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Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1081AS	A. BUILDING: _____ B. WING _____	07/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHEAST OHIO WOMEN'S CENTER	2127 STATE ROAD CUYAHOGA FALLS, OH 44223

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C 000	Initial Comments Licensure Compliance Inspection and follow up to the licensure compliance inspection completed 11/29/16. Administrator: Sherri Grossman County: Summit Number of ORs: 1 The following violations are issued as a result of the licensure compliance inspection completed on 07/11/17.	C 000		
C 104	O.A.C. 3701-83-03 (F) Governing Body The HCF shall have an identifiable governing body responsible for the following: (1) The development and implementation of policies and procedures and a mission statement for the orderly development and management of the HCF; (2) The evaluation of the HCF's quality assesment and performance improvement program on an annual basis; and (3) The development and maintenance of a disaster preparedness plan, including evacuation procedures.	C 104		

Ohio Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sherri Grossman | TITLE: Administrator | (X6) DATE: 9-12-17

STATE FORM 6899 721S11 If continuation sheet 1 of 24

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C 104	Continued From page 1 This Rule is not met as evidenced by: Based on review of governing body minutes, staff interview and review of facility documentation, the governing body failed to ensure development of a facility quality assessment and performance improvement program (QAPI) on an annual basis. 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 twelve months. Findings include: On 07/11/17 a review of the Governing Body minutes of 01/08/17 revealed the Governing Body recommended the following: a) appointed Staff J as the Director of Nursing, Quality Assurance (QA) and Infection Control trainer and monitor, b) reviewed the Quality Assurance Policy at that time with a plan to review this policy at least every 12 months, and c) documented improvement is needed in documentation of QA and infection control. The minutes contained documentation that Staff B will develop and maintain QA and infection control logs and Staff J will train and monitor QA and infection control. On 07/11/17 at 10:00 AM and 3:40 PM, an interview was conducted with Staff B regarding Governing Body minutes and Quality Assurance (QA). Staff B confirmed there were no QA meetings to discuss goals, objectives and timelines for completion of goals with the	C 104	C104 HCF has a QAPI program in place to include, Plan and mission statement. The QAPI is being monitored by the D.O.N. and reviewed by the Governing body. A QA committee has been appointed and will meet at least every 12 months to review and monitor the current program that's in place. HCF has an ongoing training program in place and is being logged and monitored to assess additional training needed. See attached #1	09/11/17

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C 104	Continued From page 2 exception of a monthly monitoring tool. Staff B also confirmed there was no QA manual in accordance with the facility policy.	C 104		
C 120	O.A.C. 3701-83-08 (B) T B Control Plan Each HCF shall develop and follow a tuberculosis control plan that is based on the provider's assessment of the facility. The control and assessment shall be consistent with the centers for disease control and prevention (CDC) "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings, 2005," MMWR 2005, Volume 54, No. RR-17. The HCF shall retain documentation evidencing compliance with this paragraph and shall furnish such documentation to the director upon request. This Rule is not met as evidenced by: Based on personnel file review, staff interview and policy review, the facility failed to ensure five staff members (Staff B, D, G, H and I) were tested for Tuberculosis (TB) on an annual basis. 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 twelve months. Findings include: The facility's policy titled "Exposure Control Plan"	C 120		

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C 120	Continued From page 3 was reviewed. The plan stated employees will be tested for TB on an annual basis. Pursuant to OAC 3701-83-08 (B): All employees will have a base line PPD upon hire, unless they provide proof upon hire. A Registered nurse will administer the test. The test will be read by a Registered Nurse or Physician within 48 to 72 hours. A negative PPD requires no additional action. A positive PPD requires a chest x-ray. TB testing will be repeated on an annual basis. If an employee has a positive PPD and a negative chest x-ray the following year. Employee should undergo a health assessment. The employee's physician should complete the TB Health Assessment Form. This will be repeated on an annual basis for all affected employees. 1. The personnel file of Staff B was reviewed. The file contained a Tuberculosis (TB) test from 10/23/13 in which Staff B tested positive for TB. The file did not contain an additional Tuberculosis test or a chest x-ray after 10/23/13. Staff A was interviewed on 07/10/17 at 1:40 PM and reported he was not aware of the positive Tuberculosis results. On 07/10/17 at 1:24 PM, the findings were shared with Staff B and confirmed. Staff B stated she did not have a current Tuberculosis test in her file. 2. The personnel file of Staff H was reviewed. The file did not contain a TB test. On 07/11/17 at 2:42 PM, The finding was shared with Staff B and confirmed. 3. The personnel file of Staff D was reviewed. The file did not contain evidence of a TB test.	C 120	C120 HCF had developed a monitoring log to ensure that all staff remain current with TB testing. To be monitored by Director of Nursing See attached #2 C 120 1.Staff B now has a follow up X-Ray in staff file and a follow up TB test on file C 120 Staff H,D,I and G now all have a current TB test in staff file	9/11/2017 9/11/2017 9/11/2017

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C 120	Continued From page 4 On 07/10/17 at 2:41 PM, the finding was shared with Staff A and confirmed. 4. The personnel file of Staff I was reviewed. The file did not contain evidence of Staff I having a current TB test in the personnel file. On 07/10/17 at 2:50 PM, the finding was reviewed with Staff A and confirmed. 5. The personnel file of Staff G was reviewed. The file did not contain evidence of Staff G having a TB test. On 07/10/17 at 3:20 PM, the finding was shared with Staff B and confirmed.	C 120		
C 122	O.A.C. 3701-83-08 (D) Job Descriptions Each HCF shall provide each staff member with a written job description delineating his or her responsibilities. This Rule is not met as evidenced by: Based on personnel file review, review of the facility's job descriptions and interview, the facility failed to ensure one staff member (Staff G) was provided with a written job description. The facility failed to ensure three registered nurses (Staff D, F and H) had current ACLS (Advance Cardiac Life Support) certification. This had the potential to affect all of the 754 patients who had procedures completed in the last 12 months.	C 122	C 122 All staff now have a current job description. Staff files will be reviewed in QA meetings to ensure that all staff have current Job descriptions and any and all certifications required. All RN's have current ACLS on file. To me monitired by administrator A staff log has been created to monitor all staff current license and certifications. See attached #2. To be monitored by administrator.	9/11/20017

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C 122	Continued From page 5 Findings include: 1. The personnel file for Staff G was reviewed. Staff G was hired on 02/01/16. The file did not contain evidence of Staff G receiving a job description. On 07/10/17 at 3:20 PM, the finding shared with Staff B and confirmed. 2. The personnel file for Staff F was reviewed. The file did not contain evidence of Staff F having current ACLS certification. On 07/10/17 at 3:02 PM, the finding was shared with Staff B and confirmed. 3. The personnel file for Staff D was reviewed. The file did not contain evidence of Staff D having ACLS certification. On 07/11/17 at 1:32 PM, Staff B reported Staff D did not have current ACLS. On 07/10/17 at 2:41 PM, the finding was shared with Staff A and confirmed. 4. The personnel file for Staff H was reviewed. The file did not contain evidence of Staff H having current ACLS certification. The finding was shared with Staff B and confirmed. The facility's Staff RN Job Description was reviewed. The job description stated the Staff RN must be ACLS certified.	C 122		

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C 123	Continued From page 6	C 123		
C 123	O.A.C. 3701-83-08 (E) Staff Orientation & 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, the facility failed to ensure the personnel file for one staff member (Staff C) contained evidence of receiving training on the reprocessing of instruments. 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 twelve months. 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	C 123	C123 Staff C has been retrained with documentation on processing and cleaning instruments. All staff will be trained and observed prior to being privialiged to process and clean instruments. Training will be documented. To be monitored by DON See attachment #3	9/11/2017

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C 123	Continued From page 7 box. Dispose of used wrap and paper in biohazard bag. Soak instrument in Enzol solution (1 oz. per gallon of water) for one minute. 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 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	C 123	c 123 HCF's instrument cleaning policy was reviewed and revised . Approved by the Board on 09/05/2007. See attached #4. Will be monitored by GB.	9/05/2017

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C 123	Continued From page 8 the solution below its MRC (manufacturer's recommended concentration). On 07/10/17 at 11:20 AM, Staff C was observed reprocessing surgical instruments. Staff C donned one pair of Latex gloves to place the surgical instruments in the MetriCide. Staff C reported a white colored basin contained Metricide OPA Plus and was mixed with cold water. Staff C reported placing a "dollop" of Metricide in the basin. Staff C reported a second basin contained bleach and water. Staff C stated "I don't measure it (the bleach)". Staff C did not verify the concentration of the MetriCide OPA Plus Solution. On 07/10/17 at 11:45 AM, Staff C confirmed the basin of MetriCide OPA Plus Solution was not labeled.	C 123		
C 124	O.A.C. 3701-83-08 (F) Staff Orientation & Training All staff shall have appropriate orientation and training regarding the facility's equipment, safety guidelines, practices, and policies. This Rule is not met as evidenced by: Based on personnel file review and interview, the facility failed to ensure one staff member (Staff G) received orientation. 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 twelve months. Findings include:	C 124		

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C 124	Continued From page 9 The personnel file of Staff G was reviewed. Staff G was hired on 02/01/16. The personnel file did not contain evidence of Staff G receiving orientation of the facility's equipment, safety, guidelines, practices and policies. On 07/10/17 at 3:20 PM, the finding was shared with Staff B and confirmed.	C 124	c124 Staff G's file has been updated. Staff G has received orientation and documentation placed in staff G's file. Staff files will all be reviewed annually by QA committee and GB to ensure that all staff files are complete and that all staff have received and completed any and all training needed and or required.	9/11/2017
C 125	O.A.C. 3701-83-08 (G) Staff Performance Evaluation Each HCF shall evaluate the performance of each staff member at least every twelve months. This Rule is not met as evidenced by: Based on personnel file review, staff interview and policy review, the facility failed to ensure one staff member (Staff G) received a performance evaluation every 12 months. 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 twelve months. Findings include: The facility's "Evaluation" policy was reviewed. The policy stated: Each employee will be subject to annual performance evaluations as required by OAC 3701-83-08 {G}. Evaluations will be written by the individual employee's supervisor and approved by Human Resources prior to the Supervisor reviewing the evaluation with the employee.	C 125	C125 Staff G has received and annual review. A staff log has been created to track when training and or reviews are due. See attached #2 To be monitored by administrator.	9/11/2017

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C 125	Continued From page 10 The personnel file of Staff G was reviewed. Staff G was hired on 02/01/16. The personnel file did not contain a performance evaluation. On 07/10/17 at 3:20 PM, the findings was shared with Staff B and confirmed.	C 125		
C 139	O.A.C. 3701-83-10 (B) Safety & Sanitation The HCF shall be maintained in a safe and sanitary manner. This Rule is not met as evidenced by: Based on observations and staff interviews the facility failed to be maintained in a sanitary and safe manner. 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 twelve months. Findings include: On 07/10/17 between 11:40 AM and 11:53 AM, observations were conducted with Staff C of the room in which sterilization of instruments were processed. Staff C was observed placing personal protective equipment (gown, gloves, mask, face shield) while pre-cleaning and processing sterile instruments. Two large boxes were observed on the floor between the pathogen (tissue) freezer and a metal cart which contained sterilized packets of instruments. One of the boxes was almost in contact with the metal cart. Clean blue colored drapes (used to wrap	C 139	C139 An inservice training has been conducted for all staff on the proper use of proper PPE C 139Bio boxes will now only be kept in the closet designated for Biohazard Materials. To be monitored by administrator.	8/10/2017

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C 139	Continued From page 11 instruments) was observed in direct contact on top of one of the two boxes, and Staff C was observed placing her gown and face shield on top of the clean drapes which was located on top of one box. Staff C left the room, then returned and donned the same gown and face shield after lifting them off the top of the box. When asked what was in the two boxes, Staff C replied it was biohazard trash that needed to be picked up. An open roll of paper towels was observed underneath the dirty sink in the surgical instrument processing room. Later that day between 4:00 PM and 5:00 PM during a tour with Staff A, the following was observed and confirmed with Staff A: a) The two large biohazard boxes that were previously in the instrument processing room were observed inside the medical gas room on the floor beside two cylinders of oxygen and two cylinders of nitrous gas. The door to the medical gas room was observed standing open throughout the day on 07/10/17 although a sign was posted on the door to keep the door closed. There was no self closing device observed on the door. b) A 1/2 full bottle of diet soda was observed sitting on the counter next to the handwashing sink where the medication cabinets were located. c) The operating room table was observed with a two tone blue vinyl like covering. The lighter blue rectangular area was observed where the patient's buttocks would come into contact with the operating room table during an examination or procedures. The rectangular area where the lighter and dark blue surfaces met were observed	C 139	C 139 Cabinet has been cleaned, paper towels removed and a review with staff as to what can and can not be stored under cabinet. To be monitored by DON	9/11/2017
			C 139 Biohazard boxes will only be stored in the closet desiganted for biohazard. A review with staff has been completed about the need to keep the door tothe gas closet closed. To be monitored by administrator.	9/11/2017
			C 139 review with staff has been completed as to where we can and can't have food and beverages. food and beverages are only permitted in the staff area by the microwave. To be monitored by administrator.	
			C 139 the vinyl on the OR table has been replaced .To be monitored by DON	8/17/2017

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C 139	Continued From page 12 covered with a blue colored tape. This tape was observed rolled up in areas and had material sticking to the sticky exposed surface of the tap. Staff A stated the table is covered only with a paper barrier during procedures. d) A white plastic container with a lid was observed in the staff bathroom on both days of the survey (07/10/17 and 07/11/17). The white lid of the container was observed very dirty and black colored on the top outer surface. Staff A stated the container was used to hold rock salt for snow and ice. e) The storage room located by the recovery room was observed with several boxes which were placed on the floor of the room underneath the shelving. These boxes were observed containing a variety of supplies and paper towels. Staff A stated most of the supplies were outdated and not in use. f) A dispenser of packing tape was observed on top of the pathogen (tissue) freezer. When Staff A opened the lid of the freezer to look for the thermometer, the tape was placed on the edge of the freezer and fell in two times. The tape was removed both times by Staff A who confirmed there was no good place to put the tape and it sometimes falls into the freezer. These observations were confirmed with Staff A during tour.	C 139	C 139The white container has been cleaned and will be cleaned on a regular basis. To be monitored by administrator. C 139The box has been inventoried and supplies put away. All supplies have been moved to shelves and off the floor. Staff has been reminded that supplies must be stored on shelves and not on the floor. To be monitored by administrator. C 139 There will be nothing stored on the Path freezer. We have designated a place to store the packing tape. To be monitored by administrator.	9/11/2017 9/11/2017 9/6/2017
C 150	O.A.C. 3701-83-12 (A) Q A & Improvement Program Each HCF shall establish a quality assessment and performance improvement program designed	C 150		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 150	Continued From page 13 to systematically monitor and evaluate the quality of patient care, pursue opportunities to improve patient care, and resolve identified problems. This Rule is not met as evidenced by: Based on review of governing body minutes, facility documentation, and staff interviews, the facility lacked evidence of a quality assessment and performance improvement program (QAPI) for monitoring and evaluating the quality of patient care, and to improve patient care and resolve identified problems. This could potentially affect all patients receiving care in the facility. A total of 954 procedures were performed in the most recent twelve months. 7542 ing there ctives e ff B ility is ews, ng a cility was not conducting routine QAPI meetings to use these findings to establish goals or use the data to improve patient care.	C 150	C 150 Patient charts are reviewed daily to identify issues and areas that need improvement. Patients fill out surveys after their procedures and a monitoring log has been created and is monitored by the administrator. C150 Daily RH blood controls are performed to ensure the accuracy of our RH testing results. To be Monitored by Lab director C 150 we follow up with patients to ensure a negative pregnancy test 4 weeks out and log the results. To be monitored by DON. C 150 A training log has been put into place with documentation of the training. To be monitored by DON.	9/11/2017 9/06/2017 9/06/2017 9/11/2017

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C 150	Continued From page 14 On 07/11/17 a review of the facility's policy titled "Quality Control", reviewed by the Governing Body in January 2017, revealed a mission statement that stated the facility is dedicated to providing the highest standards of safety and hygiene, through the use and implementation of a comprehensive Quality Assurance manual. At 3:40 PM Staff B confirmed this aforementioned policy. At 3:40 PM, Staff A was made aware of the aforementioned interview with Staff B.	C 150		
C 151	O.A.C. 3701-83-12 (B) Q A & Improvement Plan Each HCF shall develop a written plan that describes the quality assessment and performance improvement program's objectives, organization, scope, and mechanism for overseeing the effectiveness of monitoring, evaluation, improvement and problem-solving activities. This Rule is not met as evidenced by: Based on review of governing body minutes, facility documentation, and staff interviews, the facility failed to develop a written plan that describes the quality assessment and performance improvement program's (QAPI) objectives, organization, scope, and mechanism for overseeing the effectiveness of monitoring, evaluation, improvement and problem-solving activities. This could potentially affect all patients receiving care in the facility. A total of 754 surgical and medical procedures were performed in the most recent twelve months.	C 151	C 151 The HCF has developed a written plan that describes the quality assessment and performance improvement, review, audits, evaluations and inspections. The QAPI will be monitored by the DON and reviewed by the governing body on an anual basis. See attached #1	9/11/2017

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C 151	Continued From page 15 Findings include: On 07/11/17 at 10:00 AM and 3:40 PM, a review was conducted of the governing body minutes and facility documentation. An interview was conducted with Staff B at those times regarding whether the facility had a written plan that described the QAPI program. Staff B confirmed the facility currently lacks this written plan. At 3:40 PM, Staff A was made aware of the aforementioned interview with Staff B.	C 151		
C 152	O.A.C. 3701-83-12 (C) Q A & Improvement Requirements The quality assessment and performance improvement program shall do all of the following: (1) Monitor and evaluate all aspects of care including effectiveness, appropriateness, accessibility, continuity, efficiency, patient outcome, and patient satisfaction; (2) Establish expectations, develop plans, and implement procedures to assess and improve the quality of care and resolve identified problems; (3) Establish expectations, develop plans, and implement procedures to assess and improve the health care facility's governance, management, clinical and support processes; (4) Establish information systems and appropriate data management processes to facilitate the collection, management, and analysis of data needed for quality assessment and performance improvement, and to comply with the applicable	C 152	C 152 HCF is monitoring all aspects of care including effectiveness, appropriateness accessibility and patient satisfaction.The monitoring is documented,reviewed and assessed for quality and effectiveness. To be monitored by administrator andf DON C 152 Processes have been developed to collect data and analyze where improvements are needed. Monitored by administrator.	9/11/2017 8/08/2017

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C 152	Continued From page 16 data collection requirements of Chapter 3701-83 of the Administrative Code; (5) Document and report the status of quality assessment and improvement program to the governing body every twelve months; (6) Document and review all unexpected complications and adverse events, whether serious injury or death, that arise during an operation or procedure; and (7) Hold regular meetings, chaired by the medical director of the HCF or designee, as necessary, but at least within sixty days after a serious injury or death, to review all deaths and serious injuries and report findings. Any pattern that might indicate a problem shall be investigated and remedied, if necessary. This Rule is not met as evidenced by: Based on review of governing body minutes, facility documentation, and staff interviews, the facility failed to develop a quality assurance plan that monitored and evaluated all aspects of care, and failed to establish expectations, develop plans and implement procedures to improve the quality of care. The facility failed to hold regular meetings. This could potentially affect all patients receiving care in the facility. A total of 754 surgical and medical procedures were performed in the most recent twelve months. Findings include: On 07/11/17 at 10:00 AM and 3:40 PM, a review	C 152	C 152HCF has developed a comprehensive quality assurnace plan that will monitor all aspects of care in the facility. Monitored by administraotr and DON. C 152The HCF is committed to holding quarterly meetings to assess and evaluate current systems and identify where improvement is needed. Monitored by DON.	9/11/2017

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C 152	Continued From page 17 was conducted of the governing body minutes and facility documentation. An interview was conducted with Staff B at those times regarding whether the facility had a written plan that described the QAPI program. Staff B confirmed the facility currently lacks this written plan and confirmed there were no regular meetings conducted to discuss quality of care. When asked what the facility was working on for quality, and whether there were goals and measures in place to collect and analysis data to improve quality, Staff B confirmed there was no written plan. At 3:40 PM, Staff A was made aware of the aforementioned interview with Staff B.	C 152	C 152 The HCF has a written plan and has included measurable goals and the collection of patient data to quarterly meetings for assessment and improvement. monitored by DON	9/11/2017
C 153	O.A.C. 3701-83-12 (D) Q A & Improvement - 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, facility documentation, and staff interviews, the facility failed to implement a program for proactive assessment of high-risk activities related to patient safety and to undertake appropriate improvements. This could potentially affect all patients receiving care in the facility. A total of 754 surgical and medical procedures were performed in the most recent twelve months.	C 153	C 153 The HCF has added a comprehensive alarm system with camera monitors to monitor and assess high risk activity. Any issues will be assessed and reviewed. In addition we will keep any recorded activity on file for future use and or training. To be monitored by administrator. C 153 HCF has updated it's emergency transportation and protocol for handling emergincies of patients. To be monitored by DON, reviewed and assessed by the governing body anually. see attached #5	8/8/2017

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C 153	Continued From page 18 Findings include: On 07/11/17 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 153		
C 222	O.A.C. 3701-83-18 (C) Director of Nursing Each ASF shall have a director of nursing who is an RN with experience in surgical and recovery room nursing care. The director of nursing shall 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 potentially affect all patients receiving care in the facility. A total of 754 surgical and medical procedures were conducted in the most recent twelve months. Findings include: On 07/11/17 at 3:40 PM an interview was conducted with Staff B regarding whether the facility had documented evidence of the Director of Nursing's (Staff J) previous experience in surgical and recovery room nursing care. Staff B confirmed the facility lacked this documentation.	C 222	C 222 The HCF does have a qualified Director of Nursing. All approperiate and necessary evidance are now in the staff members file. Staff files will be reviewed on an anual basis to ensure that documents are not missing in the future. To be monitored by governing body. See attached # 6	9/11/2017

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C 222	Continued From page 19 The personnel file for Staff J was reviewed. The file did not contain evidence that Staff J had experience in surgical and recovery room nursing care.	C 222		
C 225	O.A.C. 3701-83-18 (F) Nurse Duty Requirements At all times when patients are receiving treatment or recovering from treatment until they are discharged, the ASF shall: (1) Have at least two nurses present and on duty in the ASF, at least one of whom shall be an RN and at least one of whom is currently certified in advanced cardiac life support who shall be present and on duty in the recovery room when patients are present; (2) In addition to the requirement of paragraph (F) (1) of this rule, have at least one RN who shall be readily available on an on-call basis; and (3) Have sufficient and qualified additional staff present to attend to the needs of the patients. This Rule is not met as evidenced by: Based on review of the facility's schedule logs, personnel file review and staff interview, the facility failed to ensure three registered nurses (Staff D, F and H) were certified in advanced cardiac life support (ACLS) when on duty in the recovery room while patients were present. The facility failed to ensure a nurse with ACLS was	C 225	C 225 The HCF has taken measures to ensure that all RN's are ACLS certified. Staff files will be reviewed anually and a staff log created to monitor renewals See attached #2	9/11/2017

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C 225	Continued From page 20 scheduled on two of 19 schedules reviewed. This had the potential to affect all of the facility's patients. The facility performed 754 surgical and medical procedures in the most recent twelve months. Finding include: The facility's Staff RN Job Description was reviewed. The job description stated the Staff RN must be ACLS certified. 1. The personnel file of Staff D was reviewed. The file did not contain evidence of Staff D having ACLS certification. On 07/11/17 at 1:32 PM, Staff B reported Staff D did not have current ACLS. The facility's Schedule Logs were reviewed and revealed Staff D was the only registered nurse scheduled in the recovery room on the following dates: 05/15/17, 05/17/17, 05/18/17, 05/22/17, 05/24/17, 05/25/17, 05/31/17, 06/01/17, 06/05/17, 06/08/17, 06/13/17, 06/14/17, 06/19/17, 06/26/17, 06/29/17, 07/03/17, and 07/06/17. On 07/10/17 at 2:41 PM, the finding was shared with Staff A and confirmed. 2. The personnel file for Staff H was reviewed. The file did not contain evidence of Staff H having current ACLS certification. The facility's Schedule Logs were reviewed and revealed Staff H was the only registered nurse scheduled in the recovery room on the following dates: 05/13/17 and 05/27/17. The finding was shared with Staff B and	C 225	C 125Staff D now has ACLS as do all RN's. Staff files will be reviewed anually to ensure all licenses and certifications are present. A staff log has been created to monitor expiration dates of all staff members. See attached #2	9/11/2017

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C 225	Continued From page 21 confirmed. 3. The facility's Schedule Logs were reviewed from 05/25/17 and 06/08/17 and revealed one registered nurse without ACLS certification (Staff D) and one licensed practical nurse without ACLS certification (Staff E) were the only two nurses scheduled for the day. The facility performed procedures on 05/25/17 and 06/08/17. On 07/11/17 at 4:30 PM, the findings were shared with Staff B and confirmed.	C 225		
C 241	O.A.C. 3701-83-20 (B) OR & Recovery Room Equipment Each ASF shall have the following equipment accessible to the operating suite and recovery area: (1) Adequate resuscitation equipment: (a) ASFs providing surgical procedures under topical and local infiltration blocks with or without oral or intramuscular preoperative sedation shall have: airways, bag mask respirator, oxygen source, suction equipment, and age-appropriate resuscitative drugs; (b) ASFs providing surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs or providing surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have: airways, endotracheal tubes, laryngoscope, oxygen delivery capability under positive pressure, suction equipment, and suitable resuscitative drugs. (2) Appropriate monitoring equipment: (a) Each ASF shall have size-specific blood pressure	C 241		

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C 241	Continued From 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 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		

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C 241	Continued From page 23 On 07/10/17 between 4:00 PM and 5:00 PM with Staff A, observations were conducted of the emergency supply box for the Operating Room. Outdated supplies were observed and confirmed with Staff B as follows: a) Four intravenous catheter start kits 24 gauge by 3/4 inches, Lot 120508A, 15 ml/min, each expired 04/17. b) Metal forceps were observed in a reprocessed package with a processing date of 08/01/16. Staff A removed the forceps from the emergency box and stated the facility practice is to reprocess sterile instruments every six months. c) Three Satin S.P.U. disposable laryngoscope handles, Ref 40650, Lot 12090063, each with an expiration date of 09/16. A review of the crash cart (emergency box) log at the time of observation revealed the emergency box had been checked by staff on 07/03/17 for contents and expiration dates; however, these outdated supplies remained in the box. This finding was confirmed with Staff A at the time of the observation.	C 241	C 241The catheter starter kits 24g by 3/4 in Lot # 120508A, 15 ml/min, have been removed, disposed of and replaced. Additional training has been provided to nurses performing the monthly crash cart exp. check list. Metal forcepts have been reprocessed and a review done with staff on checking for exp. sterile instruments. Disposable larngoscopes have been discarded and replaced. To be monitored by DON.	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: 614 9955945 Pages: 2

Re: page #14

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C 150	Continued From page 13 to systematically monitor and evaluate the quality of patient care, pursue opportunities to improve patient care, and resolve identified problems. This Rule is not met as evidenced by: Based on review of governing body minutes, facility documentation, and staff interviews, the facility lacked evidence of a quality assessment and performance improvement program (QAPI) for monitoring and evaluating the quality of patient care, and to improve patient care and resolve identified problems. This could potentially affect all patients receiving care in the facility. A total of 954 procedures were performed in the most recent twelve months. Findings include: On 07/11/17 at 10:00 AM and 3:40 PM, an interview was conducted with Staff B regarding Quality Assurance (QA). Staff B confirmed there were no QA meetings to discuss goals, objectives and timelines for completion of goals with the exception of a monthly monitoring tool. Staff B also confirmed there was no QA manual in accordance with the facility policy. During the interviews, Staff B stated the facility is collecting data in record reviews, peer reviews, and patient satisfaction surveys, and is doing a monthly audit of the facility which includes infection control; however, confirmed the facility was not conducting routine QAPI meetings to use these findings to establish goals or use the data to improve patient care.	C 150	C 150 Patient charts are reviewed daily to identify issues and areas that need improvement. Patients fill out surveys after their procedures and a monitoring log has been created and is monitored by the administrator. C150 Daily RH blood controls are performed to ensure the accuracy of our RH testing results. To be Monitored by Lab director C 150 we follow up with patients to ensure a negative pregnancy test 4 weeks out and log the results. To be monitored by DON. C 150 A training log has been put into place with documentation of the training. To be monitored by DON. C 150 The HCF has a QA manual in place and is conducting QA meetings to review and discuss goals, objective and timelines for the completion To be monitored by DON.	9/11/2017 9/06/2017 9/06/2017 9/11/2017 9/11/2017