Approved Recommend

PRINTED 01/03/2017 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: \_ COMPLETED 1081AS B. WING 11/29/2016 YAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NORTHEAST OHIO WOMEN'S CENTER 2127 STATE ROAD CUYAHOGA FALLS, OH 44223 SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL SDEE:X ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) C 999 Initial Comments C 000 Licensure Compliance Inspection Administrator: Sheri Grossman County: Summit Number of ORs: One The following violations are issued as a result of the licensure compliance inspection completed on 11/29/16. C 104 O.A.C. 3701-83-03 (F) Governing Body C 104 C 104 - Governing Body 12/15/2016 The HCF shall have an identifiable governing body responsible for the following: 1. This deficiency will be corrected with (1) The development and implementation of the following measures: policies and procedures and a mission statement a. A template will be used to properly for the orderly development and management of the HCF: document meeting notes of the Governing Board. (2) The evaluation of the HCF's quality assesment and performance improvement program on an annual basis; and 2. The following measures have been taken to ensure that the deficiency does (3) The development and maintenance of a disaster preparedness plan, including evacuation not recur: procedures. a. The Clinic Manager will review all minutes and sign off for completion. Ohio Department of Health PUSUPPLIER PRESENTATIVE'S SIGNATURE LABORATORY DIRECTOR'S OF PROVIDE

Ohic Dept Health

PRINTED 01/03/2017 **FORM APPROVED** Onio Dept Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 1081AS B. WING 11/29/2016 NAME OF PROMOER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD NORTHEAST OHIO WOMEN'S CENTER **CUYAHOGA FALLS, OH 44223** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE אַבּבּיַעַכּ PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) **T**43 CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) C 194 Continued From page 1 12/15/2016 C 104 C 104 - Governing Board (Continued) This Rule is not met as evidenced by: 3. The performance will be monitored Based on review of governing body minutes and to ensure solutions are permanent staff interview the facility failed to ensure the governing body evaluated the facility's quality through: assessment and performance improvement a. Quality assurance audits program (QAPI) on an annual basis. This could conducted by a 3rd party consulting potentially affect all patients receiving care in the facility. A total of 435 procedures were performed in the most recent twelve months. 4. This deficiency was corrected on Findings include: 12/15/2016. On 11/29/16 at 5:30 PM, a review was conducted of the governing body minutes, along with an interview of Staff A. According to this review of minutes, the last Governing Board meeting was on 02/03/15. There was no evidence of an annual review by the Governing Body of the facility's QAPI program plan policy in 2015 or 2016. This finding was confirmed with Staff A during an interview on11/29/16 at 5:30 PM. C 114 O.A.C. 3701-83-07 (A) Patient Care Policies C 114 C 114 - Patient Care Policies 12/23/2016 1. This deficiency will be corrected with The HCF shall develop and follow comprehensive the following measures: and effective patient care policies that include the following requirements: a. Policies will be developed regarding if the policy they sent is acceptable patient care including: treatment, privacy,

Ohio Department of Health

dignity and

personal care needs:

(1) Each patient shall be treated with

consideration, respect, and full recognition of

individuality, including privacy in treatment and

STATE FORM

personal care, withdraw of consent,

records management, and financial

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records. (See Amendment B).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		
SID I DON OF GORRECTION	IDENTIFICATION NUMBER:		G:		E SURVEY PLETED
	1081AS	B. WING			
WHE OF PROVIDER OF SUPPLIER	STREET A	DDRESS CITY	, STATE, ZIP CODE		29/2016
ORTHEAST OHIO WOMEN'S	CENTER 2127 STA	TE ROAD	, SIATE, ZIP CODE		
	CUYAHO	GA FALLS,	OH 44223		
TOTAL SECTION OF PROPERTY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
ACGOLATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETE
C 114 Continued From pa	ge 2	C 114	C 114 - Patient Care Policies	<del></del>	12/23/201
(2) Each patient sh	all be allowed to refuse or		(Continued)		12/23/201
withdraw consent fo	or treatment;		(======================================		1
(3) Each patient sh	all have access to his or her		2. The following measures have	e been	
medical record, unia	RSS ACCESS is connisonally		taken to ensure that the deficie	ncy does	
restricted by the atte	ending physician for medical	į	not recur:		
			a. The Governing Board wil		į 1
(4) Each patient's n	nedical and financial records		policy and procedures manual	on a	•
shall be kept in conf	idence; and		annual basis for approval.		
(5) Each patient sha	all receive, if requested, a		3. The performance will be mor	itored to	
detailed explanation an itemized bill for s	Of facility charges including		ensure that the solutions are pe		
an itemized officers	ervices received.		through:		
		'	a. The P&P will be audited	on a	
			quarterly basis by a 3rd party o	onsulting	
			firm for deficiencies.		
This Rule is not met	as evidenced by:		b. Any deficiencies identifie		
based on review of r	Olicies and staff intervieus		referred to the Governing Board development and review.	TOF	
enective patient care	evelop comprehensive and		development and review.		
pauents treatment a	Datients' refugal or		4. This deficiency was correcte	d on	
medical records for	nt for treatment, for access to maintaining patients' medical		12/23/2016.		
and imancial information	tion in a confidential manner.				
and for providing a de	BIBLIEC EXPLANATION of facility				
Charges it requested	by a patient. This could atients receiving care in the				
racility. A total of 435	DIOCECUTES Were performed i				
in the most recent two	elve months.	į			
Findings include:					
On 11/29/16 at 7:00 F	M, a review of facility				
policies revealed the	facility lacked policies in				
regard to patients' tre	atment, for nationis' refusal				
in inedical records, to	ent for treatment, for access or maintaining patients'	ŀ			٠
Department of Health	hancing patients	1			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:		SURVEY PLETED
	1081AS	B. WING			
HAME OF PROVIDER OR SUPPLIER	STREET AF	DRESS SITE		11/2	29/2016
NORTHEAST OHIO WOMEN'S	S CENTED 2127 STA	ITE ROAD	, STATE, ZIP CODE		
	CUYAHO	ga falls,	OH 44223		
A3 REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	ת חבר	(X5) COMPLETE DATE
3 114 Continued From pa	ge 3	C 114		<del></del>	i I
manner, and for pro of facility charges if	al information in a confidential political and a detailed explanation requested by a patient.  Infirmed by Staff A on 11/29/16				
C 120 O.A.C. 3701-83-08	(B) T.B. Control Plan	0.455			
Each HCF shall developed control plan that is to assessment of the flassessment shall be for disease control a "Guidelines for Previous Mycobacterium tube Settings, 2005," MN RR-17. The HCF stevidencing compliant	relop and follow a tuberculosis pased on the provider's acility. The control and e consistent with the centers and prevention (CDC) renting the Transmission of erculosis in Health Care IWR 2005, Volume 54, No. nall retain documentation are with this paragraph and ocumentation to the director	C 120	1. This deficiency will be corrected the following measures:  a. Nursing staff shall conduct TE on all employees.  2. The following measures have be taken to ensure the deficiency does recur:  a. The Director of Nursing shall responsible for maintaining a log that documents when each employee is for their annual test.	with 3 tests een not be at	12/30/2016
feview and staff inter facility failed to follow control plan and polition affect all patients ser	file review, facility policy view it was determined the v their TB (tuberculosis) cy. This could potentially ved by the facility. A total of		<ol> <li>The performance will be monitore ensure solutions are permanent throa. Personnel files shall be review a quarterly basis to ensure all eleme of the established Infectious Control are being met.</li> <li>This deficiency was corrected on 12/30/2016.</li> </ol>	ough: wed on ents I Plan	

POPULAR SERVICES

Ohio Dept Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: \_\_\_\_ COMPLETED 1081AS B. WING 11/29/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD NORTHEAST OHIO WOMEN'S CENTER CUYAHOGA FALLS, OH 44223 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) 0 120 Continued From page 4 C 120 Review of the facility TB Control Plan and the undated facility policy. "Quality Control," revealed facility employees "will be tested for TB on an annual basis," Review of the personnel files revealed Employees #1, #2, #3 and #6 had no record of TB testing in their personnel files; Employee #5's last TB testing was 6/30/15 and Employee #7's last recorded TB test was 12/19/14. This finding was confirmed during interview with Staff B at 7:10 PM on 11/29/16. C 122 O.A.C. 3701-83-08 (D) Job Descriptions C 122 C 122 - Job Descriptions 12/15/2016 Each HCF shall provide each staff member with a 1. This deficiency will be corrected with written job description delineating his or her responsibilities. the following measures: a. Job descriptions will be made part of the On-Boarding process. b. Existing staff shall be provided job descriptions for their current positions. This Rule is not met as evidenced by: 2. The following measures have been Based on review of the personnel files and staff taken to ensure the deficiency does not interview it was determined the facility failed to recur: provide each staff member a job description. This could potentially affect the patients served by a. Job descriptions have been made the facility. A total of 435 procedures were part of the new hire employment packet. performed in the most recent twelve months. b. Job descriptions have been developed for all existing positions. Findings include: Review of the personnel files noted Employees #1, #2, #6 and #7 did not have a signed job description or written acknowledgment of receipt

Ohio Dept Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED 1081AS B. WING 11/29/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD NORTHEAST OHIO WOMEN'S CENTER CUYAHOGA FALLS, OH 44223 SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION ID コンドリ・メ PREFIX (X5) REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE T4G COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 5 C 122 - Job Descriptions C 122 12/15/2016 of their job description in their personnel files. (Continued) This finding was confirmed during interview with 3. The performance will be monitored to Staff B at 7:10 PM on 11/29/16. ensure solutions are permanent through: a. Personnel files shall be audited on a C 123 O.A.C. 3701-83-08 (E) Staff Orientation & C 123 quarterly basis for content. Training Each HCF shall provide an ongoing training 4. This deficiency was corrected on program for its staff. The program shall provide 12/15/2016. both orientation and continuing training to all staff members. The orientation shall be appropriate to the tasks that each staff member will be expected C 123 - Staff Orientation & Training 12/23/2016 to perform. Continuing training shall be designed to assure appropriate skill levels are maintained 1. This deficiency will be corrected with the and that staff are informed of changes in following measures: techniques, philosophies, goals, and similar a. All staff will be trained on Blood matters. The continuing training may include attending and participating in professional Bourne Pathogens, 1st-Aid & CPR, and meetings and seminars. general responsibilities and compliance. 2. The following measures have been taken to ensure the deficiency does not recur: This Rule is not met as evidenced by: a. A regular training format is being Based on review of personnel files and facility developed by a 3rd Party Consulting firm. policy and staff interview it was determined there b. All staff will complete various training was no evidence of an ongoing training program for staff. This could potentially affect all patients programs.

months

Findings include:

served by the facility. A total of 435 procedures were performed in the most recent twelve

Review of the undated facility policy, "Quality

Control" revealed, "....training is conducted on a

12/23/2016.

3. The performance will be monitored to

ensure solutions are permanent through: a. Quarterly reviews of personnel files.

4. This deficiency was corrected on

FORM APPROVED Onio Dept Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 1081AS B. WING 11/29/2016 VAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD NORTHEAST OHIO WOMEN'S CENTER CUYAHOGA FALLS, OH 44223 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ΙD ≃<del>H</del>EE:X EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) 723 COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY C 123 Continued From page 6 C 123 regular basis and can include but is not limited to the following programs: CPR and first aid; Blood bome pathogens; OSHA safety guidelines; and Counseling/Communication skills." Review of the personnel files of facility employees #3 and #5 failed to reveal evidence of any ongoing training or competency assessment specific to their job tasks other than CPR/ACLS which they did not received through this facility. There was no evidence of blood-borne pathogens, OSHA or counseling/communications skills annual training. During interview at 6:40 PM on 11/29/16, Staff A stated, "Staff are so part-time....We have the documents, just haven't filled them out yet." On 11/29/16 at 7:00 PM, an interview was conducted with Staff A and Staff B regarding ongoing education and training of staff members. Staff B stated there were currently no ongoing inservices and continued training for staff related to their job duties and facility changes in policies. Staff A confirmed the facility did not have evidence of ongoing inservices and training for review, stating the facility administrative staff is working on putting together a plan for ongoing staff training. C 124, O.A.C. 3701-83-08 (F) Staff Orientation & 12/23/2016 C 124 - Staff Orientation & Training C 124 Training 1. This deficiency will be corrected with All staff shall have appropriate orientation and the following measures: training regarding the facility's equipment, safety guidelines, practices, and policies. a. All existing staff will undergo training on equipment.

be developed.

b. A new hire orientation program will

" of the trace " He

PRINTED 01/03/2017 On o Dept Health **FORM APPROVED** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED 1081AS B. WING 11/29/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NORTHEAST OHIO WOMEN'S CENTER 2127 STATE ROAD CUYAHOGA FALLS, OH 44223 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION SOEE X EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE 743 REGULATORY OR LSC IDENTIFYING INFORMATION) **PREFIX** TAG DEFICIENCY C 124 Continued From page 7 C 124 C 124 - Staff Orientation & Training 12/23/2016 (Continued) This Rule is not met as evidenced by: Based on personnel file review and staff interview 2. The following measures have been it was determined the facility was unable to taken to ensure that the deficiency does provide evidence of orientation regarding the facility's equipment, safety guidelines and/or not recur: policies and procedures for three (#1, #6 and #7) a. A new-hire orientation program has of seven employees. This could potentially affect been developed to ensure all new all patients served by the facility. A total of 435 employees have completed the orientation procedures were performed in the most recent process. twelve months. Findings include: 3. The performance will be monitored to ensure solutions are permanent through: Review of the personnel files revealed Staff #1 a. Quarterly reviews of all personnel had no basic orientation to the facility equipment, files will be conducted to ensure safety guidelines or policies/procedures. compliance. Review of the personnel files of Staff #6 and Staff #7 revealed no evidence of orientation to the 4. This deficiency was corrected on facility, equipment, safety practices or 12/23/2016. policies/procedures. This finding was verified during interview with Staff B at 7:10 PM on 11/29/16. C 125 O.A.C. 3701-83-08 (G) Staff Performance C 125 C 125 - Staff Performance Evaluation 12/23/2016 Evaluation Each HCF shall evaluate the performance of 1. This deficiency will be corrected with each staff member at least every twelve months. the following measures:

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This Rule is not met as evidenced by: Based on personnel file review, facility policy review and staff interview, it was determined the

a. The Clinic Director will conduct evaluations on all employees who have been employed for 12 or more months.

(See Amendment E).

Committee and the second

Ohio Dept Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A..BUILDING: \_\_\_ 1081AS B. WING 11/29/2016 VAME OF PROMDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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ya 10 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
C 125	Continued From page 8	C 125	C 125 - Staff Performance Evaluation	12/23/201
	facility failed to perform annual performance evaluations. This finding could potentially affect all patients served by the facility. A total of 435 procedures were performed in the most recent twelve months.  Findings include:  Review of the undated facility policy, "Quality Control" revealed: "Each employee will be subject to annual performance evaluations as required by O.A.C. 3701-83-08 (G). Evaluations will be written by the individual employees' supervisor, and approved by Human Resources prior to reviewing the evaluation with the employee."  Review of the personnel files revealed Employees #3, #4 and #5, all employed greater than one year had no evidence of the completion or presentation of a performance evaluation.  This finding was verified during interview with Staff B at 7:10 PM on 11/29/16.		(Continued)  2. The following measures have been taken to ensure the deficiency does not recur:  a. The Clinic Director shall document hiring dates for all employees.  b. Employee evaluations shall be conducted in the month of January to ensure compliance with O.A.C. 3701-83-08 (G).  3. The performance will be monitored to ensure solutions are permanent through:  a. Quarterly reviews of personnel files will be conducted by a 3rd party consulting firm to identify deficiencies.  4. This deficiency was corrected on 12/23/2016.	
C 139	O.A.C. 3701-83-10 (B) Safety & Sanitation  The HCF shall be maintained in a safe and sanitary manner.	C 139	C 139 - Safety & Sanitation  1. This deficiency will be corrected with the following measures:  a. A log will be developed to record autoclave testing results.  (See Amendment F).	12/23/201
	This Rule is not met as evidenced by: Based on observations, review of facility documentation, and staff interviews, it was determined the facility failed to be maintained in a		b. All staff will be trained on existing refrigeration control logs.  c. A quality assurance audit will be completed to remove all expired items.	

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	pt Health				FORM	APPROVE
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	
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		CUYAHOO		OH 44223		
X4, ID FREFX T=3	EACH DEFICIENCY	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 RE	(X5) COMPLETE DATE
C 139	Continued From pa	ge 9	C 139	C 139 - Safety & Sanitation	<del>, , , , , , , , , , , , , , , , , , , </del>	12/23/201
	safe and sanitary m	nanner in regard to sterilization		(Continued)		
	of surgical instrume	ents, monitoring of stored				
	blood. This could r	nd expired needles for drawing potentially affect all patients		2. The following measures have b		
	receiving care in the	e facility. A total of 435		taken to ensure the deficiency doe	s not	
	procedures were pe twelve months.	erformed in the most recent		recur:	41-1-	
	tweive months.			a. Clinic Director will conduct a	-	
	Findings include:			audit to ensure compliance with al QA protocols.	·	
	1 A tour won and			b. Completed audits will be sul	bmitted	
	with Staff A and Sta	ucted on 11/29/16 at 6:50 PM ff B. An autoclave and a		to clinic ownership for review.	J	
	chest freezer were	observed in the instrument		c. Staff will participate in ongoi	ng	
	processing/products	s of conception (POC) room.		training to ensure familiarity with C	•	
	posted on the top of	rating the autoclave were f the machine. The autoclave		protocols.		
	model was observe	d as Tuttnauer 2340 M				
	Manufacturer's guid	elines for this model		3. The performance will be monitor		
	sterilization indicato	ring instructions: "Place a		ensure the solutions are permaner	nt	
	wrapped pack."	in such thay of moide each		through:	ani	
	When both Stoff A	and Charge D		a. A 3rd party consulting firm was review all audits for compliance on		
	as to how they kney	and Staff B were interviewed v the autoclave was		quarterly basis.	. a	
	functioning properly	to sterilize the surgical		b. The consulting firm will also	interview	
	instruments, both st	aff replied they knew it was		staff and use results to recommen-		
	outside of the instru	checking the tape on the ment packaging, if it turned a		additional training.		
	dark color, the instru	iments were processed				
	correctly. Per these	interviews, both staff		4. This deficiency was corrected of	n	
	maintain documenta	s no process in place to ation of the processing		12/23/2016.		
	procedure.	Freedomig				
1	2 A chest fragzer u	vas observed in the autoclave				
1	room during this tou	r. Staff B stated the freezer				
1	was used to store P	OC and "pathology"				
į	specimens. When it	nterviewed as to whether the				
	freezer. Staff B conf	ng the temperature of the				

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	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  IDENTIFICATION NUMBER: A SUM DATE.		1,	(3) DATE SURVEY	
		THE TOTAL PROPERTY.	A. BUILDING	3:	COMPLETED
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AME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	THAUTEUTO
ORTHE	EAST OHIO WOMEN'S	S CENTER 2127 STA	TE ROAD		
V/ '3	C) Mara DV OT	CUYAHO	GA FALLS,	OH 44223	
X4∵D ≃REFIX T±G	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLET TE DATE
C 139	Continued From pa	age 10	C 139		
	process in place to temperatures.	manitor the freezer for correct			
	revealed expired p. needles in Room 1 needles was obser pre-packaged need 12/15. Staff B confi	29/16 at 2:30 PM with Staff B re-packaged blood collection (lab room). This open box of ved filled with expired dles with expiration dates of irmed the date of expiration of needles at the time of			1
	(solution used to pe staff). The label or with wording of 1 m	ntained expired Tubersol erform tuberculin testing on the container was observed of (10 tests) and had an 1/04/16. This was confirmed time of observation.			
C 150	O.A.C. 3701-83-12 Program	(A) Q A & Improvement	C 150	C 150 - QA & Improvement Program	12/15/20
	and performance in to systematically m of patient care, pure	rablish a quality assessment inprovement program designed onitor and evaluate the quality sue opportunities to improve esolve identified problems.		This deficiency will be corrected with the following measures:     a. A Quality Assurance Committee be developed to assess, review, and recommend QA based initiatives.	
0 m //	facility documentation facility lacked evide and performance in for monitoring and e	et as evidenced by: governing body minutes, on, and staff interviews, the nce of a quality assessment approvement program (QAPI) evaluating the quality of patient e patient care and resolve		2. The following measures have been taken to ensure that the deficiency does not recur:  a. Quality Assurance Committee we meet every two months.  b. Meeting minutes will be reviewed the Clinic Director.	es rill

Ohio Dept Health

AND PLAI	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE	SURVEY
		1081AS	B. WING		11/2	29/2016
NORTH	REGULATORY OR L	CENTER 2127 STA CUYAHO TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	DDRESS, CITY ATE ROAD GA FALLS, ID PREFIX TAG	OH 44223  PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPRIED OF CORRECTION SHOULD DEFICIENCY)	ON D.B.E.	CX5) COMPLETE DATE
	435 procedures well recent twelve month. Findings include: On 11/29/16 at 5:30 of the governing bod documentation. An Staff A and Staff B a whether the facility is stated the facility is reviews, peer review surveys; however, occurred to conducting routine of findings to establish improve patient care. Staff B confirmed the and program plan, sepecifically in charges.	This could potentially affect g care in the facility. A total of re performed in the most his.  PM, a review was completed dy minutes and facility interview was conducted with at that same time regarding had a QAPI program. Staff B collecting data in record is and patient satisfaction confirmed the facility was not QAPI meetings to use these goals or use the data to		C 150 - QA & Improvement Prograt (Continued)  3. The performance will be monitorensure solutions are permanent the a. Clinic Director will review comeeting minutes to ensure compliant. This deficiency was corrected of 12/15/2016.	ored to rough: mpleted ance,	12/15/2016
	Each HCF shall deve describes the quality performance improv organization, scope, overseeing the effect	ement program's objectives	C 151	C 151 - QA & Improvement Plan  1. This deficiency will be corrected the following measures:  a. All staff will be trained regardi existing QA Program.  b. A Quality Assurance Committ be formed to assess, review, and recommend new protocols.	with ng the	12/23/2016

PRINTED 01/03/2017 Ohio Dept Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED 1081AS B. WING 11/29/2016 WAME OF PROMDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NORTHEAST OHIO WOMEN'S CENTER 2127 STATE ROAD CUYAHOGA FALLS, OH 44223 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION EACH DEFICIENCY MUST BE PRECEDED BY FULL SPERK (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) C 151 Continued From page 12 C 151 C 151 - QA & Improvement Plan 12/23/2016 This Rule is not met as evidenced by: (Continued) Based on review of governing body minutes, facility documentation, and staff interviews, the 2. The following measures have been facility failed to develop a written plan that taken to ensure that the deficiency does describes the quality assessment and performance improvement program's (QAPI) not recur: objectives, organization, scope, and mechanism a. A standard template will be used to for overseeing the effectiveness of monitoring, record Governing Board Meetings to evaluation, improvement and problem-solving ensure QA is part of the documented activities. This could potentially affect all patients receiving care in the facility. A total of 435 agenda. procedures were performed in the most recent b. Clinic Director will review Quality twelve months. Assurance Committee meeting minutes to ensure meetings are occurring on a Findings include: bi-monthly basis.

lacks a written plan. C 153 O.A.C. 3701-83-12 (D) Q A & Improvement -

On 11/29/16 at 5:30 PM, a review was conducted of the governing body minutes and facility

An interview was conducted with Staff A and Staff

B at that same time regarding whether the facility had a written plan that described the QAPI program. Staff B confirmed the facility currently

documentation

High-Risk Activities

Each HCF shall implement a program for proactive assessment of high-risk activities related to patient safety and to undertake appropriate improvements.

This Rule is not met as evidenced by: Based on review of governing body minutes,

12/23/2016. C 153 - QA & Improvement - High-Risk

3. The performance will be monitored to

ensure solutions are permanent through: a. The Clinic Director will perform

monthly audits to ensure compliance.

4. This deficiency was corrected on

1. This deficiency will be corrected with

the following measures:

- a. The clinic will implement a pre-screening process developed to identify any high risk patients or situations. (See Amendment C).
- b. Staff will be trained to recognize indicating factors.

C 153

Activities

12/23/2016

PRINTED 01/03/2017 Onio Dept Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED 1081AS B. WING 11/29/2016 \* AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD **MORTHEAST OHIO WOMEN'S CENTER** CUYAHOGA FALLS, OH 44223 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION DEE X EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) C 153 Continued From page 13 C 153 - QA & Improvement - High-Risk 12/23/2016 C 153 facility documentation, and staff interviews, the Activities facility failed to implement a program for (Continued) proactive assessment of high-risk activities related to patient safety and to undertake 2. The following measures have been appropriate improvements. This could potentially taken to ensure the deficiency does not affect all patients receiving care in the facility. A total of 435 procedures were performed in the most recent twelve months. a. Staff will undergo routine training on high risk protocols. Findings include: b. Governing Board will review existing protocols as part of their QA review to On 11/29/16 at 5:30 PM, a review was completed of the governing body minutes and facility correct any deficiencies. documentation. An interview was conducted with Staff A and Staff B at that same time regarding 3. The performance will be monitored to whether the facility had implemented a program ensure solutions are permanent through: for proactive assessment of high-risk activities a. A monthly Audit will be conducted related to patient safety. to ensure compliance of all QA protocols. Staff B confirmed the facility currently lacks a written program. 4. This deficiency was corrected on 12/23/2016. C 202 O.A.C. 3701-83-16 (B (4) Governing Body -C 202 Infection Control C 202 - Governing Body - Infection Control 12/23/2016 Designate a qualified professional trained in 1. This deficiency will be corrected with the infection control to direct the infection control following measures: program required by paragraph (D) of rule 3701-83-09 of the Ohio Administrative Code. For a. A RN will train on Infectious Control the purpose of this rule, a qualified professional Protocols and will serve as the Training trained in infection control means a nurse or Coordinator for the clinic. physician as defined in rule 3701-83-01 of the b. All staff will undergo infectious Ohio Administrative Code, who has control training.

documentation of completion of training in infection control, including, but not limited to, continuing education units, in-service training, or academic or vocational course completion.

This Rule is not met as evidenced by:

6269

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		1081AS	B. WING		11/2	9/2016
name of I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
NORTHE	AST OHIO WOMEN'S	S CENTER 2127 STA				
		CUYAHO	A FALLS, (	OH 44223		
-X4 /5 PREFX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 232	Continued From pa	age 14	C 202	C 202 - Governing Body - Infection	Control	12/23/2016
	Based on review of	f facility documentation and		(Continued)		i
	staff interviews, the	Governing Body failed to				
	designate a qualific	ed professional trained in		2. The following measures have b	een	
	infection control to	direct the infection control		taken to ensure the deficiency doe	s not	
	program, and failed	to ensure the facility had an		recur:		•
	affect all nation to	ogram. This could potentially eceiving care in the facility. A		a. The Training Coordinator wil	l review	
	total of 435 proced	ures were performed in the		the existing Infectious Control Prog		
	most recent twelve	months.		deficiencies for the Clinic Director		
	<b></b>			review.		
	Findings include:			b. The Clinic Director will create	e new	
	On 11/29/16 at 5:3/	DPM, a review was conducted		protocol based on the Training		
	of facility document	tation including Governing		Coordinator's recommendations.		
	Body minutes. An i	nterview was conducted with		c. The Governing Board will rev	view and	
	Staff A and Staff B	at that same time regarding		approve any new protocols submitt		
	whether the facility	had an infection control		approve any new processis susmit		
	infection control D	lified professional trained in ouring this interview, Staff B		3. The performance will be monito	red to	
	confirmed the facility	ty does not have a current		ensure solutions are permanent the		
•	program in place at	nd does not have a qualified		a. The Governing Board shall re	-	
	professional trained	in infection control to direct		and approve the Infectious Control		
	an infection control	program.		Program on an annual basis.		
	Staff A was present	halinda a Alain indonésia da esta esta esta esta esta esta esta est		Program on an annual basis.		
	B.	t during this interview with Staff		4. This deficiency was corrected o	n	
	_,			12/23/2016.	III	
C 213	O.A.C. 3701-83-17	(H) Receipt of Discharge	C 213	12/23/2016.		
	Instructions	,				
	ensure that the pati acknowledge, in wr	iatrist, dentist, or a nurse shall ient or patient's representative iting, receipt of the physician's, ist's written discharge				
ig ig ig ig ig ig ig ig ig ig ig ig ig i	This Rule is not me	et as evidenced by:				

	ept Health					APPROVEC
STATEME AND PLAI	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G:		SURVEY PLETED
		1081AS	B. WING		44.4	
NAME OF	PROVIDER OR SUPPLIER	STREET	DDDEEC CITY	CTATE TIP AND THE	11/2	29/2016
MODTU	EAST OUIO WOMEN		ATE ROAD	STATE, ZIP CODE		
	EAST OHIO WOMEN'S	S CENTER CUYAHO	GA FALLS,	OH 44223		
X4; (D	SUMMARY ST	STEMENT OF DEFICIENCIES	i ID	<del></del>		<del></del>
	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIECTION OF THE APP	DRE	(X5) COMPLETE DATE
0.213	Continued From pa		C 213	C 213 - Receipt of Discharge Instru	uctions	12/23/2016
	provide evidence or	record review and staff ermined the facility failed to f the provision of written		This deficiency will be corrected the following measures:	d with	
•	uscharge instruction	INS Drior to leaving the facility		a. All staff will be retrained on a	proper	
	Surgical procedure	atients (#2 and #3) of two records reviewed. A total of		procedures regarding documentati		
	433 procedures we	re performed in the most		patient discharge instructions.		
	recent twelve month	hs.		b. Charts will be reviewed at th	е	
	Eindiana I. d. d			completion of surgery days to ensu	ıre all	t !
	Findings include:			documentation is properly recorded		
	Review of the medic	cal records of Patients #2 and		(See Amendment D).		
	#3 revealed no evid	lence of the provision of		(		
	discharge instructio	ns to the patient or the person.	}	2. The following measures have be	een	
	accompanying then	for the procedure.		taken to ensure the deficiency does		
	During interview at a	5:20 PM on 11/28/16 Staff A		recur:		
	verified there were	no discharge instructions or		a. Chart reviews will be comple	ted at	
	written acknowledge	ment of receipt for Patient #2,		the end of surgery days to ensure		
	During interview at !	5:45 PM on 11/28/16 Staff A		compliance.		
	verified there were a	2180 no discharge instructions		b. Clinic Director will retrain		
	or written acknowled	Igment of receipt for Patient		employees as needed.		1
	murse so till have to	ot the regular recovery room go over that with her."		0.7		
	Harse so thirdays to	go over mat with her."		3. The performance will be monito		-
C 222	O.A.C. 3701-83-18	(C) Director of Nursing	C 222	ensure solutions are permanent the a. Quarterly reviews will be com	-	
	Each ASF shall have	e a director of nursing who is		by a 3rd party inspector.		İ
	an KN with experien	ICE in surgical and recovery		b. Clinic will review at least 10%	6 of all	ı
	be responsible for the	The director of nursing shall ne management of nursing		patient files.		
	services.			4. This deficiency was corrected o 12/23/2016.	n	
1	This Rule is not met	t as evidenced by: file review it was determined				

Ohio De	ept Health			'	FORM	IAPPROVED
STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	IPLE CONSTRUCTION IG:	(X3) DATE	SUPVEY
-		1081AS	B. WNG _			
<b>VANEOF</b>	PROVIDER OR SUPPLIER	STREET	DDDEGG own		11/2	29/2016
: NORTH	EAST OHIO WOMEN'S	2127 ST	ATE ROAD	, STATE, ZIP CODE		
	ENOT OTHO WOMEN	CUYAHO	GA FALLS,	OH 44222		
X4 (D	SUMMARY STA	TEMENT OF DEFICIENCIES				
TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) RE	(X5) COMPLETE DATE
C 222	Continued From pa		C 222	C 222 - Director of Nursing		12/15/2016
	This could potential the facility. A total of performed in the more findings include:  Review of the person Director of Nursing the application of su experience. There is personnel file to revious obtained to do no evidence the che qualifications verifies.	d. ified during interview at 7:10		1. This deficiency will be corrected the following measures:  a. The current Director of Nursing provide the Clinic Director proof of experience, which includes over 3.5 as a nurse in an ambulatory surgical setting and 4 years as a Director of Nursing.  2. The following measures have betaken to ensure that the deficiency onto recur:  a. Staff files have been reviewed ensure evidence is present of prior experience and training.	ng will their 5 years al een does d to	13/2010
	O.A.C. 3701-83-18 ( At all times when pa or recovering from tr discharged, the ASF (1) Have at least two in the ASF, at least or and at least one of wadvanced cardiac life present and on duty patients are present; (2) In addition to the (1) of this rule, have readily available on a	F) Nurse Duty Requirements tients are receiving treatment eatment until they are shall:  nurses present and on duty one of whom shall be an RN whom is currently certified in a support who shall be in the recovery room when requirement of paragraph (F) at least one RN who shall be in on-call basis; and	C 225	3. The performance will be monitor ensure solutions are permanent throa. Quarterly reviews will be come of personnel files to audit content.  b. Staff will be required to provid supporting documents as needed.  4. This deficiency was corrected on 12/15/2016.	ough: pleted de	
	(3) Have sufficient ar	nd qualified additional staff				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	3	PLE CONSTRUCTION 3:	(X3) DATE COMP	SURVEY PLETED
		1081AS	B. WNG		11/2	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	STATE, ZIP CODE	1	10/2010
NORTHE	AST OHO WOMEN'S			·		
		CUYAHO	ga falls,	OH 44223		
X4 D PREFX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
C 225	Continued From pa	age 17	C 225	C 225 - Nurse Duty Requirements		12/01/201
	present to attend to	the needs of the patients.	1			
		The same particular and the sa		1. This deficiency will be corrected	I with the	
				following measures:		
			1	a. A staff schedule will be creat	ted to	
				ensure two nurses are scheduled a	at all	
				times during surgical procedures.		
	This Dute is not			b. A policy has been developed	j	
	Based on review of	et as evidenced by: f the facility's "Nurse Logs" it		requiring the retention of all staff		
	was determined the	facility did not have two		schedules.		
	nurses present and	on duty at all times on				
	treatment days. Thi	is could potentially affect any		2. The following measures have be		
	of the patients serv	ed by the facility on days when		taken to ensure that the deficiency	does	
	procedures were no	s scheduled. A total of 435 erformed in the most recent		not recur:		
	twelve months.	enormed in the most recent		a. All nursing staff and Clinic Di	rector	
				have undergone training regarding		
	Findings include:			Nurse Duty Requirements.		
	Dovious of the feeth	h da Hataaa I		b. Schedules will be audited on	а	
	One burse was in the	ty's "Nurse Logs" revealed only ne facility and worked both the		quarterly basis to ensure compliance	ce was	
	surgery and recove	ery room for the patients		maintained.		
	treated on the follow	wing dates: 08/12/15;				
	08/14/15; 09/06/15;	11/04/15; 11/09/15; 01/31/16:		3. The performance will be monitor	red to	
	04/06/16; 04/24/16;	05/03/16; 05/05/16; 05/22/16;		ensure solutions are permanent thr	ough:	
	11/22/16.	06/26/16; 11/08/16 and		<ul> <li>a. Monthly audits conducted by</li> </ul>	the	
	TOZETO.			Clinic Director.		
	This finding was ve	rifled during interview at 7:10		b. Quarterly audits conducted b	уа	
	PM on 11/29/16 by	Staff B.		3rd party inspector.		
C 226	O.A.C. 3701-83-18	(G) Copies of Licenses &	C 226	4. This deficiency was corrected or	_	
1	Schedules	(-) prima w. miooridud u	U ZZU	12/01/2016.	1	
	Each ASF shall mai	intain the following:				
	(1) An established sthe director to asce	system of records sufficient for rain that all individuals				

XN5211

<u>Ohio</u>	Dept Health				FORM	APPROVED
STATES AND PL	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE COMP	SURVEY
		1081AS	B. WING		4410	0.10040
NAME:	DE PROVIDER OR SUPPLIER	STREET AL	DRESS CITY	, STATE, ZIP CODE	1 11/2	9/2016
NORT	HEAST OHIO WOMEN'S		TE ROAD	, VIAIL, ZIF CODE		
		CUYAHO	GA FALLS,	OH 44223		
PAER TAG	A SACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	D RE	(X5) COMPLETE DATE
<sup>2</sup> C 22	6 Continued From pa	ige 18	C 226	C 226 - Copies of Licenses and So	chedules	12/15/2016
۹ میرید	including, but not lie Ohio license, regist required by law, an (2) Staffing schedu	SF in a professional capacity applicable to that profession, mited to, possessing a current tration, or other certification d  les, time-worked schedules, and payroll records for at least		This deficiency will be corrected the following measures:     a. Clinic Director has received training on retention schedules and scheduling process.     b. A computer file has been created to help maintain compliance in reg	d with	
	R was determined the license status for the staff. This could poserved by the facilit were performed in the months.  Findings include:  Review of the personand #5 revealed verexpiration date of 8/1 evidence to reveal the ensure they were consured.	If file review and staff interview ne facility failed to verify active eir RN (registered nurse) tentially affect all patients y. A total of 435 procedures he most recent twelve  annel files of RN Staff #3, #4, iffication of licenses with an 31/15. There was no icenses had been checked to urrent and without disciplinary.		to retention.  c. Copies of relevant licenses is been added to respective personne files.  2. The following measures have be taken to ensure that the deficiency not recur:  a. Monthly QA audits will samp personnel files for compliance.  b. Quarterly QA audits will take complete inventory of personnel file.  3. The performance will be monitod ensure solutions are permanent the a. Quarterly audits conducted it.	een does le a es. red to rough:	
C 26	This finding was ver Staff B at 7:10 PM of O.R.C. 3702.30 (B)  An ambulatory surginfection control pro-	it period expiring 08/31/17.	C 266	3rd party inspector.  4. This deficiency was corrected of 12/15/2016.	n	

Torrespondence and the control

Onic Dept Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED 1081AS 8. WING WAME OF PROVIDER OR SUPPLIER 11/29/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NORTHEAST OHIO WOMEN'S CENTER 2127 STATE ROAD **CUYAHOGA FALLS, OH 44223** SUMMARY STATEMENT OF DEFICIENCIES PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE TAG DATE DEFICIENCY) C 266 Continued From page 19 C 266 C 266 - Infection Control Program 12/23/2016 and manage infections and communicable diseases; ensure that the program is directed by 1. This deficiency will be corrected with a qualified professional trained in infection the following measures: control; ensure the program is an integral part of the ambulatory surgical facility's quality a. A template has been created to assessment and performance improvement document minutes for the Governing program; and implement in an expeditious Board meetings to ensure that the manner corrective and preventive measure that Infection Control Program is discussed. result in improvement. (See Amendment A). 2. The following measures have been This Rule is not met as evidenced by: taken to ensure that the deficiency does Based on review of facility documentation and not recur: staff interviews, the facility lacked evidence of an infection control program, and failed to ensure a a. Director of Nursing will assist in qualified professional trained in infection control developing a comprehensive Infection was present to ensure there was a program Control Program. which was an integral part of the ambulatory b. A 3rd party consulting firm will surgical facility's quality assessment and performance improvement program (QAPI). This review the Infection Control Program for could potentially affect all patients receiving care deficiencies and make recommendations. in the facility. A total of 435 procedures were performed in the most recent twelve months. 3. The performance will be monitored to ensure solutions are permanent Findings include: through: On 11/29/16 at 5:30 PM, a review was completed a. Governing Board will review and of facility documentation that included all of the approve the Infection Control Program Governing Body minutes. on an annual basis. b. Quarterly reviews of Governing An interview was completed with Staff A and Staff B at that same time regarding whether the facility Board meeting minutes will be conducted had an infection control program and a qualified to ensure the Infection Control Program professional trained in infection control. During was discussed. this interview, Staff B stated the facility does not c. Staff will be trained on all have a current infection control program in place Infection Control Program protocols. and does not have an employee designated and qualified to direct an infection control program. 4. This deficiency was corrected on

12/23/2016.

PRINTED: 01/03/2017

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STATEMENT OF DEFIC	ENCIES	(X1) PROVIDER/SUPPLIER/CLIA	avai			M APPRO
AND PLAN OF CORREC	MOIT	IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DA	TE SURVEY
		1081AS	B. WING			
NAME OF PROMOER O	R SUPPLIER		<u></u>		11	/29/2016
		STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
NORTHEAST OHIO	WUMEN'S	CENTER 212/ SI,	ATE ROAD	11		
F4 D St DOER X EACH	MMARY STAT		GA FALLS, O			
743 REGUL	ATORY OR LS	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPL DAT
C 266 Continued	From pag	e 20	C 266			<del></del>
Staff A wa 8.	s present (	during this interview with Staff				
ŧ			[			

XN5211