PRINTED: 03/09/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			E SURVEY PLETED
		11D0259351	B. WING_		10	/25/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 10	1/25/2016
FEMINIST	WOMEN'S HEALTH CEN	ITER	1924 CLIFF VALLEY WAY		*	
1 Limitio I	TOMENO HEALIN OLI	· · · · · · · · · · · · · · · · · · ·		ATLANTA, 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 CORRECT ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
D 000	INITIAL COMMENTS		DO	000		
D5209	(CLIA) recertification s October 25, 2018. Th compliance with appli found at 42 CFR 493. 493.1780. The following	Improvement Amendments survey was completed on the laboratory was not in cable CLIA requirements 1 through 42 CFR and deficiencies were cited: ETENCY ASSESSMENT	D52	09		12/14/18
	As specified in the per subpart M, the laborat follow written policies employee and, if applicompetency. This STANDARD is n A review of laboratory interview with the clinic determined that the laprovide annual Competesting personnel.  Findings include:  1. A review of testing there was no compete	ot met as evidenced by:  y personnel records and an c's administrator, it was boratory director failed to etency Assessment for its  personnel records revealed ency evaluations for testing				
AROPATORY	personnel (TP#s 2, 3, and 2018.  2. The laboratory fail policy for semi-annual for testing personnel.  3. An interview with the administrator on October the review room confir current written policy in the review room confired the review room con	ed to have current written and annual competencies ne laboratory's clinic per 25, 2018 at 02:36 PM in med that there was no		TITI E		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CRXY11

Facility ID: CLIA000635

12/14/2018

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		11D0259351	B. WING_			10/	25/2018	
	ROVIDER OR SUPPLIER WOMEN'S HEALTH CEI	NTER		192	REET ADDRESS, CITY, STATE, ZIP CODE 14 CLIFF VALLEY WAY LANTA, GA 30329			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
D5209	Continued From page competencies were n personnel #s 2,3,4,5	ot performed for testing	D52	209				
D5551	IMMUNOHEMATOLO CFR(s): 493.1271(a)(	)GY	D55	551			12/14/18	
	perform ABO groupin unexpected antibody identification, and cor following the manufact provided, and as applithrough (e).  (a)(2) The laboratory by concurrently testin a minimum, anti-A and For confirmation of Alserum must be tested cells.  (a)(3) The laboratory type by testing unknown (anti-Rho) blood typin (f) Documentation. The all control procedures this section.  This STANDARD is result and provided and intervial and intervial administrator, the laboratory (Rh anti-D, Rh(-) confirmings include:  1. Review of Immuno and QC logs revealed.	detection, antibody npatibility testing by cturer's instructions, if icable, 21 CFR 606.151(a)  must determine ABO group g unknown red cells with, at d anti-B grouping reagents. BO group, the unknown with known A1 and B red  must determine the D (Rho) wn red cells with anti-D g reagent. ee laboratory must document performed, as specified in not met as evidenced by: ne laboratory's maintenance						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			E SURVEY PLETED	
		11D0259351	B. WING_			10	/25/2018
	ROVIDER OR SUPPLIER  WOMEN'S HEALTH CEN	NTER	•	1924	EET ADDRESS, CITY, STATE, ZIP CODE I CLIFF VALLEY WAY ANTA, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
D5551	Continued From page	e 2	D55	551			
D0000	administrator on Octo approximately 01:40 confirmed QC was do daily patient work she	om in the review room one but not documented on eets and logs.					
D6000	DIRECTOR CFR(s): 493.1403	EXITY LABORATORY	D60	000			12/14/18
	the qualification requi this subpart and provi	nave a director who meets rements of §493.1405 of ides overall management dance with §493.1407 of					
	Based on the review and an interview with the laboratory's curre	not met as evidenced by: of laboratory documents the Clinic's administrator, nt laboratory director did not e complexity laboratory tandards.					
	Findings include:						
	Review of laborate personnel records of revealed that;	ory documents and the laboratory director,					
	Community Health (D Laboratory director in	. •		A SALAMA A A A A A A A A A A A A A A A A A			
		or did not have the 20 CEUs meet other qualifications for moderate complexity		***************************************			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		11D0259351	B. WING			10/25/2018
	ROVIDER OR SUPPLIER WOMEN'S HEALTH CEN	ITER		STREET ADDRESS, CITY, STATE, ZIP CODE 1924 CLIFF VALLEY WAY ATLANTA, 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
D6000		he Clinic's administrator in on October 25, 2018 at	D600	0	ı	
D6003	approximately 02:30 F change of laboratory of 116) was submitted in director did not meet moderate complexity	PM confirmed that no director request (CMS form April 2018 and laboratory requirements for a lab director by CLIA.	D600	3		12/14/18
	the performance of mand must be eligible to laboratory within the rethis part.  (a) The laboratory direcurrent license as a lathe State in which the such licensing is required.  (b) The laboratory directly (c) The laboratory directly (b) The laboratory directly (b) The laboratory directly (b) The laboratory directly (c) The laboratory d	e laboratory personnel and oderate complexity tests of be an operator of a equirements of subpart R of ector must possess a boratory director issued by laboratory is located, if ired; and ector must-f medicine or doctor of o practice medicine or e in which the laboratory is ananatomic or clinical the American Board of qualifications that are quired for such certification;				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		11D0259351	B. WING_		10	)/25/2018
	ROVIDER OR SUPPLIER  WOMEN'S HEALTH CEN	ITER		STREET ADDRESS, CITY, STATE, ZIP CODE 1924 CLIFF VALLEY WAY ATLANTA, 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 COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
D6003	(b)(2)(ii) Have had lab experience consisting (b)(2)(ii)(A) At least or supervising non-waive (b)(2)(ii)(B) Beginning at least 20 continuing hours in laboratory prathe director responsib or (b)(2)(ii)(C) Laboratory paragraph (b)(2)(ii)(B) during medical resided physicians certified eithematology and medical medical physicians certified eithematology and medical chemical, physical, bic laboratory science from and (b)(3)(i) Be certified by Medical Microbiology, Clinical Chemistry, the Bioanalysis, or the Am Laboratory Immunolog (b)(3)(ii) Have had at I directing or supervising testing; (b)(4)(i) Have earned achemical, physical, bic science or medical tectinstitution; (b)(4)(iii) Have at least training or experience testing; and (b)(4)(iii) In addition, he supervisory laboratory testing; or	poratory training or of: ne year directing or ed laboratory testing; or September 1, 1993, have medical education credit actice commensurate with edities defined in §493.1407; or training equivalent to of this section obtained ency. (For example, ther in hematology or cal oncology by the ernal Medicine); or doctoral degree in a cological, or clinical ency and accredited institution; or the American Board of the American Board of example of the ency of the en	D60	03		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
	11D0259351	B. WING_			10/25/2018		
NAME OF PROVIDER OR SUPPLIER FEMINIST WOMEN'S HEALTH CENTER	ER .		STREET ADDRESS, CITY, STATE, ZIP CODI 1924 CLIFF VALLEY WAY ATLANTA, GA 30329				
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
(b)(5)(ii) Have at least 2 training or experience, of testing; and (b)(5)(iii) In addition, have supervisory laboratory effecting; (b)(6) Be serving as a large must have previously que qualified as a laboratory §493.1406; or (b)(7) On or before Februnder State law to direct in which the laboratory is Laboratory director qualified as a laboratory in which the laboratory in which the laboratory in the laboratory director of manage and direct the latest performance.  (a) The laboratory direct current license as a laboratory direct (b)(1) Be a physician cellinical pathology (or both of Pathology or the Ame of Pathology or possess equivalent to those requivalent to those requivalent to those requivalent to those requivalent in the properties of the strain of the properties of the strain of the properties of the strain of the strai	ological science or an accredited institution; years of laboratory or both in non-waived or eat least 2 years of experience in non-waived oboratory director and talified or could have director under or	D60	003				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION  JILDING			(X3) DATE SURVEY COMPLETED	
		11D0259351	B. WING			10/	25/2018	
	ROVIDER OR SUPPLIER WOMEN'S HEALTH CEN	NTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1924 CLIFF VALLEY WAY ATLANTA, GA 30329			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
D6003	Bioanalysis, or other one of the laboratory (b)(2)(iii) Is certified by Cytology to practice of qualifications that are for such certification; (b)(2)(iv) Subsequent more years of full-time and experience of whis spent acquiring profice laboratory specialties (b)(3) For the subspeed be certified by the Ampathology, American Osteopathic possesses qualification those required for cer (b)(4) Hold an earned accredited institution biological science as (b)(4)(i) Is certified by Medical Microbiology Clinical Chemistry, the Bioanalysis, or other acceptable to HHS in specialties; or (b)(4)(ii) Subsequent more years of full-time and experience of whis spent acquiring profice laboratory specialties (b)(5) With respect to before July 1, 1971, in the direction of a laboratory, either: (b)(5)(ii) Was a physical content of the second of the content	national accrediting board in specialties; or y the American Society of cytopathology or possesses equivalent to those required or to graduation, has had 4 or e general laboratory training ich at least 2 years were iency in one of the cialty of oral pathology only, perican Board of Oral Board of Pathology or the company of Pathology or ons that are equivalent to tification; I doctoral degree from an with a chemical, physical, or a major subject and the American Board of the American Board of e American Board of e American Board of the Iaboratory to graduation, has had 4 or e general laboratory training ich at least 2 years were iency in one of the individuals first qualifying have been responsible for	D6	003				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			E SURVEY IPLETED
		11D0259351	B. WING_			1. 10	0/25/2018
	ROVIDER OR SUPPLIER WOMEN'S HEALTH CE	NTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE  1924 CLIFF VALLEY WAY  ATLANTA, GA 30329			78072010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
D6003	biological science as subsequent to gradupertinent full-time lab (b)(5)(iii) Held a bach accredited institution biological science as subsequent to gradupertinent full-time lab (b)(5)(iv) Achieved a an examination cond sponsorship of the U or before July 1, 1976 (b)(6) Qualify under Slaboratory in the Stat located.  Note: The January 1, 12 months' laboratory paragraph (b)(5) of the 1 year for each year experience obtained required by State law license. An exception qualifying date in parwas made provided to qualification approval had been employed in years of the 5 years pubmission of his qualification in the review and an interview with the laboratory's current subsequence of the subsequ	er's degree from an with a chemical, physical, or a major subject and ation had at least 4 years of oratory experience; allor's degree from an with a chemical, physical, or a major subject and ation had at least 6 years of oratory experience; or satisfactory grade through action had at least 6 years of oratory experience; or satisfactory grade through acted by or under the as. Public Health Service on a complex to the laboratory is  1968 date for meeting the end of full-time laboratory before January 1, 1958 for a laboratory director at the bully 1, 1971 agraph (b)(5) of this section that the individual requested by October 21, 1975 and a laboratory for at least 3 preceding the date of alifications.  The met as evidenced by: of laboratory director did not be complexity laboratory.	D60	003			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		11D0259351	B. WING_		10	10/25/2018	
	ROVIDER OR SUPPLIER  WOMEN'S HEALTH CEN	ITER		STREET ADDRESS, CITY, STATE, ZIP CODE 1924 CLIFF VALLEY WAY ATLANTA, GA 30329			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
D6003	Continued From page	8	D60	003			
	Findings include:						
	Review of laborato personnel records of trevealed that;						
	Community Health (De Laboratory director in	apply to the Department of CH) for a change of en the previous director was					
	lab director credits or laboratory director	or did not have the 20 CEUs meet other qualifications for mplexity required by CLIA.					
	the conference room of approximately 02:30 F change of laboratory of	lirector request (CMS form April 2018 and laboratory requirements for a					
D6033	Ref for D-6000 TECHNICAL CONSUL COMPEXITY CFR(s): 493.1409	TANT-MODERATE	D60:	33		12/14/18	
	who meets the qualific §493.1411 of this subp	ave a technical consultant cation requirements of part and provides technical se with §493.1413 of this					
	This CONDITION is n	ot met as evidenced by:					

	DF DEFICIENCIES CORRECTION			:	(X3) DATE SURVEY COMPLETED		
		11D0259351	B. WING_			10/	25/2018
	ROVIDER OR SUPPLIER  WOMEN'S HEALTH CEI	NTER		STREET ADDRESS, CITY, STATE 1924 CLIFF VALLEY WAY ATLANTA, GA 30329	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTING CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD B ED TO THE APPROPRIA CICIENCY)		(X5) COMPLETION DATE
D6033	and interviews with the laboratory failed to experson to fulfill the portion consultant (TC) to over Findings include;  1.) Personnel docume laboratory's maintenant assessments, temper Control (QC) logs for not reviewed by the laborator as the TC in 201	of laboratory documents he clinic's administrator, the imploy an active and qualified isition of Technical rersee laboratory operations.  Tents review revealed the ince logs, testing personnel rature logs and Quality Immunohematology were aboratory director who also 7 and 2018.	D60	033			
D6035	approximately 01:55 laboratory did not have Technical Consultant. TECHNICAL CONSUCFR(s): 493.1411  (a) The technical consumust possess a curred State in which the lab licensing is required. (b) The technical consusted to steepathy licensed to osteopathy licensed to osteopathy in the State located; and  (b)(1)(ii) Be certified in pathology, or both, by	PM confirmed that the re a qualified and active  LTANT QUALIFICATIONS  sultant must be qualified and int license issued by the oratory is located, if such sultant must  of medicine or doctor of o practice medicine or te in which the laboratory is	D60	035			12/14/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		11D0259351	B. WNG		,	10/2	25/2018
	ROVIDER OR SUPPLIER  WOMEN'S HEALTH CEI	NTER		19	TREET ADDRESS, CITY, STATE, ZIP CODE 924 CLIFF VALLEY WAY TLANTA, GA 30329		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
D6035	equivalent to those re or (b)(2)(i) Be a doctor of osteopathy, or doctor licensed to practice in podiatry in the State located; and (b)(2)(ii) Have at least training or experience testing, in the design subspecialty areas of technical consultant in physicians certified enhematology and mediate American Board of Into serve as the technical consultant in the serve as the serve as the technical consultant in the serve as the ser	s qualifications that are equired for such certification; of medicine, doctor of of podiatric medicine nedicine, osteopathy, or in which the laboratory is to one year of laboratory e, or both in non-waived ated specialty or of service for which the s responsible (for example, ither in hematology or lical oncology by the sternal Medicine are qualified ical consultant in	D6	035			
	degree in a chemical clinical laboratory sci from an accredited in (b)(3)(ii) Have at least raining or experience testing, in the design subspecialty areas of technical consultant (b)(4)(i) Have earned chemical, physical or medical technology from the consultant (b)(4)(ii) Have at least (b)(4)(iii) Have at least clinical raining from the consultant (b)(4)(iiii) Have at least clinical raining from the consultant (b)(4)(iiiiiiii) Have at least clinical raining from the consultant raining from the consul	, physical, biological or ence or medical technology stitution; and st one year of laboratory e, or both in non-waived ated specialty or f service for which the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		11D0259351	B. WING		1	0/25/2018		
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1924 CLIFF VALLEY WAY ATLANTA, GA 30329				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
D6035	subspecialty areas technical consultate technical consultate.  Note: The technical "laboratory training each specialty or so concurrently in mosubspecialties of some for example, an indegree in biology adocumentation of performing tests of specialties and subspecialties and interviews will aboratory perform testing in all special service.  This STANDARD Based on the reviand interviews will laboratory failed to person to fulfill the Consultant (TC) to Findings include;  1.) Personnel doculatoratory's maintressessments, tem Control (QC) logs	gnated specialty or of service for which the of service for which the of service for which the of service, or which the subspecialty may be acquired or ethan one of the specialties or ervice, excluding waived tests. Individual who has a bachelor's and additionally has 2 years of work experience of moderate complexity in all ospecialties of service, would exchnical consultant in a sing moderate complexity alties and subspecialties of sis not met as evidenced by:  ew of laboratory documents of the clinic's administrator, the openion of Technical coversee laboratory operations.	D60					
	the review room o approximately 01:	ith the Clinic's administrator in n October 25, 2018 at 55 PM confirmed that the have a qualified and active						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		11D0259351	B. WING			10/25/2018	
NAME OF PROVIDER OR SUPPLIER  FEMINIST WOMEN'S HEALTH CENTER				192	REET ADDRESS, CITY, STATE, ZIP CODE 24 CLIFF VALLEY WAY "LANTA, GA 30329		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD		_	(X5) COMPLETION DATE
D6035	Continued From page Technical Consultant. Ref for D-6033	12	D60	035			
	TECHNICAL CONSULCER(s): 493.1413(b)(s)  The procedures for evor of the staff must include review of intermediate quality control records and preventive mainte. This STANDARD is not assed on review of the records and an interview clinic administrator, the who is also the laborate maintenance records in Findings include:  1. Review of maintenare refrigerators, room temproblem logs revealed and signed on a month the laboratory director.  2. An interview with the administrator on Octob approximately 02:00 price and the staff process of the staff process.	aluation of the competency de, but are not limited to test results or worksheets, , proficiency testing results, nance records. ot met as evidenced by: e laboratory's maintenance ew with the laboratory's e Technical Consultant (TC) tory director failed to review n 2017, 2018.  ance logs including nerature, eye wash and they were not reviewed ally basis by TC who is also the laboratory's clinic for 25, 2018 at m in the review room the logs were not reviewed	D60	049			12/14/18