This Rule is not met as evidenced by:
Based on medical record review and staff interview, the facility failed to utilize personnel that had appropriate training and qualifications for the services they provided. This deficient practice affected 7 of 10 sampled patients. There were 2,128 patient visits in 2012.

A tour of the facility on 03/14/12 with Staff G revealed 4 operating rooms (ORs) which each contained a table with an electrical cord. The tables in ORs 2, 3, and 4 were observed with a bright pink sticker that stated "danger, table unsafe for use". These stickers were observed on the sides of the tables in OR 2, 3, and 4, were small in size, and not easily viewed. The male terminal ends of the electrical cords on OR tables 2, 3 and 4 were observed with plastic zipties that passed through the openings. Staff G stated the State Fire Marshall told the facility to put the zipties on the cords so they could not be plugged into the electrical outlets. The electrical cords to these tables lacked a warning label to not plug the cords into the wall. During tour, when asked what the danger was, Staff G stated when the tables are plugged into the electrical outlet, the person on the table could feel a "tingle". This employee stated all staff were informed of the danger to the tables. However, an interview with a recovery room nurse (Staff E) on 03/14/12 at 9:43 AM, revealed the employee was not aware of the danger to the tables, stating he/she does not work in the operating rooms. Staff G verified these tables are currently used to place patients on during the surgical procedures.

This Rule is not met as evidenced by:
Based on observation, staff interview, and review of medication policies, the facility failed to provide a double locked storage area for controlled substances, failed to label multidose vials when opened, and failed to label medication syringes in accordance with facility policy. The facility performed a total of 1,450 procedures in the past 12 months.

A tour of the facility was conducted on 03/15/17 at 8:46 AM. The recovery room was observed with six boxes of Epinephrine 1mg (0.1mg/ml), Lot #54-439-DK, with an expiration date of 03/01/17.

The HCF shall be maintained in a safe and sanitary manner.

This Rule is not met as evidenced by:
Based on observations and staff interview, the facility failed to maintain a sanitary environment related to a suction machine. The facility performed a total of 1,450 procedures in the past twelve months.

During the facility tour at 1:00 PM on June 3, 2009 it was noted that the facility was using the cabinets under the sink to store items used for patient care. These items present a potential health hazard by risk of infection. Under the sink in the lab there were blood collection tubes and supplies such as cotton balls. Exam Rooms #1 and #2 had chux pads and table paper stored in the cabinet below the sink. Under the sink in Exam Room #3 and #4 which are the primary procedure rooms there were chux, sanitary napkins and table paper. Sub-sterile area between exam rooms #3 and #4 contained chux and sanitary napkins and the drain below the sink contained a greenish crusty substance accumulated on the stainless steel pipes which was also found below the sink in exam room #3. The cabinet located below the sink in the nurses station located in the recovery area contained drinking cups and sanitary napkins.

At the time of the medical record review on 08/20/15 at 9:07 AM, Staff B confirmed the patient's guardian failed to sign the informed consents. Staff B confirmed the facility policy is for the guardian to sign these consents. On 08/20/15 at 3:25 PM, Staff B also confirmed the patient received two intravenous medications during the surgical procedure and stated the facility policy for obtaining informed consent for a minor by the guardian was not followed for Patient #28's surgical procedure.

#3. The oral suction machine was observed located next to the crash cart. The suction machine was observed uncovered at that time. The surfaces of the machine, and table on which the machine rested, were observed coated with a heavy layer of dust and dirt. This was verified with both facility staff during tour.

* Snapshots taken *from Columbus abortion clinic inspection records. Read more at: www.thisclinichurtswomen.*com

Think it can't happen here?
Think Again

Local abortion clinics have been cited repeatedly for failing to meet minimum business practices, health and safety standards, or pay taxes. Yet, they somehow manage to stay open. Here are a few examples:

- Hired a known sex offender as an abortion provider. He was subsequently indicted and imprisoned for child pornography. Local officials and the media ignored our calls for an investigation into if he molested patients,
- Cited for failing to maintain medical malpractice insurance and failing to notify patients that the doctor was uninsured,
- Failed to maintain basic business licenses in the State but were able to obtain/renew ambulatory surgical privileges.
- Sued for patient malpractice after performing a uterine abortion on a patient who had an ectopic pregnancy,
- Recorded as owning nearly a million dollars to local, state, and federal taxing authorities after not paying taxes for years and years.
- Cited for failing to get proper consent prior to performing abortions on patients who are minors,
- Repeated violations of health and safety standards, facilities' management, and other actions with the potential to harm patients.

Statewide, pro-life advocates report the same conditions at local abortion clinics, in several instances clinics are the site of repeated ambulance visits. One clinic affiliated with a Columbus abortion clinic was shut down after patient blood was stolen and controlled substances improperly provided to individuals. Another affiliated clinic was fined by the state Department of Health for failing to meet emergency care standards after a patient's bowl was suspected to be perforated.

Greater Columbus Right to Life is your local, grassroots, pro-life organization. We are working with boots-on-the-ground to minister to women seeking abortions by sending teams of dedicated volunteers and prayer warriors to the front-lines: the sidewalks and alleys around Columbus' abortion clinics. We are changing the culture through programs like 40 Days for Life and educational programming at churches, schools, and in the community. We are forging relationships between like-minded nonprofits, because we are stronger when we are unified. We are also serving as watchdogs of the local clinics, shining a light on the horrific conditions inside.

Want to help? Join Us.
Greater Columbus Right to Life