State of GA, Healthcare Facility Regulation Division

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	Opening Comments At the time of the survey, Atlanta Women's Medical Center was not in compliance with Chapter 290-5-32, Rules and Regulations for Performance of Abortions After the First Trimester of Pregnancy and Reporting Requirements For All Abortions, as the result of a State licensure survey.The following deficiency was written as a result of that survey.	V 000		
V 030 SS=A	290-5-32-.03(1) Procedure for Filing Certificate of Abortion In addition to the medical records requirements of Chapters 290-5-6 and 290-5-33 of the Rules and Regulations of the Georgia Department of Human Resources, the physician who performs the abortion shall file with the Commissioner of Human Resources or [redacted] designee, within ten (10) days after an abortion procedure is performed, a Certificate of Abortion. It is expressly intended that the privacy of the patient shall be preserved and, to that end, the Certificate of Abortion shall not reflect the name of the patient but shall carry the same facility number, or other identifying number reflected on the patient's medical records. A duplicate of the Certificate of Abortion will he made a part of the patient's Medical record and neither the aforesaid duplicate certificate nor the Certificate of Abortion which is filed with the Commissioner or his designee shall be revealed to the public unless the patient executes a proper authorization which permits such a release or unless the records must be made available to the District Attorney of the Judicial Circuit in which the hospital or health facility is located as provided by Code Section 16-12-141 (d) of the Official Code of Georgia Annotated.	V 030	Corrective Action: The internal process for filing the Certificate of Abortion has been updated to include defined roles and responsibilities of staff members that will be held accountable for filing the certificates of abortion. Additional documentation has been added to ensure all abortion procedures have been filed, including: • An "ITOP Worksheet" to be used internally has been instituted and will be used by staff to complete filing. • A column has been added to the Post-anesthesia Care Unit (PACU) Log for staff to indicate a completed submission/filing of each abortion procedure performed each day. Staff Education: Staff members responsible for filing the certificates of abortion have been assigned responsibility for specific days of service (i.e. Wed, Thurs, Fri, Sat) and were trained on the updated procedures and documents to ensure that all records are filed within the required 10 day time period. Monitoring: Daily PACU Logs will be reviewed under supervision of Clinic Administrator within 10 days. Random chart reviews will continue to be conducted as part of the Quality Assurance process to ensure that "Proof of Filing" form is included in medical chart. Staff members will be held accountable for any violations of the Policy for Filing Certificate of Abortion, including termination of duties, and possible termination of employment.	8/28/13

State of GA Inspection Report

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

Stacey C. | Administrator | 10/3/2013

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V 030	Continued From page 1 Repealed: F. Dec. 18, 2012; eff. Jan. 7, 2013. This REQUIREMENT is not met as evidenced by: Based on review of Georgia Code, O.C.G. 16-12-14, medical record reviews and staff interview it was determined that the facility failed to ensure that the Certificate of Abortion was filed with the Department for two (2) of ten (10) sampled medical records (#'s 2 and 8). Findings include: Review of the current Georgia Code, O.C.G. 16-12-14 on 8/9/2013, revealed a requirement that the physician who performs an abortion file a Certificate of Abortion with the Commissioner of Community Health within ten (10) days following the abortion procedure. 1. Patient #2, abortion was completed on 7/19/20/13, the Commissioner of Community Health notification was 8/9/2013. 2. Patient #8, abortion was completed on 7/18/20/13, the Commissioner of Community Health notification was 8/9/2013. Interview on 8/9/2013 at 6:30 p.m., the Administrator confirmed the findings.	V 030	Responsible Persons: Assigned Staff Members and Clinic Administrator	

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

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Stacey C. Yates | Administrator | 10/3/2013

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

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

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

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

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