GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor | Frank Berry, Commissioner

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

May 4, 2017

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 **March 14, 2017** 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

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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,

Bola Ansa

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

AA:rf

State of GA, Healthcare Facility Regulation Division

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

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

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

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

Clinic Administrator 5/3/2017

State of GA, Healthcare Facility Regulation Division

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

State of GA, Healthcare Facility Regulation Division

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

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U 302	Continued From page 3 had been suspended effective January 1, 2017 due to not providing current documentation; and he/she acknowledged the above findings.	U 302		
U 903 SS=D	111-8-4-.09(4) Professional Services. All nursing services shall be under the supervision of a registered nurse (R.N.). Each center shall have a sufficient number of currently licensed nurses present and on duty to attend to patients at all times patients are receiving treatment or recovering from treatment up to and including the time of discharge. Additional staff shall be on duty and available to assist the professional staff to adequately handle routine and emergency patient needs. This RULE is not met as evidenced by: Based on staff interview, employee file review and review of facility policies, the facility failed to have an appointed Director of Nursing (DON) / Nursing supervisor. Findings include: During the entrance interview with Director of Clinical Administration on 3/13/2017, he/she stated that the facility has not had a DON since September 1, 2016. Review of employee files failed to reveal a DON file. Review of facility policies failed to reveal a policy which addressed requirement for a DON / Nursing Supervisor.	U 903	U903 Corrective Action: Nursing Supervisor was hired on 3/23/2017. Staff Education: As part of the on-boarding process, Nurse Supervisor has been educated about the nursing roles and responsibilities of the clinic. Monitoring: Nursing Supervisor will be appointed by Medical director for a renewable two year term. Responsible Persons: Clinic Administrator, Medical Director	3/23/2017 3/23/2017

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

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

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

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

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

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

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
U1210	Continued From page 11 This RULE is not met as evidenced by: Based on review of facility policy, Medical Bylaws, medical records, and staff interview, it was determined that the facility failed to ensure that physical examinations were performed prior to procedures and that discharge orders were written, for three (3) of ten (10) sampled patient records (#6, 7, and 10). Findings: Review of facility policy entitled Medication Abortion Policies and Procedures, no policy number, last updated 05/2014, revealed patients having a medical abortions with Mifepristone and Misoprostol (medications administered to bring about an abortion) were to have a medical history and physical examination. The physical examination was to include the following: a. Pertinent physical examination, including vital signs; b. Determination of gestational age (age of fetus) by clinical assessment; and c. Ultrasonographic (specialized x-ray that determines age of fetus) examination when indicated. Review of Medical Bylaws, no date, revealed in Article VIII: Rules and Regulations, Section 3: Medical Records, B. History and Physical, 1. A complete gynecologic (female reproductive system) history and physical exam shall in all cases be performed and written by a physician, advanced practice nurse, or a Registered Nurse, and be a part of each patient's chart. C. Written, Verbal, and Standing Orders, 1. All orders for treatment shall be in writing.	U1210	U1210 Corrective Action: All professional staff have been instructed that a history and physical, as well as a discharge summary is needed on all patients being seen in the ambulatory surgical center, regardless of the procedure performed. Electronic medical records will be implemented by June 2017 to assist with compliance. History and Physicals are to be performed by the practitioner only. Staff Education: In-service has been scheduled for Professional staff and clinic staff to review Medical bylaws, as well as policies and procedures to determine the components of a complete chart for all patients treated in the ambulatory surgical center. In-service has also been scheduled in May 2017 to train professional staff on using the Electronic Medical Record, Nextgen, to record a complete history, physical and discharge summary. Monitoring: Completion of charts, including the physical exam, will be reviewed as part of the front staff chart audit, as well as by random chart audits by the Clinic Administrator, Nurse Supervisor, or Medical Director. Chart will also be reviewed as part of the quarterly peer review. Responsible Persons: Clinic Administrator, Medical Director, Nurse Supervisor, Front Office Supervisor, Professional Staff	

State of GA, Healthcare Facility Regulation Division

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

State of GA, Healthcare Facility Regulation Division

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