approved 10/13/mg

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FORM APPROVED

State of GA, Healthcare Facility Regulation Division

HEALTHCARE FACILITY REGULATION DIVISION
OCT 10 2014
RECEIVED

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 _____	09/24/2014

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

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

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

Clinic Director 10/8/14

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

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

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

Clinic Director 10.8.14

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

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

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

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