Printed: 07/06/2011 4:03:17PM
Due Date: 06/11/2011
Priority: Non-IJ Medium

Intake ID: OH00060587
Facility ID: OHL41366 / SL-AS
Provider Number:
Mgmt.Unit: BCHCFS

ACTS Complaint/Incident Investigation Report

PROVIDER INFORMATION

Name: AKRON WOMEN'S MEDICAL GROUP
Address: 692 EAST MARKET STREET
City/State/Zip/County: AKRON, OH, 44305, SUMMIT
Telephone: (330) 535-9191

License #: 0969AS
Type: SL-AS
Medicaid #:
Administrator: CAROL WESTFALL, DIRECTOR

INTAKE INFORMATION

Taken by - Staff: 25098, 25098
Location Received: CMPL - COMPLAINT UNIT
Intake Type: Complaint
Intake Subtype: State-only, licensure
External Control #:
SA Contact:
RO Contact:
Responsible Team: NLTC - CENTRAL OFFICE
Source: Anonymous

Received Start: 04/27/2011 At 10:13
Received End: 04/27/2011 At 10:13
Received by: Hotline
State Complaint ID:
CIS Number:

COMPLAINANTS

Name	Address	Home Phone	Work Phone	Link ID
Not Applicable / Anonymous (Primary)				02UIWZ

RESIDENTS/PATIENTS/CLIENTS - No Data

ALLEGED PERPETRATORS - No Data

INTAKE DETAIL

Date of Alleged: Time: Shift:
Standard Notes:
Extended RO Notes:
Extended CO Notes:

ALLEGATIONS

Category: State Licensure
Subcategory:
Seriousness:
Findings: Substantiated:State deficiencies related to the alleg are cited

Tags: C0114-Patient Care Policies (O.A.C. 3701-83-07 (A))
C0139-Safety & Sanitation (O.A.C. 3701-83-10 (B))

Details: Allegation #1: The staff are rude and treat patients in a disrespectful manner.

Allegation #2: The facility is dirty.

Allegation #3: The facility has mice.

Caller states:

"I had to take my daughter in law there recently and it was just awful. The treatment she got from the staff was unbelievable. The girl at the front desk was so rude and nasty. Nothing she said was kind in any way, she was very snappy. Then, the counselor was just a smart ass. It was like no one had any compassion, it was awful.

ACTS Complaint/Incident Investigation Report

The place is a mess, very dirty. She had to go downstairs for an ultrasound and she said it was just filthy down there. She also said that there was a mouse in the room where she had her ultrasound! This is supposed to be a healthcare facility! My daughter in law hasn't given me permission to use her name so I'm going to keep that confidential."

Findings Text: An on-site visit was made to Akron Women's Medical Group on 05/17/11 by the Ohio Department of Health, Division of Non Long Term Care. The complainant was anonymous with no telephone information provided. During the course of the investigation, the information requested and reviewed included agency policies and procedures, employee job descriptions and any complaints or concerns received by the facility. Observation of the facility was completed. Interviews were completed with administrative and direct care staff. At no time during the course of this investigation was the identity of the complainant or the specifics of the complaint divulged.

Allegation #1: The staff are rude and treat patients in a disrespectful manner.

Findings: On 05/17/11 a large sample of personnel files for agency staff were selected and reviewed. The sample of personnel files included nursing, direct care and office staff. Review of the personnel files revealed employee performance evaluations completed since March 18, 2011.

Review of one personnel file was for the employee assigned to the facility reception desk. The staff person had been employed with the facility since 12/10/04. The most recent performance evaluation was dated 03/30/11. Review of the evaluation revealed the staff person had occasional problems with patient interaction and lacked professionalism in interaction with patients.

Administrative staff was interviewed regarding the comments noted on the employee evaluation. The administrative staff verified the employee occasionally spoke to patients in a curt and short manner during the admission process. The administrator stated the curt and short interaction with patients had been addressed with the employee.

Review of the job description for persons assigned to the front desk indicated that phone counseling was to be done in a calm, supportive and understanding manner. The job description noted the employee was the first contact and the first impression so must be friendly, helpful and be pleasant. Qualifications for the position noted the staff was to possess warmth and sensitivity.

Two direct care staff were interviewed regarding staff assignments in the facility. Both staff stated that one person was assigned the front desk duties which involved admission of patients to the facility. Both staff interviewed verified the one employee assigned to the front desk had been routinely over heard to be short and curt during interaction with patients.

Conclusion: During review of personnel files one staff person was identified to have problems with interaction patients. Interview with administrative staff regarding the content of the evaluation verified the employee had been counseled regarding the manner in which patients were addressed. Interview with direct care staff revealed that only one person was assigned the front desk duties. That person was the employee noted to have problems with professional interaction by the performance evaluation.

The allegation was substantiated. A violation was cited at 3701-83-07 (A) which addressed that agency policies were not being followed with regards to patients being treated with consideration and respect.

Allegation #2: The facility is dirty.

Findings: On 05/17/11 tour of the facility was completed. Staff present at the facility revealed the facility was opened for surgical procedures on 05/14/11, closed on 05/15 and 05/16/11. Tour of the facility revealed the following observations that indicated the facility was not maintained in a sanitary manner:

1. The main waiting area on the upper floor of the facility was observed to have a used can of an energy drink sitting on the floor under a chair. Also observed was a large crumb of snack food on the floor as well as a discarded clear wrapper. The carpet in the waiting area was noted to have large stained and dirty looking areas.

Two direct care staff were interviewed regarding the cleaning practices of the facility. A receipt was provided that indicated the upper floor waiting area had the carpet cleaned in April 2011. Review of the job description for the receptionist/ telephone/cashier employees revealed that duties included responsibility for the appearance of the waiting rooms.

2. Observation of a patient holding area on the lower level of the facility revealed the carpet in the room had small pieces of white debris on the flooring. Staff interviewed verified the carpet had not been vacuumed for at least four days.

3. Observation of the operating room revealed a red instrument cart and ultrasound machine that were covered with a layer of dust and powdery white residue.

4. Observed next to the operating table was a 10 gallon red sharps container with no lid in place. The red sharps container was slightly over half full of used syringes with needles attached. Two syringes lying at the top of the pile of syringes was noted to have visible blood in the syringes.

Staff present on the tour verified the operating room had not been properly cleaned and secured after the completion of procedures, four days earlier.

Review of policies and procedures revealed facility staff failed to follow the procedures with regards to environmental cleaning.

Conclusion: An unannounced visit to the facility resulted in the facility opening earlier than planned. Staff at the facility verified the last day opened was four days earlier , which was a day when surgical procedures were performed. Tour of the facility resulted in observation of a discarded drink can, snack and wrapper debris in the main waiting area. The carpet in the waiting room had numerous and large stained areas present. Observation of the patient holding area and operating room on the lower level revealed both areas had not been vacuumed or cleaned for at least four days. Staff present on tour verified that after surgical procedures were completed four days earlier minimal cleaning of the operating room had been completed prior to staff leaving for the weekend.

The allegation was substantiated. A violation was cited at 3701-83-10 (B) which addressed safety and sanitation of the facility.

Allegation #3: The facility has mice.

Findings: A tour of the entire facility was completed. Noted on the lower level of the facility was a patient holding area (small waiting room), an ultrasound room, operating room and the recovery room. During tour, special attention was made to observed for any evidence of rodent or insect infestation. No droppings, traps or other evidence was seen during the tour.

Staff was interview regarding visits made to the facility by pest control companies. Documentation was provided that noted a visit was completed on 04/12/11. A chemical spray was identified as being used. Interview of staff present at the facility verified the pest control company routinely came to the facility for preventative work. Staff stated there was no known rodent infestation and no rodents had been seen in the facility.

Conclusion: Tour of the facility and review of pest control information did not reveal any issue with mice or other rodent infestation. The allegation was unsubstantiated due to lack of sufficient evidence. No licensure violations were cited.

Based on review of employee personnel files, review of employee job descriptions and staff interview and verification, the facility failed to ensure that each patient was treated with consideration, respect, and full recognition of dignity and individuality. The facility provided care and services for 461 patients between 03/17/11 and 05/17/11.

Findings included:

On 05/17/11 review of the facility personnel files was completed. Review of the personnel file for Staff G7 revealed employment with the facility began 12/10/04. Staff G7's most recent performance evaluation was dated

03/30/11. According to documentation, Staff G7 was noted to hold a position which required receptionist, telephone and cashier duties. Review of the most recent performance evaluation revealed Staff G7 had occasional problems with patient interaction and lacked professionalism while interacting with patients.

On 05/17/11 Staff C was interviewed regarding the comments noted on the employee evaluation. Staff C verified that Staff G7 occasionally speaks in a curt and short manner to patients during the admission process. Staff C stated the curt and short interaction with patients had been addressed with Staff G7.

Review of the job description for Staff G7 indicated that phone counseling was to be done in a calm, supportive and understanding manner. The job description noted the employee was the first contact and the first impression so must be friendly, helpful and be pleasant. Qualifications for the position noted the staff was to possess warmth and sensitivity.

Interview on 05/17/11 with Staff A and B regarding staff assignments in the facility revealed Staff G7 was only assigned to the receptionist, phone and cashier duties. Staff A and B further verified that Staff G7 had been over heard to be short and curt during interaction with patients.

This violation substantiated Allegation #1 in Complaint Number OH00060587.

Recite

Based on tour of the facility, review of facility maintenance receipts, employee job descriptions, facility policy and procedures and staff interview and verification it was determined the staff failed to ensure the facility was maintained in a safe and sanitary manner. Although the previous safety and sanitary issues identified during the licensure inspection completed 03/17/11 were corrected, observation during the revisit revealed the facility continues to be not maintained in a safe and sanitary manner. The facility provided care and services for 461 patients between 03/17/11 and 05/17/11.

Findings included:

On 05/17/11 between 9:50 A.M. and 10:20 A.M., tour of the facility was completed with Staff A and revealed the following:

1. The main waiting area on the upper floor of the facility was observed to have a used can of an energy drink sitting on the floor under a chair. Also observed was a large crumb of a snack food on the floor as well as a discarded clear wrapper. The carpet in the waiting area was noted to have large stained and dirty looking areas.

Staff A and B were interviewed regarding the cleaning practices of the facility. A receipt was provided that indicated the upper floor waiting area had the carpet cleaned in April 2011. Review of the job description for the receptionist/ telephone/cashier employees revealed that duties included responsibility for the appearance of the waiting rooms.

2. Observation of the lower level of the facility, specifically the main operating room, revealed unlocked cabinets where antibiotics and physician prescription pads were kept.

A red instrument cart and ultrasound machine were covered with a layer of dust and powdery white residue.

Twenty-six multi-dose bottles of a blood thinning medication and one ampule of a heart medication were sitting on a counter top in the operating room.

Five cardboard boxes of extension sets commonly used by the certified registered nurse anesthetist (CRNA) for intravenous sedation during procedures were observed sitting on the operating room floor. Staff A verified the boxes had been delivered to the facility four days earlier.

ACTS Complaint/Incident Investigation Report

One multi-dose bottle of lidocaine (an analgesic) approximately half full, was observed sitting on a window sill with a needle inserted and still in place in the stopper of the bottle. The bottle was not dated as to when it was initially opened. Staff A verified the lidocaine was last used during procedures performed in the operation room four days ago.

Six, 22 gauge caths, used by the CRNA during intravenous sedation, were observed in their wrappers, openly lying on a surface close to the operating table.

Observed next to the operating table was a 10 gallon red sharps container with no lid in place. The red sharps container was slightly over half full of used syringes with needles attached. Two syringes lying at the top of the pile of syringes was noted to have visible blood in the syringes.

Staff A verified the operating room had not been properly cleaned and secured after the completion of procedures, four days earlier.

3. Observation of a patient holding area on the lower level of the facility revealed the carpet in the room had small pieces for white debris on the flooring. Staff A verified the carpet had not been vacuumed for at least four days.

Review of facility policy and procedures revealed facility staff failed to follow facility policy and procedures with regards to storage of clean and sterile supplies, universal precautions including CDC recommendations, multi-dose vials, control of restricted items, inspection of drug storage area, general security measures, physician ordering of medication, prescription blanks, medication administration, and environmental cleaning.

This violation substantiated Allegation #2 of Complaint Number OH00060587.

SURVEY INFORMATION

Event ID	Start Date	Exit Date	Team Members	Staff ID
YYE311	05/17/11	05/17/11		

Intakes Investigated: OH00060587(Received: 04/27/2011)

SUMMARY OF CITATIONS:

Event ID	Exit Date	Tag
YYE311	05/17/2011	
		State - Link to This Intake
		C0114-Patient Care Policies
		C0139-Safety & Sanitation
		State - Not Related to any Intakes
		C0000-Initial Comments
YYE312	06/21/2011	
		State - Link to This Intake
		C0139-Safety & Sanitation
		C0114-Patient Care Policies
		State - Not Related to any Intakes
		C0000-Initial Comments

EMTALA INFORMATION - No Data

ACTIVITIES

Type	Assigned	Due	Completed	Responsible Staff Member
Schedule Onsite Visit	05/17/2011	05/17/2011	05/17/2011	

INVESTIGATIVE NOTES - No Data

CONTACTS - No Data

ACTS Complaint/Incident Investigation Report

AGENCY REFERRAL - No Data

LINKED COMPLAINTS - No Data

DEATH ASSOCIATED WITH THE USE OF RESTRAINTS/SECLUSION - No Data

NOTICES

PROPOSED ACTIONS

Proposed Action	Proposed Date	Imposed Date	Type
Plan of Correction	05/17/2011		Federal

END OF COMPLAINT INVESTIGATION INFORMATION