\	nspection Report / DIRECTOR'S OR PROVIDI	ER/SUPPLIER REPRESENTATIVE	'S SIGNATURE	TITLE	for Life
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State of	GA, Healthcare Faci	lity Regulation Division			
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NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE	
SUMMIT	MEDICAL ASSOCIA	TES 1874 PIEI		NE, SUITE 500-E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTIES OF T	D BE COMPLETE
U 000	Associates was in s Chapter 111-8-4, R Ambutory Surgical	urvey, Summit Medical substantial compliance with ules and Regulations for Treatment Centers, as the nvestigation #GA153119. No ted.	U 000	DEFICIENCY)	
					mericans Inited
State of GA I	Inspection Report	ED/OLIDALIED REPORTED TO THE STATE OF			
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State of	<u>GA, Healthcare F</u> aci	lity Regulation Division			
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
SUMMIT	MEDICAL ASSOCIA	\ I = \	DMONT RD, A, GA 30324	NE, SUITE 500-E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
	14, 2015. Summit I compliance with Ch	urvey was conducted on April Medical Associates is in napter 111-8-4, Rules and bulatory Surgical Treatment ncies were cited.			
State of GA I	nspection Report			U	SS mericans Inited
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State of GA. Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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V 000	Opening Comment	ts	V 000			
V 000	At the time of the s Medical Associates Chapter 290-5-32,	survey on 4/14/2015, Summit is was in compliance with Rules and Regulations for ortions as the result of a State	V 000		Ameri Unit	
State of GA I	I Inspection Report Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	for I	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
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AILANI	A WOMEN O MEDIO	ATLANT	A, GA 30342		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
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TAG	REGOLATORTORE	.50 IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	MAIL
			+		
U 000	Initial Comments.		U 000		
		y, Atlanta Women's Medical			
		oliance with Chapter 111-8-4,			
		ons for Ambulatory Surgical			
		as the result of complaint			
		er GA00158266. No			
	deficiencies were ci	ted.			
					CV
					8.8
				\mathbf{A}	mericans
					Inited
24-4	Inanastian Davis				MIIICU
state of GA I ABORATORY	Inspection Report Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN,	ATURF	TITLE	or Laife
	. SINESTONO ON FROVID	2.000 FEIER REFREDENTATIVE O OIGH	OINE	11144	UI LIIT



Nathan Deal, Governor

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

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Healthcare Facility Regulation Division

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PRINTED: 11/17/2016 FORM APPROVED

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NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS CITY	STATE ZIP CODE	
		235 WES	T WIEUCA F		
ATLANT	A WOMEN'S MEDICAI	L CENTER ATLANTA	, GA 30342		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
U 000	Initial Comments.		U 000	HEALTHCARE FACILITY REGULATION DRANGS	
	Medical Center was with Chapter 111-8-	rvey, Atlanta Women's in substantial compliance 4, Rules and Regulations for I Treatment Centers, as the	*	JAN 0 9 2017 RECEIVED	
	result of a relicensu deficiencies were ci	re survey. The following ted as a result of that survey.		CORRECTIVE ACTION: The Administrator has reassigned the chart review process to the Medical Director	
U 302 SS=D	The governing body responsible for appoint and shall establish equality assurance ar		, U 302	for at least Quarterly. The Medical Director was notified of change on 11/29/16; therefore, ensuring adherenc to established Peer Review & Quality Plan as outlined by the Quality Improvement Plan.	e
	This RULE is not m Based on credential Medical Staff By-Lav	file review, review of facility's vs and 2015-2016 Quality		The Medical Director will review at le 30 randomly selected physician's chart for appropriate signatures, dates, treatment information, appropriate follow-up, standard-of-care, and complications.	
	governing body faile mechanisms for qua	and staff interview, the d to establish effective lity assurance and to ensure the center's medical staff.		EDUCATION: The revision of duties were discussed with the Medical Direct 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 review will be communicated to the Governing Body at each Quarterly meeting by the	vs S
	undated, revealed th Responsibilities inclu 3. Each member woo	uld cooperate with and dical Staff Peer Review and		Administrator. RESPONSIBLE PERSON(S): Administrator, Medical Director, Governing Body	
	The Reappointment				America

State of GA, Healthcare Facility Regulation Division

HARREM

Chief Clinical Administrator



STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A BUILDING	CONSTRUCTION		E SURVEY PLETED
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AI LAITI	A WOMEN O MEDION	ATLANTA	, GA 30342			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
U 302	Continued From pa	ge 1	U 302			
	3. In addition to the applicant as previous would be given to the valuable reasonable qualifications for real and evaluation. Peer recommend professional performation of the facility to communicate the results of Quand evaluation. Review of the facility Improvement Plans 3. Physician Performance and evaluation of the performance of t	information provided by the usly prescribed, consideration he following and to other eliminators of the applicant's appointment: lation regarding the applicants mance, individual judgement, skills, ethics, conduct and ate. lation regularly conducted the eliminator would be sician regularly contracted. Lations would be conducted elician regularly contracted for to ensure all contracted services and documentation facility's protocols, ssion. Records for review andomly.				







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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER		(X2) MULTIPE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
ATLANT	A WOMEN'S MEDICA	CENTER 235 WES	T WIEUCA R	OAD	
MI LANI	A WOMEN'S MEDICA	ATLANT/	A, GA 30342		
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U1210	Continued From pa	ge 2	U1210		
	111-8-412(2)(b) R	ecords.	U1210		
SS=D			•	CORRECTIVE ACTION: The	12/01/10 1
		ual medical records shall		Administrator updated the Pati	
	normally contain the	e following at least:		History form on 11/30/16 to it the patient's family history: (1)	
	(b) History and phys	sical examination data:	•	Diabetes, (3) TB, (4) Heart Dis	
		I history (including all current		History of Twins, (6) Kidney I	
	medication that the			(7) Malignant Hyperthermia.	
	2. Family medical h				
	3. Physical examina		,	Also, the Administrator provid	
	4. Psychiatric exam	ination (if applicable)	,	on 11/16/17 to all licensed clin	
			3	(e.g., RN's, MD's and CRNA's	
	This RULE is not m	est an evidenced by:	;	them to ensure completion of t H&P per patient and that the M	
		ecord review, review of facility		validate the H&P prior to any p	
		terview, the facility failed		This is Atlanta Women's Cente	
		nts received a history and	ì	practice.	
		n by a physician prior to their	v.	•	
		it included family histories.	***	EDUCATION: The Administra	•
			***************************************	reviewed the changes on 11/30	
	Findings include:			staff during an inservice related	
	Deview of homes (0)	0\lll		addition of family history on the History Form and the memo w	
		medical records revealed: 20) did not contain a history	§	the licensed clinical staff on 11	
		nation by a physician		related to the H&P process.	
		9) which did contain a history	v	,	į.
		nation, did not include family		MONITORING: Compliance v	vill be
	histories.	•		monitored by the Administrato	
				designee as part of the Quarter	ly chart
		licy, Medical History &		review process in the Quality Improvement Plan.	
		5/14, revealed the RN/NP -anesthesia evaluation and	,	ипрочением ган.	1
		eening by the MD or CRNA.		RESPONSIBLE PERSON(S):	
		ve diagnosis would be		Administrator	
	reviewed on a case-				
	The DMAID				Can
		eview with the patient current yell as medical history. Any	,		
		n outpatient abortion			A
		consulted with the physician	,		Americans
	spection Report				Haitad
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State of GA, Healthcare Facility Regulation Division

State of	GA, Healthcare Fac	ility Regulation Division	4.1.		
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		PLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
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		060-011	8 WING_		11/02/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY	STATE, ZIP CODE	
A-1 A M	4 11/04/27100 4/270104/	235 WES	T WIEUCA	ROAD	
AILANI	A WOMEN'S MEDICAI	CENTER ATLANT	A, GA 30342	2	
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U1210	Continued From pa	ge 3	U1210		
		propriate. All findings are	:		
	documented in the	patient's medical record.	;		
	Patients Receiving I revealed that throug screening and physician, NP, CRN patient's health state for the suction curet facility. The physicial medical history and examination, which examination. The administrator at the physical examination.				
U1214		closing conference.	: : U1214	CORRECTIVE ACTION: The Administrator created a specific Physic	
SS=D		al medical records shall		Orders Sheet (APPENDIX A) to reflect treatment orders for Pre-Op and General Patient Care on 11/29/16.	
	Chart; surgical purpo 6. Special examination x-ray and lab reports 7. Signed informed of 8. Operation record. 9. Anesthesia record	e-Respiration (Graphic oses only). on(s) and reports (include). onsent form. (if applicable).		The current practice and policy is that the Post-Procedure Record (APPENDIX Big reflects the post-operative orders and discharge with the signature of the physician providing care. We will continue to adhere to this practive which is consistent with the GAin Regulations and Atlanta Women's Centificial Policy.	ice,
	 Consultation reco Tissue findings w 				Amorios

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State o	f GA, Healthcare Fac	lity Regulation Div	ision			
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NAME OF	PROVIDER OR SUPPLIER				TATE. ZIP CODE	
ATLAN1	A WOMEN'S MEDICAL	L CENTER		T WIEUCA RO ., GA 30342	OAD	
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U1214	Continued From page 12. Where dental se		ed, a	U1214	STAFF EDUCATION: A new Phys Order Sheet was created by the	
	complete dental cha treatment, prescript be part of the clinical	art with dental diag ion and progress r	nosis,	,	Administrator on 11/15/16. The Streeducated about the new Physician's Sheet during an inservice and via nother MD's on 11/16/16, by the Administrator. Additionally, the	s Order nemo to
	This RULE is not m Based on medical re review of facility's Pa and Doctors' Guidel	ecord review, staff atient Treatment G ines, review of fac	interview, Buidelines Builty policies,		Administrator reinforced the impor of physician orders for both Pre-op Post-Op phases. MONITORING: The Administrato	and
	and review of emplo ensure that medical orders for treatment	records contained			Designee will monitor compliance weekly.	
	Findings include:				RESPONSIBLE PERSON(S): Administrator	
	Review of twenty (20 A. None contained p. B. Ten (#s 5-8, 10, 1 contain post-operation of the contain post-operation of the complete of birth, surgery 1-day or 2nd Day of the second section include areas to doct 1. Vital signs, height index), time and name 2. Admission assess scale, nausea yes/no (ROM) yes/no, and ticompleting. The third section title	pre-operative orders. 15, 16, 18, and the orders or dischards contained a form of the patient of the first selected and Day of a compand of person composment which includes rupture of membine and name of person composment which includes the person composment which includes the person compand of the person composment which includes the person composment which is person composment	rs 20) did not arge orders m titled included s name, age, and ectionDay y mass leting led pain branes person			
	areas to document g location, inserted by, and time, and check well and IV patent, go	auge size (24, 22, number of attemp boxes for patient	20, 18), ts, date tolerated			America

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State of	GA, Healthcare Fac	ility Regulation Division			
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AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY. S	TATE ZIP CODE	
		235 WES	T WIEUCA RO	DAD	
TLANT	A WOMEN'S MEDICA	L CENTER ATLANTA	A, GA 30342		
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U1214	Continued From pa	ge 5	U1214		
	well.		:		
		ncluded a table which			
		for times, medications,	;		
	doses, route, and in	itials. Multiple doses for			
		5/325 mg (hydrocodone-a	•		
		de from codeine and Tylenol,			
		deine- a narcotic pain	ì		
		isoprostol, and Azithromycin	\$ \$		
		ed to choose from. The right ection contained an area titled	france of		
		s which was lined for free			
		The bottom of the form			
		nes for RN signatures, one (1)	; l		
		e, one (1) line for date, and			
	one (1) line for time.		,		
		signed by the physician at	· .		
	various times rangin administration to ho	g from the time of medication			
		and later.	,		
		Iministrator on 11/1/2016 at	;		
		kroom revealed that nurses	;		
		cols for pre-operative			
	medication administ		,		
		on the Pre-Procedure	:		
	Nursing Record serv	red as an order.	΄,		
	Upon surveyor reque protocols, the admin	est for facility pre-operative istrator provided:			
	1. Patient Treatment	Guidelines			
	2. Doctors' Guideline		,		
	Standing Orders finders	or Post-Operative			
		ر المحادة مشعم المساوية والمواد			-00-
		atient Treatment Guidelines,			Chico
		aled directives for Laminaria	<u> </u>		Carlo
		ertion (used to dilate the			
		and 2 day procedures, -medical abortion pill),			
		in red blood cells that carry			America

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State of GA. Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** COMPLETED A BUILDING B WING 060-011 11/02/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 235 WEST WIEUCA ROAD ATLANTA WOMEN'S MEDICAL CENTER ATLANTA, GA 30342

(X4) ID SUMMARY STATEM
PREFIX (EACH DEFICIENCY MU:

TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

U1214

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETE DATE

U1214 Continued From page 6

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.



State of	GA, Healthcare Faci	lity Regulation Division			
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		060-141	B. WING		11/03/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
SUMMIT	MEDICAL ASSOCIA	\ I E \	DMONT RD, A, GA 30324	NE, SUITE 500-E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTY)	D BE COMPLETE
U 000	Associates was in o 111-8-4, Rules and Surgical Treatment	urvey, Summit Medical compliance with Chapter Regulations for Ambulatory Centers, as the result of a urvey. No deficiencies were	U 000		
					mericans Inited
State of GA I	nspection Report				
LABORATORY	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN,	ATURE	TITLE	or Life

State of	<u>GA, Healthcare Faci</u>	lity Regulation Division			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		060-141	B. WING		11/03/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AND	DRESS CITY S	TATE, ZIP CODE	
		1874 PIFF		NE, SUITE 500-E	
SUMMIT	MEDICAL ASSOCIA	1 = >	A, GA 30324		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE DATE
				,	
V 000	Opening Comment	s	V 000		
		urvey, Summit Medical			
		compliance with Chapter			
		s and Regulations for Abortion ult of a relicensure survey. No			
	deficiencies were ci				
	denoier loies were or	tou.			
					SK
				\mathbf{A}_{1}	mericans
					Inited
	Inspection Report			C	
_ABORATOR`	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	or Lafe

State of GA Healthcare Facility Regulation Division

State of	GA, HealthGare Facil	ity Regulation Division				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		025-115	B. WING		03/0	2/2017
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
SAVANN	IAH MEDICAL CLINIC	C1	t 34th Street IAH, GA 3140 [,]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
U 000	Initial Comments.		U 000			
	A State Re-licensur 2/28/2017 through Clinic was in compli Rules and Regulation	e survey was conducted on 3/2/2017. Savannah Medical iance with Chapter 111-8-4, ons for Ambulatory Surgical No deficiencies were cited.			Ameri Unit	3 cans ted
State of GA I LABORATOR	Inspection Report Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	for I	(XSTDATE)
					101 1	

State of CA. Healtheare Eacility Population Division

		IITY REQUIATION DIVISION	/Y2\ MIII TIDI E	CONSTRUCTION	/Y3) DATE SUDVEY
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		025-115	B. WING		03/02/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	TATE, ZIP CODE	
SAVANN	IAH MEDICAL CLINIC	C.	34th Street	4	
	CUMMA DV CT		AH, GA 3140		5W
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)	D BE COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE DATE
1/ 000	0	-	1/ 000		
V 000	Opening Comment	S	V 000		
	At the time of the si	urvey, Savannah Medical Clinic			
	was in compliance	with Chapter 290-5-32, Rules			
		Performance of Abortions ester of Pregnancy and			
		nents For All Abortions, as the			
	result of a State lice				
					-CC-
					Chol C
					(M)
				Λ.	morioans
					mericans
					<u>Inited</u>
	nspection Report / DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE f	or L×ife
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Accepted 5/4/17 AA

PRINTED: 03/30/2017 FORM APPROVED

State of	GA, Healthcare Faci	lity Regulation Division			
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		044-287	B. WING		03/14/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
			F VALLEY W		•
CLIFF VA	ALLEY CLINIC	ATLANTA	, GA 30329		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) HEALTHCARE FACILITY REGULATION	D BE COMPLETE PRIATE DATE
U 000	Initial Comments.		U 000	DIVISION DEPARTMENT OF COMMUNITY HEA	LTH
		urvey, Cliff Valley Clinic was in nce with Chapter 111-8-4,	TO THE TAXABLE PROPERTY.	MAY 04 2017	
	Treatment Centers, re-licensure survey.	ons for Ambulatory Surgical as the result of a State. The following deficiencies result of that survey.	*** **********************************	RECEIVED	
U 300 SS=D	111-8-403(1) Orga	nization and Administration.	U 300	See next page for plan of corre	ction
	be organized with a that establishes the and assumes full le overall conduct of the with all applicable la to the center. The n	urgical treatment center shall in identifiable governing body objectives, sets the policies gal responsibilities for the ne center and for compliance aws and regulations pertaining nembership of the governing fied in the application to the nsure.			
	Based on medical r employee and cred- policies, and staff in	net as evidenced by: ecord review, review of ential files, review of facility iterview, the Governing Body sible for the overall conduct of	Commence of the Control of the Contr		
	Findings include:		2		
	1103 - Personnel 1104 - Personnel 1105 - Personnel 1210 - Records 1214 - Records	and Administration Services			Americans
State of GA I	nspection Report ORECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	United
,	N/WILK			Clinic Administrator 5/3/20	of for I if

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State of GA, Healthcare Facility Regulation Division (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 03/14/2017 044-287 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1924 CLIFF VALLEY WAY, NE **CLIFF VALLEY CLINIC** ATLANTA, GA 30329 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) U 300 U302 U 300 Continued From page 1 5/15/2017 Corrective Action: All records for 2001 - Sanitation and Waste Disposal professional staff were reviewed for V tags completeness. Request was made to 0030 - Procedure for Filing Certificate of Abortion professional staff to submit any missing documents. Practitioners were given a U 302 U 302 111-8-4- 03(3) Organization and Administration. time frame to supply missing SS=D The governing body of the center shall be documentation or have privileges responsible for appointing the professional staff temporarily suspended. All completed and shall establish effective mechanisms for charts that are due for reappointment will quality assurance and to ensure the accountability of the center's medical and/or be forwarded to medical director and then dental staff and other professional personnel. back to medical staff administration at least 30 days prior to reappointment being This RULE is not met as evidenced by: due. Peer reviews will be conducted and Based on credential file review, review of facility's documented quarterly. Medical Bylaws, and staff interview, the facility Staff Education: In-service has been 5/15/2017 failed to ensure that professional staff were appointed, and that quality reviews were scheduled for Professional staff as well as conducted. clinic administration to review Medical bylaw requirements for appointment. Findings include: Monitoring: Summary of Medical Bylaws Review of four (4) credential files (#s 1-4) has been created to be distributed to revealed: professional staff annually about File #3 did not contain requested privileges. Files #3 and 4 did not contain evidence that necessary documentation which is privileges had been approved. necessary for credentialing at the clinic. A Files #2, 3, and 4 did not contain Medical Staff or separate document will be forwarded Governing Body approval. Files #3 and 4 did not contain re-appointment quarterly to professional staff with the dates. status of items that is required for re-None of the files contained evidence that peer appointment. It will also include the status review had been conducted. File #3 did not contain an agreement to abide by of quarterly peer review. the Governing Body Bylaws. Responsible Persons: Clinic Administrator, Medical director

State of GA Inspection Report STATE FORM

Review of facility's Medical Bylaws, undated,

8899



	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	СОМ	E SURVEY PLETED
		044-287	B. WING		03/	14/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
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		· · · · · · · · · · · · · · · · · · ·	, GA 30329			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE BE APPROPRIATE	(X5) COMPLETE DATE
U 302	Continued From pa	ige 2	U 302	U302		
	for the oversight of the professional sta	edical Director is accountable clinical services provided by aff, clinical policies & edical quality assurance sibilities include:		See previous page for plan o	of correction	
	and credentialed. Monitors Physicians and Advanced Prace privileges as required Participates actively management processection 3: Reappoint B. All applicants for					
	1. Conformation of	admitting privileges.				
	Medical Staff memi	ons for the reappointment of ber and clinical privileges to be pointment will be based upon, he member's:	7 0			
	quarterly basis. The review would be pe entered as a statist charts would be eva diagnosis and treat The peer review wo	view view view view view view view view		•		Sign
		7 at 1:00 PM with the Director ration revealed that MD #2			A1	neric mita

State of GA Inspection Report



State of GA, Healthcare Facility Regulation Division (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: B. WING 03/14/2017 044-287 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1924 CLIFF VALLEY WAY, NE **CLIFF VALLEY CLINIC** ATLANTA, GA 30329 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) U 302 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 903' 111-8-4-.09(4) Professional Services. U 903 SS=D All nursing services shall be under the U903 supervision of a registered nurse (R.N.). Each 3/23/2017 Corrective Action: Nursing Supervisor was center shall have a sufficient number of currently hired on 3/23/2017 licensed nurses present and on duty to attend to Staff Education: As part of the on-boarding patients at all times patients are receiving treatment or recovering from treatment up to and process, Nurse Supervisor has been educated including the time of discharge. Additional staff about the nursing roles and responsibilities of shall be on duty and available to assist the the clinic. professional staff to adequately handle routine Monitoring: Nursing Supervisor will be and emergency patient needs. appointed by Medical director for a renewable two year term. This RULE is not met as evidenced by: Responsible Persons: Clinic Administrator. Based on staff interview, employee file review Medical Director 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 Review of employee files failed to reveal a DON Review of facility policies failed to reveal a policy which addressed requirement for a DON / Nursing Supervisor.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		044-287		B. WING			
NAME OF PROVIDER OR SUPPLIER STREET ADDRES				B. WING 03/14/2017 RESS, CITY, STATE, ZIP CODE VALLEY WAY, NE GA 30329			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE		
U 907	Continued From pa	nge 4	U 907	U907			
U 907	111-8-409(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.		U 907	Corrective Action: The OR logs have be updated to have a monthly signature from lead Health Advocate, Nursing Supervis Clinic Administrator. Any abnormalities be immediately reported. The Operation manager has been accepting bids from companies to convert the pathology roomegative pressure room. Staff Education: In-service was held for	are to ns HVAC m to a		
	Based on review of Temperature and H Exchange and Bala staff interview, it was failed to have effect	net as evidenced by: if the Operating Room (OR) lumidity (T&H) Logs, Air ance report, observation, and as determined that the facility tive policies and procedures to s remained free from fections.		staff reviewing the temperature and hun logs were to be performed every day the was used. Also during the in-service, it reviewed with staff that abbreviations ar permissible in the logs. Should the equinot function properly, it is to be immedia reported. Staff will also be trained how	nidity e OR was e not ipment itely		
	through 3/11/17 and reviewed from 03/1 logs revealed that the was 30% to 60%. If the T&H for both 0 for the above time to logs revealed that 0 noted as equipment noted that the mon	vas reviewed from 01/15/16 d OR #2's T&H Log was 1/16 through 03/11/17. Both he acceptable humidity range Documentation revealed that Rs was documented as "EE" frames. Further review of the DR #1 on 11/14/14 "EE" was it error and OR #2 on 01/09/15 itor was not working.		perform the tissue test for the pathology to ensure that it stays a negative pressuroom once converted. Monitoring: O.R. Logs will be reviewed monthly. Should there be any abnormal on the daily record, they are to be immediately reported by the OR staff. The tissue test will be performed and docum monthly for the pathology room. Responsible Persons: Lead Health Advection Clinic Administrator, Nursing Supervisor	lities he ented		
,	from Medical Equip 06/16/14 revealed to	exchange and Balance report oment Technology, Inc. dated that the Pathology Room (dirty had a positive pressure and oper hour.		Operations Manager			
,		14/16 at 9:30 a.m. revealed Room failed the tissue test			Americ		

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		044-287	B. WING		03/1	<u>4/2017</u>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
CI IEE W	ALLEY CLINIC		F VALLEY				
		ATLANTA	, GA 30329				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
U 907	Continued From pa	ge 5	U 907	U907			
	(tissue held at bottom of door and if it blows under the closed door the room is negative pressure).			See previous page for plan of correction			
i	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.			·			
	111-8-410(n) Phys Standards.	sical Plant and Operational	U1027	U1027 Corrective Action: A lock was purchase		3/14/2017	
		stored in a conveniently nock, and only licensed access.		placed on medication refrigerator with b lock. Staff Education: In-service was held for nursing staff about which medications not be stored in a locked unit.	г	4/21/2017	
	Based on review of and staff interview,	net as evidenced by: facility's policy, observation, the facility failed to ensure that ecured with only licensed ess.		Monitoring: All locked units will be chec and documented that they are functioning properly weekly. Any malfunctions must reported immediately to Nursing Superv	ng at be visor.		
	Findings:			Responsible Persons: Nurses, Nursing Supervisor, Clinic Administrator, and			
	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).			Operations Manager		Sign	
		13/17 at 3:30 p.m., e facility's Director of Clinic aled the following unsecured			An	nerio	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		044-287	B. WING		03/	14/2017	
	PROVIDER OR SUPPLIER	1924 CLIF	DRESS, CITY, F VALLEY , GA 30329				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
	Post Anesthesia C. a. Five (4) Rhogal from human blood Rh-negative 300 micrograms (no 8/20/17; b. One (1) Rhogal date 10/27/17; c. Eight (8) Rhogexpiration date 06/d. Ten (10) Rhogexpiration date 10/e. Seven (7) Rhogexpiration date 12/f. Four (4) Rhogal date 02/20/18; g. A bottle of liquit treat genital warts) 12/31/2017. h. Twelve (12) on Methergan (used the childbirth or an about the expiration date i. One (1) one (1) Derivative (PPD use 5TU/0.1 ml or 50 to j. Five (5) Hepatition (1) ml vial expiration conhad been broken for that the PACU documents of the childbirth or an about the confirmed of the childbirth or some conhad been broken for the childbirth or confirmed of the childbirth or ch	unlocked refrigerator in the are Unit (PACU): am (a sterile solution made plasma that is given to in the form of an injection) ncg) syringes expiration date am 300 mcg syringe expiration am 300 mcg syringes 23/17; am 300 mcg syringes 20/18; am 300 mcg syringes 20/18; am 50 mcg syringes 20/17; am 50 mcg syringes expiration id Trichloroacetic Acid (used to 80% solution expiration date and (1) milliliter vials of the ohelp stop bleeding after portion) 0.2 milligrams (mg) per 05/20/18; and tis B vaccines 10 mg per one	U1027	U1027 See previous page for plan of con		merican	
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State of GA, Healthcare Facility Regulation Division





State of GA, Healthcare Fac STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION (X	(3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COMPLETED	
		B. WING		02/4//2047	
	044-287	U. WING		03/14/2017	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
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CLIFF VALLEY CLINIC	ATLANTA	, GA 30329	the state of the s		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
U1103 Continued From pa	age 7	U1103	U1103		
U1103 111-8-4- 11(4) Pers	sonnel	U1103	Corrective Action: All employee staff rec	ords 5/15/2017	
SS=D	Each center shall require that each employee		were reviewed. Request for missing		
			documentation was made to staff. Staff	uarill	
receives a health e	xamination upon employment		be given a time frame to supply missing		
and a policy shall p	and a policy shall provide for follow-up examinations. The examination shall be in			ool	
			documentation, which may include physic	tai j	
	sufficient detail, including pertinent laboratory and		exams. Failure to provide missing	j 4	
	re that the employee is		documents will result in the staff member		
	physically and mentally qualified to perform the job to which the sassigned.		being allowed to work. Request has bee	n ·	
Job to which	issigned.		submitted to the Directors to have the Hu	ıman	
:			Resources Policy to reflect this change in	۱	
This RULE is not r	met as evidenced by:		policy.	İ	
	Based on review of employee files, facility policies, and staff interview, the facility failed to		Staff Education: In-service has been	5/15/2017	
policies, and staff i			scheduled for staff to review requirement	s to	
	rees received a health	\$	work in the clinic and the frequency these	1	
	examination upon hire, and to have a policy which addressed follow up examinations.		documents are to be maintained.	·	
addressed follow u			Monitoring: Summary of requirements to	work :	
Fig. discount in absolute			in the clinic has been created to be distril		
Findings include:				Juleu	
· Poviou of fivo (5)	w of five (5) employee files (#s 6-10)		to staff annually about necessary		
revealed:	employee thes (#8 0-10)		documentation which is needed. A sepa		
	examination by a physician or		document will be forwarded to them with		
mid-level provider			status of items that are required for		
	and 9) contained a health		employment. The orientation/ annual che	eck '	
' questionnaire com	pleted by the employee post		list will be updated and documented at le	ast i	
hire.			annually. Once updated, it will be signed	by	
•) did not contain evidence of		the supervising manager then submitted	to	
IB testing.	TB testing.		the Clinic Administrator to be included in	the	
Daviou of four (A)	credential files (#s 1-4)		personnel file.	ļ	
revealed:	oregenial mes (ms 1-1)		Responsible Persons: Clinic Administrat	or.	
	did not contain evidence of		Front Office Supervisor, Nursing Supervi		
current TB testing.			Train Office Oupervisor, reursing Oupervi	Sul	
Review of facility p	olicy #HR 180, Employment			. 05	
Physical Assessme	ent, effective 01-01-07, revised	Į		Americ	
	I that each employee must	i		W Yi • 4	
undergo an emplo	yment physical assessment by	<u> </u>		linit	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		lity Regulation Division (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CLE CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		044-287	B. WING		03/14/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY,	STATE, ZIP CODE	
CLIFF VA	ALLEY CLINIC		F VALLEY GA 30329	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL OF THE PROPERTY OF T	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	employee must sche Clinical Director for assessment. At the employee would be health form for comphysician or nurse (The employee health would be kept with medical file. The policy did not a examinations. The Director of Clinical acknowledged the analysis of the employee, including qualifications for enexamination (including qualifications for enexamination (including qualifications for enexamination (including the employee, including qualifications for enexamination (including the employee, including the employee, including the employee, including the employee, including the employee, and staff in assure that files incomplicities, and staff in assure that files incomply the employee policies, and staff in assure that files incomply the employee policies, and staff in assure that files incomply the employee policies, and staff in assure that files incomply the employee policies, and staff in assure that files incomply the employee policies, and staff in assure that files incomply the employee policies, and staff in assure that files incomply the employee policies. The employee policies include:	month of employment. The edule an appointment with the the employment physical time of the appointment, the given a FWHC employee pletion and then seen by a NP or RN) for assessment the form/physical assessment the employee's personnel/ddress follow up ical Administration above findings on 3/13/2017. connel. parate personnel folder in employee. This file shall el information concerning the ployment, physical ing laboratory and x-ray e), job description and the tas evidenced by: a file review, review of facility aterview, the facility failed to luded evidence of orientation	U1104	U1104 Corrective Action: All employee staff recovere reviewed. Request for missing documentation was made. Staff will be gatime frame to supply missing documentation, which may include TB teropy the complex of the co	ords iven st, ve an 5/15/2017 s to work outed rate eck ast by to the
;	revealed: Four files (4- #s 6, 7	7, 8, and 9) did not contain		Front Office Supervisor, Nursing Supervis	Amend
ate of GA I	nspection Report M		6899	9VR811 If	continuation sheet 6 of 1

STATEMEN	GA, Healthcare Fac IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 044-287		LE CONSTRUCTION	(X3) DATE SU COMPLE 03/14/	TED
					, 0 01171	EVII
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CLIEF VALLEY CLINIC		FF VALLEY ' , GA 30329				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
U1104	Continued From pa	ge 9	U1104	U1104		
	Two (2-#s 6 and 8) description. One (1-#9) did not	sts signed by the supervisor. did not contain a job contain current CPR iired by job description.		See previous page for plan of correction	nc :	
	effective, revised at revealed: Hiring procedure: A attend an orientatio Manager prior to the portions of the perschecklist to the empaupervisor complete Checklist under "Josupervisor signs an signature for the Orientalist control of the	olicy #A01, Orientation policy, and approved 10/21/09, Ill new hires and re-hires must in with the HR and Office eir start date. The completed onnel file and the orientation ployee's supervisor. The est asks on Orientation ob Specific Orientation. The dobtains employee's ientation Checklist, and ployee's personnel file.				
	acknowledged the	above findings on 3/13/2017.			 	
U1105	at least quarterly ar There shall be an o education for all pe fire safety and the o	saster drills shall be conducted at the results documented. Ingoing program of continuing reonnel concerning aspects of lisaster plan for moving ents to safety, and for handling	U1105	U1105 See next page for plan of correction		-00
:	31-7-1 et seq. Adm Rule entitled "Perso	Secs. 31-2-4 et seq. and inistrative History. Original onnel" was filed on January 22, ch 1, 1980, as specified by the			Am	eric

tate of GA Inspection Report

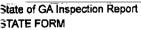
STATE FORM

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STATEMEN	N OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		X3) DATE SURVEY COMPLETED 03/14/2017		
	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE WAY, NE	
(X4) ID PREFIX TAG	SUMMARY STA	ATLANTA ITEMENT OF DEFICIENCIES If MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	, GA 30329 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
U1105	Based on review of Preparedness Plan staff interview, it was failed to conduct quand disaster drills. Findings: Review of the facility Plan, no policy numbrills and disaster or quarterly. Review of the facility manual revealed the following drills: a. Forth (4th) quanc. Forth (4th) quanc. Forth (4th) quance. Forth (4th) quance. Forth (4th) quance During an interview the Conference Roadministration confidence.	net as evidenced by: I the facility's Disaster I, fire and disaster drills, and as determined that the facility I arterly fire and disaster drills by's Disaster Preparedness I ber or date, revealed that fire I rills were to be conducted by's Fire and Disaster Drill I e facility failed to conducted arter fire drill; I arter disaster drill; I and	U1105	U1105 Corrective Action: Fire and internal disadrills will be pre-scheduled at the begins the calendar year. The first quarter drills he been scheduled for June 20, September and December 5, of 2017. Staff Education: In-service has been scheduled for staff to review fire and displans for the clinic. The in-services will included as part of staff meetings through the year. Monitoring: Dates of the last performed and upcoming scheduled drills will be documented on the monthly signed, OF The dates of the conducted drills will also documented by the Operations Manager quarterly. Responsible Persons: Clinic Administrational control of the properties of the conducted drills will also documented by the Operations Manager Quarterly.	s was ave r 26, 5/22/2017 saster pe ghout drill k log. so be
U1210	111-8-412(2)(b) R Contents of individu normally contain the	ual medical records shall	U1210	U1210 See next page for plan of correction	
	1. Personal medical medication that the 2. Family medical him 3. Physical examinations	nistory.			Americ



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PRINTED: 03/30/2017 FORM APPROVED

AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1224 CUIFF VAILLEY CLINIC ATLANTA, GA 30329 PROVIDER'S RAN OF CORRECTION EACH DEPICIENCY MUST BE PRECEDED BY TULL TAKE RESULATION OR LSG IDENTIFYMG INFORMATION) 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 of 5/2014, revealed patients having a medical abortions with Milepristone and Misoprostol (medicalions 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 Physicala, advanced practice and mistory and physical examination when indicated. Review of Medical Bylaws, no date, revealed in Article VIII: Rules and Regulations, Section 3: Medical Records, B. History and Physical, a. Acomplete gynecologic (female reproductive system) history and physical examination when indicated. Review of Medical Bylaws, no date, revealed in Article VIII: Rules and Regulations special	State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			LE CONSTRUCTION	(X3) DATE COMP	Survey Leted	
PARTICIPE VALLEY CLINIC 1924 CLIFF VALLEY WAY, NE ATLANTA, GA 30329 PREFIX CLIFF VALLEY CLINIC SUMMARY STATEMENT OF DEFICIENCISS (EACH DEFICIENCY MUST BE PRECEDED BY PULL RESOLATORY OR LSC IDENTIFYING INFORMATION) 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 56/2014, 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 with midcated. Review of Medical Bylaws, no date, revealed in Aricie 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 writen by a physican, and be a part of each patient's chart. C. Written, Verbal, and Standing Orders, 1. All			044-287	B. WING		03/1	4/2017
SUMMAY STATELISET OF DEPICTACES FORTH STATE			1924 CLIF	F VALLEY	WAY, NE		
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. 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 Vill: 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 physical and dvanced practice nurse, or a Registered Nurse, and be a part of each patients chart. C. Written, Verbal, and Standing Orders, 1. All	(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE	COMPLETE
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	- 1	This RULE is not in Based on review of medical records, and determined that the physical examination procedures and that written, for three (3 records (#6, 7, and Findings: Review of facility por Abortion Policies and mumber, last update having a medical at Misoprostol (medical about an abortion) and physical examination was to a. Pertinent physisigns; b. Determination fetus) by clinical as c. Ultrasonograph determines age of indicated. Review of Medical Article VIII: Rules a Medical Records, Ecomplete gynecolo	net as evidenced by: I facility policy, Medical Bylaws, and staff interview, it was I facility failed to ensure that ans were performed prior to at discharge orders were I) of ten (10) sampled patient II). Dilicy entitled Medication and Procedures, no policy and 05/2014, revealed patients bortions with Mifepristone and ations administered to bring were to have a medical history ination. The physical I include the following: I ical examination, including vital of gestational age (age of sessment; and anic (specialized x-ray that fetus) examination when Bylaws, no date, revealed in and Regulations, Section 3: Bylaws, and Physical, 1. A gic (female reproductive		U1210 Corrective Action: All professional state been instructed that a history and physically as a discharge summary is needed patients being seen in the ambulatory center, regardless of the procedure per Electronic medical records will be impleted by June 2017 to assist with compliance History and Physicals are to be performed the practitioner only. Staff Education: In-service has been scheduled for Professional staff and control to review Medical bylaws, as well as performed and procedures to determine the complete chart for all patients treat the ambulatory surgical center. In-service has been scheduled in May 2017 to the professional staff on using the Electron Medical Record, Nextgen, to record a complete history, physical and dischart summary. Monitoring: Completion of charts, incluphysical exam, will be reviewed as part front staff chart audit, as well as by rechart audits by the Clinic Administrato Supervisor, or Medical Director. Chart be reviewed as part of the quarterly pereview. Responsible Persons: Clinic Administrations.	sical, as ad on all surgical erformed. lemented le. med by linic staff colicies ponents ated in vice has rain nic rge uding the rt of the ndom r, Nurse t will also eer	
		cases be performe advanced practice and be a part of ea C. Written, Verbal,	d and written by a physician, nurse, or a Registered Nurse, ch patient's chart. and Standing Orders, 1. All		Office Supervisor, Professional Staff	An	neric

State of GA Inspection Report STATE FORM

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If continuation sheet 12 of 14

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FORM APPROVED State of GA, Healthcare Facility Regulation Division (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: 03/14/2017 B. WING 044-287 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1924 CLIFF VALLEY WAY, NE **CLIFF VALLEY CLINIC** ATLANTA, GA 30329 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) U1210 U1210 U1210 Continued From page 12 See previous page for plan of correction 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. U2001 U2001 U2001 111-8-4-.20(2) Sanitation and Waste Disposal. 4/15/2017 SS=D Corrective Actions: All clean containers have . All garbage, trash and waste shall be stored and been relocated from the biohazard closet. disposed of in a manner, by approved methods, Only containers that contain biohazardous that will not permit the transmission of disease, waste will be stored in the biohazard closet. create a nuisance, or provide a breeding place for Staff Education: In-service has been 5/22/2017 insects or rodents. scheduled to review how to properly dispose of biohazardous waste. Also, OSHA compliant This RULE is not met as evidenced by: videos for Infection Control Essentials: Every Based on observation, staff interview, and review Action and Infection Control for Ambulatory of facility policies, the facility failed to store Care Settings training handbooks by Coastal biohazardous waste properly. Training Technologies Corp will be reviewed Findings include: and the quiz will be taken by everyone in attendance. Observation during a tour on 3/13/2017 at 3:30 Monitoring: Quarterly mock inspection will be PM with the Director of Clinical Administration performed. As part of the mock inspection, revealed a closet which contained boxed biohazardous waste and full sharp containers, disposal methods will be reviewed to along with clean sharp containers. determine if the method is appropriate. Responsible persons: Clinic Administrator, The Director of Clinical Administration Nurse Supervisor, Health Advocates, Nurses acknowledged the above findings at the time.

State of GA Inspection Report STATE FORM

Review of facility policy titled Waste Disposal,



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IAME OF	PROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY,	STATE, ZIP CODE			
I IEE V	ALLEY CLINIC		FF VALLEY				
LILL VA		ATLANTA	A, GA 30329				
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U2001	revealed that regulation handled in accorda	loped/reviewed 12/13, ated medical waste would be nce with the blood-borne ds of OSHA (Occupational	U2001	See previous page for pla	an of correction		
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Nathan Deal, Governor

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,

Abimbola (Bola) Ansa, RN

Program Director, Acute Care Unit Department of Community Health

Healthcare Facility Regulation Division

AA:rf





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,

Abimbola (Bola) Ansa, RN

Program Director, Acute Care Unit Department of Community Health

Healthcare Facility Regulation Division

Aset-Scalot RN, MS

AA:rf





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

Bola Clusa

Healthcare Facility Regulation Division

AA:rf



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FORM APPROVEE

State of GA, Healthcare Facility Regulation Division		113011000	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ARACEMARE CACELLET RET. 1 - 110-1 - 111-1 - 11			•
025-115	B. WING		04/10/2018
NAME OF PROVIDER OF SUPPLIER STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
Amo 27	34th Street		
SAVANNAH MEDICAL CLINIC RECEIVED 120 East: SAVANNA	H, GA 3140	01	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOODS - REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
U 000 Initial Comments.	U 000		
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 907 111-8-409(8) Professional Services.	U 907		
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/ecords (#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		A L	Inited
tate of GA Inspection Report ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGN		fomin.	or Life
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State of GA, He	althcare Faci	ility Regulation Division				
STATEMENT OF DE AND PLAN OF CORE	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		025-115	B. WING		04/1	0/2018
NAME OF PROVIDE	R OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAVANNAH MEI	NOAL CLIMIC		34th Street			
SAVANIVAN MEI	JICAL CLINIC	SAVANNA	AH, GA 3140		<u> </u>	
	ACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
U 907 Contir	•	Ť	U 907			
attem six rec	ots to follow u cords.	up were noted in any of the (6)				
04/10/ reveal compl report month	18 at 2:00 p.led that two (2 ications but the dor documents and that the tive complications.)	tered nurse (staff #1)on m. in the counselors office 2) patients had experienced here were no infections ented in the past twelve ere is no log to follow post tions/infections within the				
(staff couns there follow	#7) during the elors office of is no log or fo	the assistant administrator exit conference in the n 04/10/18 at 4:54 p.m. that ormal follow-up procedure to s/infections of patients after				
•			, in the second			
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					-00	
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State of GA Inspectio	n Report					
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Tag # U907

7/30/18 000

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 checkup 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



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State of GA. Healthcare Facility Regulation Division

State U	GA, Healthbale Labi	ity Regulation Division			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
_ :			A. BUILDING: _		
		025-115	B. WING		04/10/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	TATE, ZIP CODE	
SAVANN	IAH MEDICAL CLINIC	1	34th Street AH, GA 3140	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETE
V 000	Opening Comment	s	V 000		
V 000	was in compliance was in Regulations for After the First Trime	urvey, Savannah Medical Clinic with Chapter 290-5-32, Rules Performance of Abortions ester of Pregnancy and nents For All Abortions, as the	V 000		
					Americans United
State of CA I	Inspection Depart				Omteu
_ABORATOR\	Inspection Report Y DIRECTOR'S OR PROVIDI	ER/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	for Life

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State of GA. Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		060-011	B. WING		04/12/2018
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST		
ATLANT	A WOMEN'S MEDIC	AL CENTER	T WIEUCA RO A, GA 30342	OAD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETE
V 000	Opening Commen	ts	V 000		
V 000	At the time of the s Medical Center wa 290-5-32, Rules at of Abortions After t	survey, Atlanta Women's s in compliance with Chapter and Regulations for Performance the First Trimester of Pregnancy quirements For All Abortions, as			SB Americans United
State of GA I ABORATORY	nspection Report / DIRECTOR'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	for Life
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State of	State of GA, Healthcare Facility Regulation Division							
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		060-011	B. WING		04/12/2018			
NAME OF F	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, S	STATE, ZIP CODE				
ATLANT	'A WOMEN'S MEDICA	AL CENTER	WEST WIEUCA F ANTA, GA 30342					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETE			
U 000	Medical Center was 111-8-4, Rules and	urvey, Atlanta Women's in compliance with Chapte Regulations for Ambulator Centers, as the result of a		DEFICIENCY)	SS Americans United			
State of GA I	 Inspection Report		I					
_ABORATOR\	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S	SIGNATURE	TITLE	for Life			

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State of	GA, Healthcare Faci	lity Regulation Division				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		060-141	B. WING		03/27/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
SUMMIT	MEDICAL ASSOCIA	\ I E \	DMONT RD, A, GA 30324	NE, SUITE 500-E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
U 000	Initial Comments.		U 000			
U 000	At the time of the si Associates was in o 111-8-4, Rules and Surgical Treatment	urvey, Summit Medical compliance with Chapter Regulations for Ambulatory Centers, as the result of a No deficiencies were cited.	U 000		SS mericans Jnited	
State of GA	Inspection Report					
_ABORATOR`	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	or Life	

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State of GA. Healthcare Facility Regulation Division

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MILITIDIE	CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		060-141	B. WING		03/2	7/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
SUMMIT	MEDICAL ASSOCIA	11-5	DMONT RD, I A, GA 30324	NE, SUITE 500-E			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
	Associates was in of 290-5-32, Rules and of Abortions After the and Reporting Requirement of a relice were cited.	urvey, Summit Medical compliance with Chapter and Regulations for Performance are First Trimester of Pregnancy uirements For All Abortions, as ensure survey. No deficiencies	V 000	DEFICIENCY)	& Ameri Unit	ted	
LABORATOR	Inspection Report Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	TITLE	for I	(X6) DATE	
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State of CA. Healtheare Eacility Population Division

State of	GA, Healthcare Faci	lity Regulation Division				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		c	
		060-011	B. WING		09/13/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
ATLANT	TA WOMEN'S MEDICA	ALCENIER	TWIEUCA R ., GA 30342	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
V 000	Opening Comment	s	V 000			
	At the time of the si Medical Center was 290-5-32, Rules an of Abortions After th and Reporting Requ the result of investi	urvey, Atlanta Women's in compliance with Chapter de Regulations for Performance he First Trimester of Pregnancy uirements For All Abortions, as gation of complaint #GA00190237. No			\$3 mericans Inited	
State of GA	Inspection Report					
_ABORATOR`	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	or Life	

State of	<u>GA, Healthcare Faci</u>	lity Regulation Division			
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		044-287	B. WING		R 08/17/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, S	TATE, ZIP CODE	
CLIFF V	ALLEY CLINIC		IFF VALLEY V A, GA 30329	WAY, NE	
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State of	GA, Healthcare Faci	lity Regulation Division			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
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	Initial Comments.		{U 000}	J	SS mericans Inited
State of GA I LABORATORN	nspection Report / DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	or Life
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State of GA Healthcare Facility Regulation Division (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION A.BUILDING:_

STATEMENT OF DEFICIENCIES

IDENTIFICATION NUMBER:

(X3) DATE SURVEY COMPLETED

044-287

B.WING

05/02/2018

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1924 CLIFF VALLEY WAY, NE CLIFF VALLEY CLINIC

CLIFF VALLEY CL	INIC:	A, GA 30329	
PRÉFIX (EA	SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL JLATORY OR LSC IDENTIFYING INFORMATION)	i ID PREFIX TAG	PROVIDER'S PLANOF CORRECTION (XS) (EACH CORRECTIVE ACTIONSHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
U 000 Initial C	omments.	U 000	
not in co and Reg Treatmo survey.	me of the survey, Cliff Valley Clinic was ompliance with Chapter 111-8-4, Rules gulations for Ambulatory Surgical ent Centers, as the result of a relicensure The following deficiencies were cited as of that survey.	!	HEALTHCARE FACILITY REGULATION DIVISION JUN 0 & 2018
U 300 111-8-4 SS=E	.03(1) Organization and Administration.	U 300	RECEIVED
Each ar be orga that est and ass overall o with all a to the co body sh	abulatory surgical treatment center shall nized with an identifiable governing body ablishes the objectives, sets the policies umes full legal responsibilities for the conduct of the center and for compliance applicable laws and regulations pertaining enter. The membership of the governing all be identified in the application to the cent for licensure.		
Based of procedure perform data, International facility f	LE is not met as evidenced by: n review of the facility's policies and res, QAPI (quality assurance ance improvement) meeting minutes and ection Control meeting minutes and data, f interview, it was determined that the alled to establish an ongoing QAPI or Control program.		
Findings	:		
the Med medical discharg	of the Medical Staff Bylaws revealed that ical Staff is responsible for the quality of care in the facility and must accept and the that responsibility, subject to the authority of the facility governing body.	I	SS
	of the facility policy, no policy number, Assessment and Improvement Plan",		Americans

State of GA Inspection Report

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

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State of GA. Healthcare Facility Regulation Division				
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 , ,		(X3) DATE SURVEY COMPLETED	
044-287	B.WING		05/02/2018	
		VAI, NE		
/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	DBE COMPLETE	
evealed that the facilty would in place to provide a systemic and direct quality provement activities provided egistered nurses, nurse workers, health educators, a staff. A further review summary data would be lated by the Quality icy revealed that the QAPI under the responsibility of the in collaboration with the nd the committee would meet rely. A continued review lated by a initially be discussed would be initially be discussed would be initially be discussed ity policy, no policy number, Infection Control, last revealed that the Quality entitee would monitor and quality or the infection control or mittee would meet monthly ealed that statistical data based on surveillance and ed quarterly during the Quality s. Ity Meeting Minutes for 2017 plan was not discussed or re no meeting minutes for sing Supervisor's (Employee on revealed that the Nursing monitor the development and			S	
with the Administrator	İ	An	nericans	
	STREET AD 1924 CLIF ATLANTA ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) THE PROVIDER'S CONTROL TO THE PROVIDER'S CLIFT AND ATLANTA ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) THE PROVIDER'S CLIFT AND ATLANTA ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) THE PROVIDER'S CLIFT AND ATLANTA ATEMENT OF DEFICIENCIES ATLANTA ATLANTA ATLANTA ATLANTA ATLANTA ATLANTA THE PROVIDER'S CLIFT ATLANTA (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 044-287 STREET ADDRESS, CITY, 1924 CLIFF VALLEY	(X2) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 044-287 STREET ADDRESS, CITY, STATE, ZIP CODE 1924 CLIFF VALLEY WAY, NE ATLANTA, GA 30329		

State of GA Inspection Report
STATE FORM One P. Hawkers Clinic Administration



State of GA . Healtm:are Fa	edity Pagulation Division			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIP A BUILDING	LE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED
	044-287	B.WING		05/02/2018
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY	∕, STATE, ZIP CODE	
CLIFF VALLEY CLINIC		, GA 30329	*	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
Conference Room, the facility had no control committees Administrator acknot stated the committee quarterly and would and surveillance revulations. U 302 111-8-403(3) Organ SS=E The governing body responsible for appoand shall establish equality assurance ar accountability of the	5/02/18 at 8:00 a.m. in the the Administrator stated that arrent QAPI or Infection or plans in place. The wledged that the facilty policy as would meet at least have ongoing plans, studies, iew. nization and Administration. of the center shall be sinting the professional staff affective mechanisms for	U 300	Corrective Action: Effective 2 nd Quarter 2018 QAPI meetiheld on a Quarterly basis to ensure a syorganize and direct quality assessment. The Nursing Supervisor/Manager has a organizing and implementing the QAPI. The Nurse Manager has received and since Program Supervisor. June 30, 2018 QAPI program will be infor the 2 nd Quarter of 2018. Corrective Action will include the reins Meetings to facilitate ongoing plans and necessary to maintain both the program facilities services. Responsible Person: Nurse Manager	stematic process to ssumed the task of re- program. igned a Job ponsibilities as QAPI place and up to date stitution of regular QA d studies as deemed
Based on review of the procedures, QAPI (Content of the procedures) performance Improved the facility failed to enter the facility failed to enter the facility failed to enter the facility and indicated the sent of the facility and indicated the sent o	rement) meeting minutes and riews, it was determined that establish an ongoing QAPI and quality indicators that and tracked patient care ting of priorities for ement activities. The policy, no policy number, and improvement Plan", wealed that the facility would an place to provide a systemic		An	SS

State of GA Inspection Report
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State of GA. Healthcare Facility Reaulation Division					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	044-287	B.WING		05/02/2018	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CLIFF VALLEY CLINIC		F VALLEY V A, GA 30329	VAY, NE		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
U 302 Continued From pa	ge 3	U 302			
submitted and eval Committee. I he por Program would fall Nursing Supervisor Medical Director, a no less than quarte revealed that the Quarte limprovement Data with the board. A review of the faci revealed that a QA reviewed. There we 2018. A review of the Nur #10) Job Description specific duties or in to the management During an interview (Employee #2) on Quartering Conference Room, the facility had no operate the policy stated least quarterly and srud s.	summary data would be uated by the Quality plicy revealed that the QAPI under the responsibility of the individual that the committee would meet why. A continued review equality Assessment and would be initially be discussed would be initially be discussed or ere no meeting minutes for 2017 PI plan was not discussed or ere no meeting minutes for ere no meeting minutes for ere no meeting minutes for with the QAPI program. If with the Administrator 205/02/18 at 8:00 a.m. in the the Administrator stated that surrent QAPI committee or rator acknowledged that the I the committee would meet at would have ongoing plans and				
agreement and/or t admitting privileges documented arrang necessary backup t center must have th	ave a hospital affiliation he medical staff must have or other acceptable gements to insure the for medical complications. The ne capability to transfer a to a hospital with adequate	U 906	An	SS nericans	

State of GA Inspection Report
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Ciaia af	CA Haalthaan Fasii	like Danelation Division			FORM APPROVED
STATEME	GA, Healthcare Facil NT OF DEFICIENCIES I OF CORRECTION	itv Regulation Division (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIF	PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED
		044-287	B.WING		05/02/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY	, STATE, ZIP CODE	
			FF VALLEY		
CLIFF V	ALLEY CLINIC		A, GA 3032		
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U 906	Based on review of interview, the facility affiliation agreemen medical staff to ensumedical complication. Findings: A review of the facility policy (not dated), "I Center's Cliff Valley Article V: Procedure Reappointment, Sec Appointment, required 3. Information as to membership status ever been revoked, renewed at any other involvement in any process of the facility of the fac	ervices. net as evidenced by: facility's records and y failed to maintain hospital ts, admitting privileges of ure the necessary backup for ns. ity's Medical Staff Bylaws Feminist Women's Health Clinic Medical Staff Bylaws", for Appointment and ction 1: Application for ed physicians to provide: whether the applicant's and/or clinical privileges have suspended, reduced or not er hospital or institution; professional liability actions; led files #16, #17, revealed no hospital privileges with the Clinic Administrator /1/18 at 11:45 a.m., in the room, the Administrator not locate #16 or#17's	U 906	Corrective Action: All Physician files in accordance with Professional Services have undergone of Clinic Administrator. Those Physician files lacking or missin information have been updated in complacilities Medical Staff ByLaws, as hav This process shall be completed by Jun Responsible Person: Clinic Administration of the Process of the Person of th	g the required bliance with the reall Physician files. e 8, 2018.
U 907 SS=E	111-8-409(8) Profe		U 907		SS
		re effective policies and Iling infection control and for	1	Λn	noricans

State of GA Inspection Report STATE FORM



State of	GA Haalthaara Easi	ility ReQuiation Division			PRINTED: 05/22/2018 FORM APPROVED
STATEMEN	OA FREMICATE FACI IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIF A BUILDING	PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED
		044-287	B.WING		05/02/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
CLIFF VA	ALLEY CLINIC		F VALLEY		
(X4)ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	A, GA 30329 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDEFICIENCY)	D BE COMPLETE
 U 907	Continued From page	ge 5 , L	1907	Corrective Action:	
	after surgery, which mechanism for patie postoperative comp This RULE is not m Based on review of procedures, Infectio and data, and staff ithat the facility falled Infection Control proreport reportable costatistical data, facili and surveillance rev	cions which occur during or includes a reporting ents who develop infections or dications after discharge. The facility's policies and on Control meeting minutes interview, it was determined to establish an ongoing ogram that included a plan to mmunicable disease, lity infection rates or trends, view or studies.		The Clinic Administrator as per her recredentialed and assigned the INFECT oversight to the Nurse Manager & Merprescribed by FWHC P&P. In addition, an OR Supervisor has recemaintain all Logs pertinent to Infection Suite. Quality Control Meetings will be held to enhance and complete the requirement data driven review of surveillance at F Responsible Persons: Nurse Manager Supervisor	TON CONTROL dical Director as ently been employed to a Control in the OR Quarterly as prescribe ent for an effective and WHC.
	"Quality Assurance: reviewed 12/2013, relimprovement Commevaluate the overall program, and the conformal A further review revewould be complied a studies and reviewe Assurance meetings." A review of the facility revealed that Infection reviewed. There we	ity policy, no policy number, Infection Control", last evealed that the Quality nittee would monitor and quality of the infection control ommittee would meet monthly. ealed that statistical data based on surveillance and d quarterly during the Quality s. ity Meeting Minutes for 2017 on Control was not discussed were no documented meeting			
,	#10) Job Descriptio	rsing Supervisor's (Employee n revealed that there were no isks listed that related to			SS

State of GA Inspection Report

During an interview with the Administrator

State Of	GA Healthcare Facil	ity Regulation Division			PRINTED: 05/22/2018 FORM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A.BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		044-287	B.WING		05/02/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY.	STATE, ZIP CODE	
CLIFF VA	LLEY CLINIC		FF VALLEY \ GA 30329	WAY, NE	
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u 907'	Continued From page	ge 6	U 907		
	Conference Room, the facility had no committee or plan in acknowledged that Infection Control conquarterly and would and surveillance revadministrator stated responsible for the Imoving forward.	I that Employee #10 would be i Infection Control Program			
	111-8-41 0(g) Phys Standards.	sical Plant and Operational	U1007		
		s shall be constructed, tained to assure the safety of nel.			
	Based on review of terview, the facility fa	net as evidenced by: the facility's policy and staff tiled to ensure all procedure led to assure the safety of liel.			
	Findings:				
	no documentation o	ity's policies showed revealed f an Operating Room lity tracking policy or protocol.			
	Dusting and Cleanir Humidity for OR #1, checked the temper operating room (OR	rating Room (OR) Daily ng Log & Temperature & revealed that the facility last ature and humidity of ature and humidity for erature and humidity for vere provided.	'] 		SS

State of GA Inspection Report

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State of GA Healthcare Fac	ility Regulation Division			FORIM AFFROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTII A.BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-287	B.WING		05/02/2018
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY	', STATE, ZIPCODE	
CLIFF VALLEY CLINIC		FFVALLEY A, GA 303	•	
PRÉFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BEPRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLANOF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	EAPPROPRIATE DATE
Temperature & Hun revealed that the fatemperature and hu #2. on 5/6/17. No fit temperature and his were provided. During an interview the Clinic Administrator state the operating room logs since the facility 3/14/17. U1103 111-8-411(4) Personal SS=E Each center shall receives a health e and a policy shall pexaminations. The sufficient detail, indox-ray data, to assure	ility's OR #1 Daily Log nidity, Dusting & Cleaning log I ncility last checked the midity of operating room (OR) urther checks of the umidity for operating room #2 of on 4/30/18 at 12:50 p.m. in rator's office, the Clinic d the facility had not checked s' temperature and humidity ity's last inspection dated	U1007	terminally cleaned ev 2. Temp and Humidity surgery is performed. 3. OR Supervisor will a	constructed to maintain record sting & Cleaning: OR's will be very Wednesday. Logs are notated every day ssign Health Advocates on a cry to clean and sanitize the Oay's surgery. Sing used. Equipment Repairs R Table is repaired will remain ted. We was conducted on May 23, Manager, OR Supervisor and Physical Requirements will have been completed to meet the
job to which he is	assigned.			
, Based on a review o	met as evidenced by: of employee health records, taff interview, the facility failed			Americans
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PRINTED: 05/22/2018 FORM APPROVED State of GA, Healthcare Facility Regulation Division (X1) PROVIDER/SUPPLIER/CUA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING-**B.WING** 044-287 05/02/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1924 CLIFF VALLEY WAY, NE **CLIFF VALLEY CLINIC** ATLANTA, GA 30329 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4)ID (XS) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX PREFIX REGULATORYORLSCIDENTIFYINGINFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) U1103 Continued From page 8 U1103 examination upon employment. Review of employee files #1, 2, 3, 4, 5, 6, 7, 13, 15, and 18, revealed no documentation of aphysical 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. U1105 111-8-4-.11(6) Personnel. U1105 SS=E 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 seg. and 31-7-1 et seq. Administrative History, Original Rule entitled "Personnel" was filed on January 22, ;;

State of GA Inspection Report

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Ctoto	of CA Hoolthoore Facil	ity Bogylation Division			FORM APPROVED
STATE	of GA Healthcare Facil MENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A BUILDIN	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
		044-287	B.WING		05/02/2018
CLIFF (X4)IE	•	1924CLIF ATLANTA ATEMENT OF DEFICIENCIES	FVALLEY\ A, GA 3032	PROVIDER'S PLANOF CORRECTION	
PREF TAG		Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	
U11	Agency. This RULE is not m Based on record re failed to conduct fire least quarterly and of Findings: A review of records for fire or disaster d During an interview (Employee #2) on 5 facility's conference stated he/she could and disaster drills. T had been no drills of #2 further stated, he disaster drills neede	ch 1, 1980, as specified by the	U1105	Corrective Action: To meet the Compliance Requirements Personnel as it relates to Fire/Disaster I process of hiring a new Facilities & IT will schedule Fire/Disaster Drills, recor complete and record for QA documents Drills will be conducted on a Quarterly 2nd Quarter 2018 drill will be completed Monitoring is the responsibility of the I Coordinator. The Executive Director has made an of the facility has determined a start day o Responsible Persons: Facilities IT Co Executive Director	Orills FWHC is in the Coordinator who desame as well as attion of same. basis. Completion of the by June 30, 2018. Facilities/IT fer to a candidate who fe/25/2018.
	Each center shall prequipment and ensumaintenance is sufficiely of good repair. Propprovided as necession	rovide sufficient space and ure that housekeeping and icient to keep the center and n and tidy condition and state ter maintenance shall be ary to correct, prevent, or neet and/or correct other	U1500		
		net as evidenced by:			SS

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Based on review of facility policy, observation,

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PRINTED: 05/22/2018 State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLJER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A.BUILDING:_ **B.WING** 044-287 05/02/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1924 CLIFF VALLEY WAY, NE CLIFF VALLEY CLINIC ATLANTA, GA 30329 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Corrective Action: U1500 Continued From page 10 U1500 Effective 5/14/2018 with the hiring of a Operating Room and staff interview, the facility failed to ensure that Supervisor the following protocols were set and Health maintenance to keep the equipment rooms clean Advocate assignments given: and in good repair. 1. OR will be terminally cleaned after each surgery day to include disinfection, dusting, floor scrub as Findings: prescribed in the FWHC policy. 2. Terminal Cleaning of the entire OR Suite was Review of the facility policy, no policy number, conducted by Service Master on 5/24/2018 and will "Specific Terminal Cleaning", reviewed on be maintained. 12/2013, revealed that terminal cleaning will take 3. OR Supervisor is preparing "standing orders" for place at the end of each surgical day by the the proper cleaning of the OR Suite. These orders health workers and the housekeeping crew. A will be completed by June 18, 2018. further review revealed that each Operating As regards the tear in the OR Table in use, Staff is covering Room (OR) suite will be terminally cleaned daily. the tear with proper materials to avoid any patient contact A continued review revealed that terminal with the angular tear until the arrival of a new OR Table cleaning would be completed to reduce the which should be in-house and operational no later than July amount of dust, organic debris and 30, 2018. microorganisms (germs) present in the surgical environment. Terminal cleaning by the staff will Staff Education: OR Supervisor will be conducting an In include daily cleaning of furniture and equipment., Service for all Health Advocates working in the OR Suite. This In Service will be completed by June 15, 2018. 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) Ir2. 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

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the vinyl on the side of the OR table.

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

Clinic administrator



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		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING:		(X3) DATE SURVEY COMPLETED
		044-287	B.WING		05/02/2018
CLIFF VALLE	SUMMARY STA	1924 CLIF	PRESS, CITY, F VALLEY , GA 30329 ID PREFIX TAG		
170	NEGOLATON ONE		IAG	DEFICIENCY)	FINALE DATE
OR con sub also tabl U1600 111	ofirmed that the vertical stance around the confirmed a teal teal teal teal teal teal teal te	ge 11 Supervisor (Employee #10) rentilator had dust and a waxy he door knob. The employee ar was present on the OR torage and Dispensing.	, U1500 U1600		
SS=E Eacleque and Fector Aut 31- Ruli filect 198 This Bas and exp use . per Finc	ch center shall partipment and staff administered in deral laws and research for the facility of the facility policy. The center of the facility of the facility policies eview of the fa	rovide adequate space and f to assure that drugs are stored compliance with State and egulations. Secs. 31-2-4 et seq. and inistrative History. Original Storage and Dispensing" was, 1980; effective March 1, by the Agency. The tas evidenced by: facility policy, observation, the facility failed to ensure that is were not available for patient medications were discarded ity policy, no policy number, and Procedures", last		Corrective Action: The Nurse Manager or RN (per responsible for monthly check of for expiration date and wasting FWHC facility protocol for Equip Supplies. Responsible Person: Nurse Mar Correction: Immediate The CRNA Staff will undergo ar refresher with the Medical Direct storage of vials and labeling as disposal of expired anesthesia dequipment in accordance with the and procedures. This process is by June 30, 2018 with the proper in the QAIP program. Responsible Person: Medical Dimanager	of sterile supplies as needed per the oment and nager In Service stor regarding the well as the drugs and ne facilities policies hall be completed er notation provided
revi rem with ope che All e Rev "Eq	sed 11/2013, reviating in a multi- in the date opene ening the vial. All ocked for expiration expired medication of the facility of the facility of the facility of the solution.	vealed that any medication -dose vial must be labeled d and the initials of the person medications would be on dates on a monthly basis. ons would be discarded. y policy, no policy number, oplies", last revised on		8FU211 U	ericans



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State of	GA Healthcare Faci	litv Regulation Division			FORM APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CUA	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		044-287	B.WING		05/02/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
CLIFF V	ALLEY CLINIC		F VALLEY 1 4, GA 30329	WAY, NE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CRUSS-REFERENCEU TO THE APPR DÉFICIENCY)	JLD BE COMPLETE
U1600	Continued From pag	ge 12	U1600		
	to be checked prior during monthly inve	hat sterile patient supplies are to use for their expiration date entory. erating Room (OR) #2 on			
	05/01/2018 at 1:45 observations were r cart:	p.m. the following made in the locked anesthesia			
		nil (to treat drowsiness ons used to produce a state of rial expired 3/2018;			
	solution, date, time	l syringes with no name of solution was drawn up into f the person opening the vial;			
	"mini-spiked" conne	e 1% 30 ml vial spiked with a ector with only month/day with the person opening the vial;			
		e HCl 1% 20 ml vial opened als of the person opening the			
		rmal Saline (NS) 30 ml vial als of the person opening the			
	A continued tour of expired supplies:	OR #2 revealed the following			
	a. Four (4) winged in "yellowed" tubing;	nfusion sets with no date, but			-00-
	b. One (1) CO2 dete	ector expired 112017;			Sis
	c. One (1) cuffed tra	acheal tube expired 10/2014;			
	d One (1) Jaryngeal	mask ainway expired 2/28/16:		\mathbf{A}	mericans

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State of	GA Healthcare Fac	ility Regulation Division			FORM APPROVED
STATEME	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING: _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		044-287	B.WING		05/02/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
CLIFF V	ALLEY CLINIC		IFF VALLEY V A, GA 30329	WAY,NE	
(X4)ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PIAN OFCORREC' (EACH CORRECTIVE ACTIONSHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTE
U1600	Continued Frompa	ge 13	U1600		
	e. One (1) nasopha 12/2015.	ryngeal airway expired			
	e. One (1) nasopharyngeal airway expired				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:

JULY 0 to 2018

A LA Parala de Roman de maissa de la comercia del comercia del comercia de la comercia del la comercia del la comercia de la comercia de la comercia de la comercia de la comercia de la comercia de la comercia de la comercia de la comercia de la comercia de la comercia de la c

(X3) DATE SURVEY

044-287

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05/02/2018

NAME OF PROVIDER OR SUPPLIER

CLIFF VALLEY CLINIC

STREET ADDRESS, CITY, STATE, ZIP CODE

1924 CLIFF VALLEY WAY, NE ATLANTA, GA 30329

(X4)1D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG

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PROVIDER'S PLANOF 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 030 290-5-32-.03(1) Procedure for Filing Certificate of 'v 030 SS=E 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.

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

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

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State of GA Healthcare Faci	lity Regulation Division			FORM APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-287	B.WING		05/02/2018
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	
CLIFF VALLEY CLINIC		IFF VALLEY \ A, GA 30329	WAY, NE	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLÉTE E APPROPRIATE DATE
v 030 Continued From pa	ge 1	V030		
by: Based on facility po and staff interview, i facility failed to ensu Abortion were filed of Human Resources of a termination of pres (12) sampled patient and#11.) Finding Review of the facility last revised 03/2011 Terminiation of Pres by the facility would ten (10) days of the law. Review of seven (7) records reviewed (# revealed that the Ce filed after the ten (10) a. A review of medi the abortion procedu however, not filed until the procedure; b. A review of medi the abortion procedu	licy, medical record review, t was determined that the are that Certificates of with the commissioner of within ten (10) days following gnancy for seven (7) of twelvest records (#3, 5, 6, 7, 8, 9, revealed that all Induced gnancies (ITOPs) performed be filed with the State within procedure, as required by of twelve (12) medical 3, 5, 6, 7, 8, 9, and 11) ertificates of Abortion were color day requirement as follows: cal record #3 revealed that are was performed on the Certificate of Abortion was twenty-six (26) days after cal record #5 revealed that are was performed on the Certificate of Abortion was thirty-eight (38) days after thirty-eight (38) days after			
c. A review of medi	cal record #6 revealed that			Americans

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State of GA, Healthcare	Facility Regulation Division			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
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V 030 Continued Fro	ompage 2	V030		
	rocedure was performed on ever, the Certificate of Abortion was thirty-three (33) days after •	1		
the abortion pr	f medical record #7 revealed that recedure was performed on ever, the Certificate of Abortion was sixty-four (64) days after			
the abortion pr	medical record #8 revealed that rocedure was performed on ever, the Certificate of Abortion was thirty-one (31) days after	i'		
abortion proced however, the C	f. A review of medical record #9 revealed that the , abortion procedure was performed on however, the Certificate of Abortion was not filed until twenty-four (24) days after the procedure;			
the abortion pr	medical record #9 revealed that recedure was performed on ever, the Certificate of Abortion was twenty-four (24) days after			
(Employee #2) Administrator's that he/she is in the facility was areas. The Ad	rview with the Administrator on 04/30/18 at 9::47 a.m. in the office, the Administrator revealed new to the position and stated that not in compliance in numerous ministrator revealed that many of not been filed with the State within in (10) days.			SS
			An	nericans

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	0.000		Ī		
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				DEFICIENCY)	
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	oponing common		' 555		
	At the time of the si	urvey, Atlanta Women's			
		in compliance with Chapter			
	290-5-32, Rules an	d Regulations for Performance			
		e First Trimester of Pregnancy			
		uirements For All Abortions, as			
		Re-licensure survey. No			
	deficiencies were ci	ted.			
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				A	mericans
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_ABORATOR	Inspection Report Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	or Life

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State of	<u>GA, Healthcare Faci</u>	lity Regulation Division			
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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
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		000 011			02/10/2010
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
ATI ANT	A WOMEN'S MEDICA	AL CENTER 235 WES	T WIEUCA R	OAD	
AILANI	A WOMEN O MEDIO	ATLANT	A, GA 30342		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
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TAG	REGOLATORTORE	ESO IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	MAIL
U 000	Initial Comments.		U 000		
		urvey, Atlanta Women's			
		s in compliance with Chapter			
		Regulations for Ambulatory			
		Centers, as the result of a			
	Re-licensure survey	y. No deficiencies were cited.			
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state of GA I ABORATORY	Inspection Report Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN.	ATURF	TITLE	or Laife
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			A. POILDING.		
		060-141	B. WING		02/20/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	FATE, ZIP CODE	
SUMMIT	MEDICAL ASSOCIA	11 = 5	OMONT RD, I A, GA 30324	NE, SUITE 500-E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
U 000	Initial Comments.		U 000		
	At the time of the re Summit Medical As compliance with Re 111-8-4, Rules and	elicensure survey on 02/18/19, sociates was in substantial equirements with Chapter Regulations for Ambulatory to deficiencies were cited.		A	SS mericans Inited
State of GA I	Inspection Report	ED/GUDDLUED BERDESENTATIVES CONT	TUDE	TITLE C	
_ABORATOR\	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGNA	NIURE	TITLE	or Lorfe