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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION :	(X3) DATE 5 COMPL	
		1081AS	B. WING		07/11	/2017
	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NORTHE	AST OHIO WOMEN'S	CENTER	TE ROAD GA FALLS, (OH 44223		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
C 000	Initial Comments	· · · · · · · · · · · · · · · · · · ·	C 000			
	Licensure Compliar the licensure compl 11/29/16.	ice Inspection and follow up to lance inspection completed				
į	Administrator: Sher	ri Grossman				
	County: Summit				:	
ļ	Number of ORs: 1					
	The following violati the licensure complion 07/11/17.	ons are issued as a result of ance inspection completed	77000			
C 104	O.A.C. 3701-83-03	(F) Governing Body	C 104		:	
	The HCF shall have body responsible for	an identifiable governing r the following:				
	policies and procedu	it and implementation of ures and a mission statement opment and management of				
!	(2) The evaluation o assesment and perf program on an annu	ormance improvement				
	(3) The developmen disaster preparedne procedures.	it and maintenance of a iss plan, including evacuation				
mio Departn	ent of Health	FRISIPA IER BEPRESENDATUES SIG	- 			

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administratos

STATE FORM

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STREET AD	B. WING			
STREET AD			07/1	1/2017
- · · · · · · · · · · · · · · · · · · ·	DRESS CITY	STATE, ZIP CODE	, 0711	172011
2127 STA	TE ROAD			
FICIENCIES CEDED BY EUL!	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOUL	DBE	(X5) COMPLETE DATE
	C 104			
development of a development of 754 severe conducted as development of Nursing, detion Control of the Quality tha plan to development of the Quality of t		to include, Plan and mission stated. The QAPI is being monitored by the D.O.N. and reviewed by the Governing body. A QA committed has been appointed and will meet at least every 12 months to review monitor the current program that place. HCF has an ongoing train program in place and is being loand monitored to assess addition	ement. e e t w and es in ing gged	09/11/17
		FICIENCIES CEDED BY FULL SINFORMATION) C 104 C 10	CUYAHOGA FALLS, OH 44223 FICIENCIES CEDED BY FULL SINFORMATION) C 104 CC 10	CUYAHOGA FALLS, OH 44223 FIGIENCIES DEED BY FULL SINFORMATION) PREFIX TAG C 104 C

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AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		1081AS	B. WING		07/1	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	1 0111	112011
NORTHE	AST OHIO WOMEN'S	CENTER 2127 STAT	TE ROAD SA FALLS, C	NL 44222		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	·····
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LS	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETE DATE
C 104	Continued From page	ge 2	C 104			
	exception of a mont also confirmed there accordance with the	hly monitoring tool. Staff B was no QA manual in a facility policy.				
C 120	O.A.C. 3701-83-08	(B) T B Control Plan	C 120			
	control plan that is to assessment of the for disease control a "Guidelines for Prev Mycobacterium tube Settings, 2005," MM RR-17. The HCF st evidencing complian	relop and follow a tuberculosis based on the provider's acility. The control and econsistent with the centers and prevention (CDC) renting the Transmission of erculosis in Health Care IWR 2005, Volume 54, Nothall retain documentation acce with this paragraph and ocumentation to the director				
	and policy review, the staff members (Staff tested for Tubercuio This could potentiall care in the facility. A medical procedures recent twelve month.	I file review, staff interview he facility failed to ensure five if B, D, G, H and I) were sis (TB) on an annual basis. y affect all patients receiving A total of 754 surgical and were conducted in the most is.				
	ine racility's policy t	itled "Exposure Control Plan"				

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Ohio De	<u>pt Health</u>				FORM	APPROVED
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	
			A. BUILDING	:	COMP	LETED
		1081AS	B. WING		07/1	1/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
NORTHE	AST OHIO WOMEN'S	CENTER 2127 STA	TE ROAD GA FALLS, (OH 44223		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETE DATE
C 120	Continued From pa	ge 3	C 120			
	was reviewed. The tested for TB on an OAC 3701-83-08 (E base line PPD upon proof upon hire. A F administer the test. Registered Nurse of hours. A negative P	plan stated employees will be annual basis. Pursuant to B): All employees will have a hire, unless they provide Registered nurse will. The test will be read by a pur Physician within 48 to 72 PD requires no additional PD requires a chest x-ray. TB		C120 HCF had developed a molog to ensure that all staff rema current with TB testing. To be monitored by Director of Nursin See attached #2	in	9/11/2017
	testing will be repeatemployee has a positive chest x-ray the followindergo a health as physician should confide the Assessment Form.	ated on an annual basis. If an sitive PPD and a negative owing year. Employee should assessment. The employee's omplete the TB Health This will be repeated on an affected employees.				
	file contained a Tub 10/23/13 in which S	e of Staff B was reviewed. The erculosis (TB) test from staff B tested positive for TB, tain an additional Tuberculosis after 10/23/13.		C 120 1.Staff B now has a follow X-Ray in staff file and a follow up on file		9/11/2017
		wed on 07/10/17 at 1:40 PM s not aware of the positive s.				
	with Staff B and cor	PM, the findings were shared offirmed. Staff B stated she did Fuberculosis test in her file.				
	2. The personnel file The file did not cont	e of Staff H was reviewed. tain a TB test.		C 120 Staff H,D,I and G now al a current TB test in staff file	I have	9/11/2017
	On 07/11/17 at 2:42 with Staff B and cor	PM, The finding was shared firmed.				
	3. The personnel file. The file did not confi	e of Staff D was reviewed. tain evidence of a TB test.				
thio Donada	ent of Health		·	<u>'</u>		

STATEMEN	pt Health NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(V2) DATE	SUBVEN
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	4			SURVEY PLETED
		1081AS	B. WING		07/	11/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	1 077	11/2017
ORTHE	AST OHIO WOMEN'	S CENTER 2127 STA	ATE ROAD			
		CUYAHC	GA FALLS, O	— · · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
C 120	Continued From pa	age 4	C 120			
	On 07/10/17 at 2:4 with Staff A and co	1 PM, the finding was shared nfirmed.				
	4. The personnel fi file did not contain current TB test in t	lle of Staff I was reviewed. The evidence of Staff I having a he personnel file.				
	On 07/10/17 at 2:5 with Staff A and co	0 PM, the finding was reviewed nfirmed.	i			
	5. The personnel fi The file did not cor a TB test.	le of Staff G was reviewed. ntain evidence of Staff G having	1			
	On 07/10/17 at 3:2 with Staff B and co	0 PM, the finding was shared infirmed.				
C 122	O.A.C. 3701-83-08	3 (D) Job Descriptions	C 122			
	Each HCF shall prowritten job descript responsibilities.	ovide each staff member with a tion delineating his or her				
	Based on personne facility's job descrip failed to ensure on provided with a writ failed to ensure that F and H) had curred Life Support) certifit to affect all of the 7	et as evidenced by: el file review, review of the otions and interview, the facility e staff member (Staff G) was tten job description. The facility ee registered nurses (Staff D, ent ACLS (Advance Cardiac ication. This had the potential 754 patients who had eted in the last 12 months.		C 122 All staff now have description. Staff files we in QA meetings to ensure staff have current Job do and any and all certificate All RN's have current ACT or me monitired by administration.	ill be reviewed re that all escriptions tions required CLS on file. hinistrator aff current s. See	d 9/11/20

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	pt Health				FORM	1 APPROVED
STATEME! AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		1081AS	B. WING		07/	11/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
NORTHE	EAST OHIO WOMEN'S	CENTER 2127 STA	TE ROAD GA FALLS, C			
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT 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)	ILD BE	(X5) COMPLETE DATE
C 122	Continued From pa	ge 5	C 122			
	Findings include:					-
	Staff G was hired o	e for Staff G was reviewed. n 02/01/16. The file did not f Staff G receiving a job				
	On 07/10/17 at 3:20 Staff B and confirm	PM, the finding shared with ed.				
	The personnel file The file did not cont current ACLS certifi	e for Staff F was reviewed. tain evidence of Staff F having cation.				
	On 07/10/17 at 3:02 with Staff B and cor	2 PM, the finding was shared firmed.				
	3. The personnel file The file did not cont ACLS certification.	e for Staff D was reviewed. tain evidence of Staff D having				
	On 07/11/17 at 1:32 did not have current	PM, Staff B reported Staff D t ACLS.				
	On 07/10/17 at 2:41 with Staff A and con	PM, the finding was shared firmed.				
	4. The personnel file The file did not cont current ACLS certifi	e for Staff H was reviewed. tain evidence of Staff H having cation.				
;	The finding was sha confirmed.	ared with Staff B and				
•	The facility's Staff R reviewed. The job d must be ACLS certi	RN Job Description was lescription stated the Staff RN fied.				

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Ohio Dept Health STATEMENT OF DEFICIENCIES. (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING: B. WING 1081AS 07/11/2017 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 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG** TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) C 123 | Continued From page 6 C 123 C 123 O.A.C. 3701-83-08 (E) Staff Orientation & C 123 Training Each HCF shall provide an ongoing training program for its staff. The program shall provide both orientation and continuing training to all staff members. The orientation shall be appropriate to the tasks that each staff member will be expected to perform. Continuing training shall be designed to assure appropriate skill levels are maintained and that staff are informed of changes in techniques, philosophies, goals, and similar matters. The continuing training may include attending and participating in professional meetings and seminars. This Rule is not met as evidenced by: Based on observation, personnel file, policy, and manufacturer's instructions and staff interview. C123 Staff C has been retrained with the facility failed to ensure the personnel file for documentation on processing and one staff member (Staff C) contained evidence of 9/11/2017 cleaning instruments. All staff will be receiving training on the reprocessing of trained and observed prior to being instruments. This could potentially affect all privialiged to process and clean patients receiving care in the facility. A total of instruments. Training will be 754 surgical and medical procedures were documented. To be monitored by DON conducted in the most recent twelve months. See attachment #3 Findings include: The facility's "Instrument Cleaning" policy was reviewed. The policy stated: Instrument cleaning is completed on a daily basis and in accordance with the following guidelines: Unwrap used tray. Dispose of syringe and vacurette in biohazard

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PRINTED: 08/21/2017 FORM APPROVED 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 07/11/2017 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 (X4) ID PROVIDER'S PLAN OF CORRECTION ΙĐ PRÉFIX (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 TAG DATE DEFICIENCY Continued From page 7 C 123 Dispose of used wrap and paper in biohazard c 123 HCF's instrument cleaning policy 9/05/2017 bag. was reviewed and revised. Approved Soak instrument in Enzol solution (I oz. per by the Board on 09/05/2007. See gallon of water) for one minute. attached #4. Will be monitored by GB. Use steel brush and scrubby sponge to clean debris off instruments. Rinse instruments with water. Soak instruments in bleach solution (1:10 bleach/water ratio) for 20 minutes. Rinse instruments in water. Dry instruments. Wrap instruments as per Medical Director's desire The personnel file of Staff C was reviewed. The file did not contain evidence Staff C received training on the reprocessing of surgical instruments. On 07/10/17 at 2:31 PM, the findings was shared with Staff A and Staff B and confirmed. Staff A reported the facility must not have documented the education. The manufacturer instructions for MetriCide were reviewed. The instructions stated: MetriCide OPA Plus Solution is gentle on instruments, provides a broad spectrum of kill. and does not require activation or dilution. When handling disinfectants, the user should always wear appropriate safety gear. Be sure to wear protective equipment, including nitrile gloves. fluid-repelling gown and eye protection at all times when handling high-level disinfectants and

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contaminated instruments. The concentration of your MetriCide OPA Plus Solution must be verified by a MetriCide OPA Plus Solution Test Strip prior to each use to guard against dilution that may lower the ortho-Phthalaldehyde level of

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TATEMEN ND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	E SURVEY
			A. BUILDING:		COV	MPLETED
		1081AS	B. WING		07	/11/2017
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		111/2017
ORTHE	AST OHIO WOMEN'S	S CENTER 2127 ST	ATE ROAD			
X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	DGA FALLS, O			<u> </u>
REFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
C 123	Continued From pa	age 8	C 123			
:	the solution below recommended con	its MRC (manufacturer's centration).				
	On 07/10/17 at 11:	20 AM, Staff C was observed				:
	reprocessing surgion	cal instruments. Staff C				
	donned one pair of surgical instrument	Latex gloves to place the s in the MetriCide. Staff C				1
	reported a white co	lored basin contained				
:	Metricide OPA Plus water Staff Cireno	and was mixed with cold rted placing a "dollop" of				
	Metricide in the bas	sin. Staff C reported a second				
	basin contained ble	each and water. Staff C stated (the bleach)". Staff C did not				
	verify the concentra Plus Solution.	ation of the MetriCide OPA				
	On 07/10/17 at 11:4 basin of MetriCide (labeled.	45 AM, Staff C confirmed the OPA Plus Solution was not				
C 124	O.A.C. 3701-83-08 Training	(F) Staff Orientation &	C 124			
	All staff shall have a training regarding the guidelines, practice	appropriate orientation and ne facility's equipment, safety s, and policies.				
	This Rule is not me	et as evidenced by: If file review and interview, the				
	facility failed to ensi received orientation all patients receivin	ure one staff member (Staff G) This could potentially affect g care in the facility. A total of edical procedures were				
	conducted in the me	ost recent twelve months.				
	Findings include:					

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STATEMENT OF DEFINAND PLAN OF CORRE	CHON	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY
AND I DAN OF CORRE	CHON	IDENTIFICATION NUMBER:		:	COMPLETED
					<u> </u>
		1081AS	B. WING		07/11/2017
NAME OF PROVIDER	OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
NORTHEAST OHI	O WOMEN'S	S CENTER 2127 STA			
(X4) ID	SHMMADV CT	CUYAHO:	GA FALLS, (
TAG REGI	H DEFICIENC JLATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED (CROSS-REFERENCED TO THE APPROPRIED (CROSS-REFERENCE))	DIRE COMPLETE
C 124 Continu	ed From pa	age 9	C 124		
G was hoot contorientation guideline on 07/1 with Sta	ired on 02/ ain evidence on of the fa es, practice 0/17 at 3:20 ff B and co	of Staff G was reviewed. Staff 01/16. The personnel file did be of Staff G receiving scility's equipment, safety, as and policies. O PM, the finding was shared infirmed. (G) Staff Performance	C 125	c124 Staff G's file has been up Staff G has received orientatic documentation placed in staff file. Staff files will all be reviewed a by QA committee and GB to el that all staff files are complete and that all staff have received completed any and all training and or required.	on and 9/11/2017 Innually sure
This Rul Based o and polic staff me evaluation affect all total of 7 conducted Findings The facil The polic to annual OAC 376 by the in approved	e is not men personner personner (Staffon every 12 patients re 54 surgical in the minclude: ity's "Evaluel performan (1-83-08 (Odividual em do y Human or reviewin	aluate the performance of at least every twelve months. et as evidenced by: el file review, staff interview he facility failed to ensure one in the facility. A least every in the facility. A least every every months. This could potentially eceiving care in the facility. A least recent twelve months. ation" policy was reviewed. Each employee will be subject not evaluations as required by a least evaluations will be written in the ployee's supervisor and in Resources prior to the leg the evaluation with the		C125 Staff G has received and review. A staff log has been cretrack when training and or reviedue. See attached #2 To be moby administrator.	eated to 9/11/2017 ws are

STATEMEN AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION 6	K3) DATE SURVEY
A GUELL DAY	OF CORRECTION	IDENTIFICATION NUMBER:		i:	COMPLETED
	·	1081AS	B. WING		07/11/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY.	STATE, ZIP CODE	077777
NORTHE	AST OHIO WOMEN'S				
		CUYAHO	GA FALLS, (OH 44223	
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
TAG	REGULATORY OR LO	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
C 125	Continued From page	ge 10	C 125		
	G was hired on 02/0 not contain a perfor				
	On 07/10/17 at 3:20 with Staff B and cor	PM, the findings was shared firmed.			
C 139	O.A.C. 3701-83-10	(B) Safety & Sanitation	C 139		· ·
; ; !	The HCF shall be m sanitary manner.	naintained in a sa f e and			:
	facility failed to be meaning safe manner. This contains receiving careful and meaning safe and meaning safe surgical and meaning safe safe safe safe safe safe safe safe	et as evidenced by: ons and staff interviews the naintained in a sanitary and could potentially affect all are in the facility. A total of edical procedures were ost recent twelve months.			
	Findings include:	•			
	observations were of room in which sterili processed. Staff C personal protective mask, face shield) v	en 11:40 AM and 11:53 AM, conducted with Staff C of the ization of instruments were was observed placing equipment (gown, gloves, while pre-cleaning and		C139 An inservice training has conducted for all staff on the pruse of proper PPE C 139Bio boxes will now only b	oper 8/10/2017
	were observed on the (tissue) freezer and sterilized packets of boxes was almost in	struments. Two large boxes ne floor between the pathogen a metal cart which contained instruments. One of the contact with the metal cart. drapes (used to wrap		kept in the closet designated fo Biohazard Materials. To be monitored by administrator.	
hia Departe	ant of Health			<u> </u>	

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AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE	SURVEY
		1081AS	B. WING		07/1	4:004-
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE	<u> 07/1</u>	1/2017
NORTHE	EAST OHIO WOMEN'S			STATE, ZIP CODE		
		CUYAHO	GA FALLS, (OH 44223		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
C 139	Continued From pa	ge 11	C 139		***	
	top of one of the two observed placing hof the clean drapes one box. Staff Clean donned the same glifting them off the two what was in the two	bserved in direct contact on to boxes, and Staff C was er gown and face shield on top of which was located on top of the room, then returned and lown and face shield after op of the box. When asked b boxes, Staff C replied it was the needed to be picked up.				
	underneath the dirt instrument process Later that day betw	een 4:00 PM and 5:00 PM staff A, the following was		C 139 Cabinet has been cle paper towels removed and a with staff as to what can an be stored under cabinet. To be monitored by DON	a review	9/11/20
	previously in the insurer observed inside the floor beside two cylinders of nitrous gas room was obsethroughout the day was posted on the	chazard boxes that were strument processing room de the medical gas room on cylinders of oxygen and two gas. The door to the medical erved standing open on 07/10/17 although a sign door to keep the door closed. closing device observed on the		C 139 Biohazard boxes will stored in the closet desigant biohazard. A review with state completed about the need to door to the gas closet closed monitored by administrator.	ted for off has been to keep the	9/11/20
	sitting on the countries ink where the med c) The operating rotwo tone blue vinyl rectangular area wapatient's buttocks withe operating room or procedures. The	f diet soda was observed er next to the handwashing lication cabinets were located. om table was observed with a like covering. The lighter blue as observed where the rould come into contact with table during an examination e rectangular area where the e surfaces met were observed	·	C 139 review with staff h completed as to where w can't have food and beverages are permitted in the staff are microwave. To be monito administrator. C 139 the vinyl on the OR table has been replaced monitored by DON	ve can and erages. only a by the pred by	8/17/201

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AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		COMPLETED	
		1081AS	B. WING		07/11/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NORTHE	AST OHIO WOMEN'S	CENTER 2127 STA	TE ROAD GA FALLS, O	NI 44222		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LE	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
C 139	Continued From page	ge 12	C 139			
·	observed rolled up in sticking to the stick, Staff A stated the tall paper barrier during					
	observed in the staf the survey (07/10/1' of the container was black colored on the	entainer with a lid was if bathroom on both days of if and 07/11/17). The white lid is observed very dirty and is top outer surface. Staff A is was used to hold rock salt for		C 139The white container has leaned and will be cleaned on regular basis. To be monitored administrator.	a 9/11/2017	
	room was observed were placed on the the shelving. These containing a variety Staff A stated most and not in use.	n located by the recovery with several boxes which floor of the room underneath boxes were observed of supplies and paper towels of the supplies were outdated		C 139The box has been invent and supplies put away. All sup have been moved to shelves a the floor. Staff has been remin that supplies must be stored or shelves and not on the floor. To monitored by administrator.	plies nd off ded 9/11/2017 1	
	top of the pathogen A opened the lid of the thermometer, the ta the freezer and fell it removed both times	acking tape was observed on (tissue) freezer. When Staff the freezer to look for the pe was placed on the edge of in two times. The tape was by Staff A who confirmed place to put the tape and it the freezer.		C 139 There will be nothing sto on the Path freezer. We have designated a place to store the packing tape. To be monitored administrator.	9/6/2017	
	These observations during tour.	were confirmed with Staff A				
C 15 0	O.A.C. 3701-83-12 Program	(A) Q A & Improvement	C 150			
		ablish a quality assessment provement program designed				

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STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:		(X3) DATE SURVEY COMPLETED
			7		
		1081AS	B. WING		07/11/2017
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
NORTHE	AST OHIO WOMEN'S	CENTER 2127 STA CUYAHO	TE ROAD SA FALLS, O	H 44223	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 150 Continued From page 13		C 150			
	of patient care, purs	onitor and evaluate the quality sue opportunities to improve solve identified problems.		C 150 Patient charts are review to identify issues and areas that improvement. Patients fill out surveys after the procedures and a monitoring lookas been created and is monito by the administrator.	eir 9/11/2017 9
	Based on review of facility documentati facility lacked evide and performance in for monitoring and care, and to improvidentified problems	governing body minutes, on, and staff interviews, the ence of a quality assessment approvement program (QAPI) evaluating the quality of patient patient care and resolve. This could potentially affect		C150 Daily RH blood controls a performed to ensure the accura of our RH testing results. To be Monitored by Lab director	су
		g care in the facility. A total of re performed in the most		C 150 we follow up with patient to ensure a negative pregnancy test 4 weeks out and log the results. To be monitored by D0	9/05/2017
		ing there ectives le ff B		C 150 A training log has bee into place with documentation of the training. To be monito DON.	on 9/11/2017
		ility is ws, ng a			
		icility routine QAPI meetings to use stablish goals or use the data care.			

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STATEMEN AND PLAN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		1081AS	B. WING		07/1	1/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	<u> </u>	172017
NORTHE	AST OHIO WOMEN'S	CENTER 2127 STA				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
C 150	Continued From pa	ge 14	C 150	<u> </u>		
	On 07/11/17 a revies "Quality Control", re Body in January 20 statement that state providing the highes hygiene, through the comprehensive Quality. At 3:40 PM Staff B opolicy. At 3:40 PM, the aforementioned O.A.C. 3701-83-12	w of the facility's policy titled eviewed by the Governing 17, revealed a mission and the facility is dedicated to st standards of safety and a use and implementation of a ality Assurance manual. confirmed this aforementioned Staff A was made aware of interview with Staff B. (B) Q A & Improvement Plan velop a written plan that	C 151			
	performance improorganization, scope overseeing the effect evaluation, improve activities. This Rule is not me Based on review of facility documentation facility failed to develope the evaluation, improve activities. This could receiving care in the	vement program's objectives, and mechanism for ctiveness of monitoring, ment and problem-solving et as evidenced by: governing body minutes, on, and staff interviews, the elop a written plan that y assessment and vement program's (QAPI) ation, scope, and mechanism effectiveness of monitoring, ment and problem-solving d potentially affect all patients ef facility. A total of 754 all procedures were performed		C 151 The HCF has developed written plan that describes the q assessment and performance improvement, review, audits, evaluations and inspections. The QAPI will be monitored by the D and reviewed by the governing ton an anual basis. See attached #1	uality e ON	9/11/2017

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	pt Health			· ·	FORM APPROVED
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X:	B) DATE SURVEY COMPLETED
		1081AS	B. WING		07/11/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE	
NORTHE	AST OHIO WOMEN'S	CENTER 2127 STAT	E ROAD SA FALLS, C	OH 44223	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
C 151	Continued From pa	ge 15	C 151		
C 152	was conducted of tand facility docume conducted with State whether the facility described the QAP the facility currently At 3:40 PM, Staff A aforementioned into	20 AM and 3:40 PM, a review he governing body minutes entation. An interview was ff B at those times regarding had a written plan that I program. Staff B confirmed lacks this written plan. was made aware of the erview with Staff B. (C) Q A & Improvement	C 152		
	Requirements The quality assess improvement programment programment programment processibility, continuation outcome, and patient (2) Establish expedimplement procedulation of care and (3) Establish expedimplement procedulation of	ment and performance am shall do all of the following: aluate all aspects of care less, appropriateness, buity, efficiency, patient ent satisfaction; ctations, develop plans, and ares to assess and improve the resolve identified problems; ctations, develop plans, and ares to assess and improve the s governance, management,		C 152 HCF is monitoring all aspe of care including effectiveness, appropriateness accessibility and patient satisfaction.The monitoring is documented,reviewed and asse for quality and effectiveness. To monitored by administrator andf D	9/11/2017 I ssed be
	data management collection, manage needed for quality	nation systems and appropriate processes to facilitate the ment, and analysis of data assessment and performance to comply with the applicable		C 152 Processes have been developed to collect data and analyze where improvements are needed. Monitored by administrator.	8/08/2017

	pt Health				FORM	APPROVED
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY
		1081AS	B. WING		07/1	11/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		· •
NORTHE	AST OHIO WOMEN'S	CENTER	TE ROAD GA FALLS, C	DH 44223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) RF	(X5) COMPLETE DATE
C 152	Continued From pa	ge 16	C 152		· · · · ·	
	data collection requ of the Administrative	irements of Chapter 3701-83 e Code;				
	(5) Document and massessment and imgoverning body eve	eport the status of quality provement program to the ry twelve months;				
: !	complications and a	eview all unexpected idverse events, whether ath, that arise during an ure; and				
	director of the HCF but at least within si or death, to review a and report findings.	etings, chaired by the medical or designee, as necessary, xty days after a serious injury all deaths and serious injuries. Any pattern that might shall be investigated and ary.				
	facility documentation facility failed to develope that monitored and and failed to establish plans and implement quality of care. The meetings. This could receiving care in the surgical and medical in the most recent to Findings include:	governing body minutes, on, and staff interviews, the elop a quality assurance plan evaluated all aspects of care, sh expectations, develop at procedures to improve the facility failed to hold regular d potentially affect all patients a facility. A total of 754 all procedures were performed		C 152HCF has developed a comprehensive quality assurned plan that will monitor all aspects of care in the facility. Monitored by administraotr and C 152The HCF is committed to quarterly meetings to assess an evaluate current systems and id where improvement is needed. Monitored by DON.	DON. holding	9/11/2017

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AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
			A. BUILDING:		COMPLETED
		1081AS	B. WING		07/11/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE	
NORTHE	AST OHIO WOMEN'S	CENTER 2127 STAT	'E ROAD SA FALLS, O	H 44223	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 152	and facility docume conducted with Sta whether the facility described the QAP the facility currently confirmed there we conducted to discussive asked what the facility and whether there is place to collect and quality, Staff B confiplan.	ne governing body minutes ntation. An interview was ff B at those times regarding had a written plan that program. Staff B confirmed lacks this written plan and re no regular meetings as quality of care. When lity was working on for quality, were goals and measures in analysis data to improve firmed there was no written was made aware of the	C 152	C 152 The HCF has a written plathas included measurable goals a collection of patient data to quart meetings for assessment and improvement, monitored by DON	and the erly 9/11/2017
C 153	High-Risk Activities Each HCF shall improactive assessment of the patient state of the patient state of the properties of the proactive assessment of the proactive assessment of the properties of the patient state of the patient state of the patient of the pat	plement a program for ent of high-risk activities afety and to undertake	C 153	C 153 The HCF has added a comprehensive alarm system with camera monit to monitor and assess high risk a Any issues will be assessed and reviewed. In addition we will kee recorded activity on file for future use and or training. To be monito by administrator. C 153 HCF has updated it's emergency transportation and protocol for handling emergincie of patients. To be monitored by DON, reviewand assessed by the governing anually, see attached #5	activity. I ep any e ored es 8/8/2017

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					FORM	APPROVED
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			
		1081AS	B. WING		07/1	1/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE ZIP CODE		1,2011
NORTHE	AST OHIO WOMEN'S	CENTER 2127 STA	TE ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	DBE !	(X5) COMPLETE DATE
NAME OF PROVIDER OR SUPPLIER 1081AS B. WING O7/11/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223 (X4) ID PREFIX REGULATORY OR LSC IDENTIFY/ING INFORMATION) C 153 Continued From page 18 Findings include: On 07/11/7 at 10:00 AM and 3:40 PM an interview was conducted with Staff B regarding whether the facility had implemented a program for proactive assessment of high-risk activities related to patient safety. Staff B confirmed the facility currently lacks this written program. Staff A was present during this interview. C 222 C.A.C. 3701-83-18 (C) Director of Nursing be responsible for the management of nursing san! be responsible for the management of nursing services. This Rule is not met as evidenced by: Based on personnel file review and staff interview it was determined the facility failed to show evidence the Director of Nursing met the requirements of the position. This could						
	Findings include:				į	
C 222	interview was cond whether the facility for proactive assess related to patient sa facility currently lace A was present during O.A.C. 3701-83-18. Each ASF shall have an RN with experience room nursing care, be responsible for the same of the facility o	ucted with Staff B regarding had implemented a program sment of high-risk activities afety. Staff B confirmed the ks this written program. Staffing this interview. (C) Director of Nursing the a director of nursing who is not in surgical and recovery.	C 222			
	Based on personne it was determined the evidence the Direct requirements of the potentially affect all facility. A total of 75 procedures were on twelve months. Findings include: On 07/11/17 at 3:40 conducted with State facility had docume of Nursing's (Staff surgical and recovers)	el file review and staff interview the facility failed to show or of Nursing met the position. This could patients receiving care in the 54 surgical and medical		Director of Nursing. All appropand necessary evidance are not in the staff members file. Staff files will be reviewed on an anubasis to ensure that documents not missing in the future.	eriate ow ual s are	9/11/2017

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
· · · · · · · · · · · · · · · · · · ·		1081AS	B. WING	and the state of t	07/11	1/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
NORTHE	AST OHIO WOMEN'S	CENTER 2127 STA	TE ROAD 3A FALLS, O	H 44223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
C 222	Continued From pa	ge 19	C 222			
	file did not contain e	or Staff J was reviewed. The evidence that Staff J had call and recovery room nursing				
C 225	O.A.C. 3701-83-18	(F) Nurse Duty Requirements	C 225			
	or recovering from the discharged, the ASI (1) Have at least two in the ASF, at least and at least one of advanced cardiac lipresent and on duty patients are present (2) In addition to the (1) of this rule, have readily available on (3) Have sufficient at	o nurses present and on duty one of whom shall be an RN whom is currently certified in fe support who shall be y in the recovery room when		C 225 The HCF has taken mea ensure that all RN's are ACLS Staff files will be reviewed anu- a staff log created to monitor re See attached #2	certified. ally and	9/11/2017
	Based on review of personnel file revier facility failed to ensign (Staff D, F and H) vicardiac life support recovery room while	et as evidenced by: the facility's schedule logs, w and staff interview, the ure three registered nurses were certified in advanced (ACLS) when on duty in the e patients were present. The ure a nurse with ACLS was				

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STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI			E CONSTRUCTION	(X3) DATE :	
				A. BUILDING:		COMP	.E.IEQ
		1081AS		B. WING		07/1	1/2017
NAME OF I	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		**
NORTHE	AST OHIO WOMEN'S	CENTER	2127 STAT	ΓE ROAD SA FALLS, Ο	H 44223		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 225	Continued From pa	ge 20		C 225			
	had the potential to patients. The facility medical procedures months.	f 19 schedules review affect all of the facility performed 754 surg in the most recent to	ty's Jical and				
	Finding include: The facility's Staff Freviewed. The job of must be ACLS certi	RN Job Description w lescription stated the fied.	as Staff RN				
	The file did not cont ACLS certification.	e of Staff D was revie tain evidence of Staff On 07/11/17 at 1:32 l did not have current A	f D having PM, Staff		C 125Staff D now has ACLS as RN's. Staff files will be reviewed to ensure all licenses and certificate present. A staff log has been	d anually ications	9/11/2017
	revealed Staff D was scheduled in the re- dates:	ule Logs were review as the only registered covery room on the f	nurse ollowing		created to monitor expiration da of all staff members. See attach		971172011
	05/25/17, 05/31/17,	05/18/17, 05/22/17, 06/01/17, 06/05/17, 06/19/17, 06/26/17, 6/17.	06/08/17,				
	On 07/10/17 at 2:4' with Staff A and cor	1 PM, the finding was nfirmed.	shared				
		e for Staff H was rev tain evidence of Staf ication.					
	revealed Staff H wa	lule Logs were review as the only registered covery room on the f	Inurse		•		
	The finding was sha	ared with Staff B and					

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Ohio De	pt Health				FORM.	APPROVED
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
			A. BUILDING:		COMP	LETED
		1081AS	B. WING		07/1	1/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	<u>,, , , , , , , , , , , , , , , , , , ,</u>	
NORTHE	AST OHIO WOMEN'S	CENTER 2127 STA	TE ROAD GA FALLS, O	H 44223		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)						(X5) COMPLETE DATE
C 225	Continued From pa	ge 21	C 225			
	confirmed.					
	from 05/25/17 and registered nurse with D) and one licensed certification (Staff Escheduled for the disprocedures on 05/2	PM, the findings were shared				
C 241	O.A.C. 3701-83-20 Equipment	(B) OR & Recovery Room	C 241			
		ve the following equipment perating suite and recovery				
	providing surgical procal infiltration block intramuscular preopairways, bag mask suction equipment, resuscitative drugs procedures perform parenteral, or intravunder analgesic or surgical procedures regional block anesbodily functions should be positive pressuitable resuscitative (2) Appropriate mo	dissociative drugs or providing that require general or thesia and support of vital all have: airways, endotracheal e, oxygen delivery capability sure, suction equipment, and				

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TAG REGULATORY OR I SC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP		pt Health				FORM	APPROVEI
NORTHEAST OHIO WOMEN'S CENTER 2127 STATE ROAD CUYAHOGA FALLS, OH 44223 PRICE STAGE PROVIDER STANDARD OF DEPOSITIONS COUNTY AND PROVIDER'S PLAN OF CORRECTION PROCESS ON THE PRICE STAGE PROVIDER'S PLAN OF CORRECTION PROCESS OF THE PRICE STAGE PROVIDER'S PLAN OF CORRECTION PROCESS OF THE PRICE STAGE PROVIDER'S PLAN OF CORRECTION PROCESS OF THE PRICE STAGE PROVIDER'S PLAN OF CORRECTION PROCESS OF THE PRICE STAGE PROVIDER'S PLAN OF CORRECTION PROCESS OF THE PRICE STAGE PROVIDER'S PLAN OF CORRECTION PROCESS OF THE PRICE STAGE PROVIDER'S PLAN OF CORRECTION PROCESS OF THE PRICE STAGE PROVIDER'S PLAN OF CORRECTION PROCESS OF THE PRICE STAGE PROVIDER'S PLAN OF CORRECTION PROCESS OF THE PRICE STAGE PROVIDER STAGE PROVIDER'S PLAN OF CORRECTION PROCESS OF THE PRICE STAGE PROVIDER STAGE	STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
NORTHEAST OHIO WOMEN'S CENTER 212 T STATE ROAD CUYAHOGA FALLS, OH 44223 SUMMARY STATEMENT OF DEFICENCIES EACH DEPICENCY MUST BE PRECEDED BY FULL RECOLLARORY OR LSC IDENTIFYING INFORMATION) C 2411 C 2411 Continued From page 22 apparatus and stethoscopes, electrocardiogram, oscilloscopes and when pediatric patients are treated, size-specific emergency equipment and medications; (b) ASF's performing surgical procedures in conjunction with oral parenteral, or intravenous sedation or under ananalgesic sc or dissociative drugs, or performing surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have a detirilator, pulse oximeter with alarm, and temperature monitor. (c) ASF's using inhalation anesthesia shall have an anosthesia machine. (3) Each ASF'shall have suitable surgical instruments customarily available for the planned surgical procedure in the operating suite. (4) Each ASF'shall have suitable surgical instruments customarily available for the planned surgical procedure in the operating suite. (4) Each ASF'shall have suitable surgical instruments customarily available for the planned surgical procedure in the recovery room, an emergency call system that is connected electrorically, electrically by radio transmission or in a like manner and that effectively alerts staff. This Rule is not met as evidenced by: Based on observations, review of the crash cart (emergency use was maintained with current expiration dates. This could potentially affect all patients receiving care in the facility, A total of 754 surgical and medical procedures were conducted in the most recent 12 months. Findings include:			1081AS	B. WING		07	144 12047
AC 241 CONTINUED TO SUMMERY STATEMENT OF DETRICIBIOUS PREPRY MAGE PROCESSION STATEMENT OF DETRICIBIOUS PROCESSION STATEMENT OF DETRICIBION STATEMEN	NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS CITY S	STATE ZIPCODE	1 077	11/2017
OW, ID PREFIX SUMMARY STATEMENT OF DEFICIENCISES EACH DEPICIENCY MUST BE PRECEDED BY FULL REQUATORY OR LSC DENTIFYING INFORMATION) C 241	NORTHE	AST OHIO WOMEN'S			JACE, ZIF GODE		
REACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CONTINUED FOR PAGE 22 apparatus and stethoscopes, electrocardiogram, oscilloscopes and when pediatric patients are treated, size-specific emergency equipment and medications; (b) ASFs performing surgical procedures in conjunction with oral, parenteral, or intravenous sedation or under ananalgesic sic or dissociative drugs, or performing surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have a defibrillator, pulse oximeter with alarm, and temperature monitor. (c) ASFs using inhalation anesthesia shall have an anesthesia machine. (3) Each ASF shall have suitable surgical instruments customanily available for the planned surgical procedure in the operating suite. (4) Each ASF shall have in the recovery room, an emergency call system that is connected electronically, electrically by radio transmission or in a like manner and that effectively alerts staff. This Rule is not met as evidenced by: Based on observations, review of the orash cart (emergency box) logs and staff interviews the facility failed to ensure the equipment for emergency use was maintained with current expiration dates. This could potentially affect all patients receiving care in the facility. A lotal of 754 surgical and medical procedures were conducted in the most recent 12 months. Findings include:		ACT OFFIC WOMEN	O CENTER)H 44223		
apparatus and stethoscopes, electrocardiogram, oscilloscopes and when pediatric patients are treated, size-specific emergency equipment and medications; (b) ASFs performing surgical procedures in conjunction with oral, parenteral, or intravenous sedation or under ananalgesic[sic] or dissociative drugs, or performing surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have a defibrillator, pulse oximeter with alarm, and temperature monitor. (c) ASFs using inhalation anesthesia have an anesthesia machine. (3) Each ASF shall have suitable surgical instruments customarily available for the planned surgical procedure in the operating suite. (4) Each ASF shall have in the recovery room, an emergency call system that is connected electroically, electrically by radio transmission or in a like manner and that effectively alerts staff. This Rule is not met as evidenced by: Based on observations, review of the orash cart (emergency box) logs and staff interviews the facility failed to ensure the equipment for emergency use was maintained with current expiration dates. This could potentially affect all patients receiving care in the facility. A total of 755 surgical and medical procedures were conducted in the most recent 12 months. Findings include:	PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
oscilloscopes and when pediatric patients are treated, size-specific emergency equipment and medications; (b) ASFs performing surgical procedures in conjunction with oral, parenteral, or intravenous sedation or under ananalgesic/sic/ or dissociative drugs, or performing surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have a defibrillator, pulse oximeter with alarm, and temperature monitor. (c) ASFs using inhalation anesthesia shall have an anesthesia machine. (3) Each ASF shall have suitable surgical instruments customarily available for the planned surgical procedure in the operating suite. (4) Each ASF shall have in the recovery room, an emergency call system that is connected electronically, electrically by radio transmission or in a like manner and that effectively alerts staff. This Rule is not met as evidenced by: Based on observations, review of the crash cart (emergency box) logs and staff interviews the facility failed to ensure the equipment for emergency use was maintained with current expiration dates. This could potentially affect all patients receiving care in the facility. A total of 754 surgical and medical procedures were conducted in the most recent 12 months. Findings include:	C 241	Continued From pa	age 22	C 241			
Based on observations, review of the crash cart (emergency box) logs and staff interviews the facility failed to ensure the equipment for emergency use was maintained with current expiration dates. This could potentially affect all patients receiving care in the facility. A total of 754 surgical and medical procedures were conducted in the most recent 12 months. Findings include:		oscilloscopes and of treated, size-specific emergency equipm ASFs performing seconjunction with one sedation or under a drugs, or performing require general or a support of vital boddefibrillator, pulse of temperature monitoranesthesia shall has (3) Each ASF shall instruments custom surgical procedure in the open (4) Each ASF shall emergency call systelectronically, electronically, electronically.	when pediatric patients are ic lic lent and medications; (b) urgical procedures in al, parenteral, or intravenous ananalgesic[sic] or dissociative ig surgical procedures that regional block anesthesia and lily functions shall have a eximeter with alarm, and or. (c) ASFs using inhalation are an anesthesia machine. have suitable surgical harily available for the planned perating suite. have in the recovery room, an atem that is connected crically by radio transmission or				
ATE CODIC		Based on observat (emergency box) lo facility failed to ens emergency use wa expiration dates. TI patients receiving of 754 surgical and m conducted in the m	ions, review of the crash cart ogs and staff interviews the ure the equipment for s maintained with current his could potentially affect all care in the facility. A total of redical procedures were				
FATE CODIA	io Denarto	nent of Health		1	-		
				6899 7	/21S11	lf continuati	on sheet 23 of

	<u>pt Health</u>				FORM	APPROVED
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE : COMP	
		1081AS	B. WING		07/1	1/2017
	PROVIDER OR SUPPLIER	CENTER 2127 STA	ODRESS, CITY, S NTE ROAD GA FALLS, C	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIEMENCY)	DBE i	(X5) COMPLETE DATE
C 241	Staff A, observation emergency supply Outdated supplies with Staff B as follo a) Four intravenous by 3/4 inches, Lot 1 expired 04/17. b) Metal forceps we package with a prostaff A removed the box and stated the sterile instruments c) Three Satin S.P. handles, Ref 40650 expiration date of 0 A review of the crast the time of observation box had been check contents and expira outdated supplies refer to the time of the crast the cr	en 4:00 PM and 5:00 PM with as were conducted of the box for the Operating Room, were observed and confirmed ws: a catheter start kits 24 gauge (20508A, 15 ml/min, each ere observed in a reprocessed cessing date of 08/01/16. The forceps from the emergency facility practice is to reprocess every six months. U. disposable laryngoscope of Lot 12090063, each with an		C 241The catheter starter kits 2 3/4 in Lot # 120508A, 15 ml/min been removed, disposed of an replaced. Additional training ha provided to nurses performing to monthly crash cart exp. check I Metal forcepts have been represend a review done with staff or checking for exp. sterile instrur Disposable larngoscopes have discarded and replaced. To be monitored by DON.	n, have d s been the ist. coessed in ments.	9/11/2017

Northeast Ohio Women's Center

(330) 923-4009

www.northeastohioabortion.com

FAX COVER SHEET

To: ODH	From: NEOWC
Fax: 614-564-2416	Date: 11/22/17
Phone: 414 9955945	Pages: 2
Re: Page #14	

11/22/2017 10:42:00 AM PAGE

3/004 Fax Server

AND PLA	ENT OF DEFICIENCIES N OF COMPRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTI A. SUILDIN	PLE CONSTRUCTION (3)	(X3) DAY	TE SURVEY MPLETED
		1081AS	a. WING_			
NAME OF	PROVIDER OR SUPPLIER	STREET.A	IRRESE AM		07	/11/2017
NORTH	EAST OHIO WOMEN'S	2127 STA	idress, chy I'e road	, STATE, ZIP CODE		•
		CUYAHO	ga falls,	OH 44222		
(X4) ID PREF/X	SUMMARY STA	TENENT AS ASSISTANCE	aı			•
YAG		Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLET DATE
G 150	Continued From pa	ge 13	C 150		*************	<u> </u>
	to systematically me	onitor and evaluate the quality				
	A Panelli Cale: Dills	SUB Ottooriunities to improve				-
	patient care, and re-	solve identified problems.				į
i		,		C 150 Patient charts are review	ved daily	j
]				the locality issues and areas the	it need	1
		\$		"TIPLOVEITIENE		
				Patients fill out surveys after the	eir	9/11/201
ĺ	This Rule is not me	as evidenced by:		Procedules and a monitoring in		
	DESEU OF TOVIEW OF	Coverning hady pringles	:	has been created and is monitor by the administrator.	red	
- 1	lacility documentatio	n and staff intervious the		by the administrator.	Í	
	recent recked 6Ald8U	CE OT 8 OUBLITY acceptomant			i	
	for monitoring and a	provement program (QAPI)		C150 Daily RH blood controls at	! !	
	care, and to improve	valuating the quality of patient patient care and resolve		PSHOULED to ensure the coause.	1	9/06/201
1 4	ACCINICACI DI COINUIS	I DIS COULD PORONSIALL ACCURATE	i	Of Our IND LESSING regular To be	Jy	
1 6	an handing tecelvice	Care in the facility A test of a		Monitored by Lab director	1	
• •	954 procedures were recent twelve months	DSCOMMON in the most			į	
•	ecent twelve months	i.			1	
F	indings include:	jf.		C 150 we follow up with patients		
		&	-	to ensure a negative program.		9/06/2017
ļÇ	On 07/11/17 at 10:00	AM and 3:40 PM, an		rest 4 weeks out and log the		J. J.J. ZU 1
£ 14	ITELATEM MGS COLIGHO	ted with Staff B regardian		results. To be monitored by DOI	V	
: 0	rvany Assurance (Q)	A). Staff A confirmed these	İ		*-	
1 42	no milenies in com	to discuss goals, objectives pletion of goals with the				
, G	weshing in a Wouldi	/ Monitorion tool States		C 150 A training log has been	m. 1.16	
į •••	on committed MGIS A	Vas no CJA manusi is 1	ļ	into place with documentation		5 / 4
a	coordance with the fa	cility policy.	į	of the training. To be monitore	id by	9/11/2017
	Uring the intendence	Cansir		DON.	- ~ j	
CC	ellecting data in rece	Staff B stated the facility is direviews, peer reviews,	_			
a a	in banelii sacstactioi	SUIVEVS, and is doing a 1		C 150 The HCF has a QA manual	in alaca	
1 414	ALCOHOLD TO BE ASSOCIATED IN THE PROPERTY OF T	Cility Which includes 1		and is conducting OA	iii biace	
13	region control howe	Ver confirmed the facility	İ	and is conducting QA meetings t	o reviev	v 9/11/2:
l na<	as not conducting tot	IME OAP! meetings to use I		and discuss goals, objective and	timeline	es .
1 11 11	ese findings to estab improve patient care	ISB 008/s or use the date		for the completion To be monito	red by I	OON.
į	· · · · · · · · · · · · · · · · · · ·	··	1			