Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0763AS	A. BUILDING: _____ B. WING _____	06/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL CARE NETWORK	1160 WEST SYLVANIA AVENUE TOLEDO, OH 43612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments Licensure Compliance Inspection Administrator: Victor James, Administrator County: Lucas Number of Operating Rooms: 3 The following violations are issued as a result of the licensure compliance inspection completed on 06/06/13.	C 000	2014 MAY -8 AM 11:45 OHIO DEPT OF HEALTH DOA-BCHCFS	
C 120	O.A.C. 3701-83-08 (B) T B Control Plan The 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, policy review and staff interview it was determined the facility failed to ensure a tuberculin (TB) test was done annually for each staff member in accordance with facility policy. This affected two of seven direct patient care staff whose personnel files were reviewed.	C 120	C 120 - TB Control Plan 1. This deficiency will be corrected with the following measures: a. A review of all personnel files will be completed to identify deficiencies. b. TB tests will be conducted on any staff member, whose personnel file is lacking test results. c. All test will be performed according to the company's existing Infectious Control Plan. 2. The following measures have been taken to ensure the deficiency does not recur: a. Periodic reviews of personnel files by the HR Manager to ensure all required documentation is present. b. All newly hired staff to be tested within the first 30 days of their employment. Existing staff has been placed on a tiered schedule for re-testing.	06/30/2013

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C 120	Continued From page 1 Findings include: Review of facility personnel files was completed on 06/06/13. The personnel file for registered nurse (RN) Staff F contained a form revealing TB test results but the form lacked a date. The personnel file for licensed practical nurse (LPN) Staff I did not contain documentation a TB test had been done since Staff I was hired for employment on 05/19/12. Review of facility policy for Tuberculosis (TB) was completed on 06/06/13. The policy reveals "TB testing will be done on an annual basis." The policy was presented to the surveyor from the human resources director, Staff B, on 06/06/13 at 11:50 AM. This finding was confirmed with the CEO, Staff A, and Staff B on 06/06/13 at 1:00 PM.	C 120	C 120 - TB Control Plan (Continued) 3. The performance will be monitored to ensure solutions are permanent through: a. Monthly Safety inspection now requires all personnel files to be complete. 4. This deficiency was corrected on June 30, 2013.	06/30/2013
C 126	O.A.C. 3701-83-08 (H) Staff Schedules Each HCF shall retain staffing schedules, time-worked schedules, on-call schedules, and payroll records for at least two years. This Rule is not met as evidenced by: Based on medical record review, documentation review and staff interview it was determined the facility failed to maintain time-worked schedules in the facility. This affects all patient's receiving services from the facility. The facility provided services to 654 patients in the last 12 months. The total sample size was 23 records reviewed.	C 126	C 126 - Staff Schedules 1. This deficiency will be corrected with the following measures: a. All staff schedules will be kept electronically, allowing for ease of access at all locations. b. HR Manager will update staff schedules on a bi-weekly basis to ensure all scheduling changes are properly reflected. c. Payroll will be kept electronically, allowing for ease of access at all locations. d. All electronic files will be kept according to SSL and XML encryption standards to ensure safe record keeping.	06/30/2013

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C 126	Continued From page 2 Findings include: Medical records review was completed on 06/06/13. Eight medical were reviewed for patients who had procedures on 04/05/13. Eight of eight medical records revealed one RN, Staff G, had entered nursing notes into all eight records. Review of the staff schedule for 04/05/13, revealed RN, Staff F was scheduled to work on 04/05/13. Interview with Staff A and B on 06/06/13 at 10:45 AM revealed Staff G was not put on the schedule. When asked by the surveyor to check payroll records to see if Staff F had worked on 04/05/13, Staff B reported he/she could not access payroll records from this Toledo location. Staff A and B confirmed during the interview that time-worked schedules are not maintained in this facility.	C 126	C 126 - Staff Schedules (Continued) 2. The following measures have been taken to ensure the deficiency does not recur: a. All locations have access to the electronic data management center to ensure all records can be accessed upon request. b. Electronic timekeeping has been implemented to ensure payroll records automatically update with the staff on schedule. c. HR Manager reviews all payroll records on a bi-weekly basis to identify discrepancies with the staff schedule. 3. The performance will be monitored to ensure solutions are permanent through: a. Monthly reviews of staff schedules to ensure corrections from payroll reports are made prior to saving the schedules. 4. This deficiency was corrected on June 30, 2013.	06/30/2013
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 observation, staff interview and policy review it was determined the facility failed to maintain operating rooms and associated equipment in a safe and sanitary manner. This deficient practice had the potential to negatively effect the entire census of 654 patients who visited the facility in the preceding 12 months. Findings include:	C 139	C 139 - Safety & Sanitation 1. This deficiency will be corrected with the following measures: a. Tape from OR table was removed and area disinfected. b. Any existing tears will be repaired to ensure the risk of contamination is mitigated. c. All staff will be re-trained on proper terminal cleaning procedures. d. All rooms have been properly stocked with necessary equipment and supplies. e. Re-training will be conducted with all staff concerning proper protocols for sanitation.	02/21/2014

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C 139	Continued From page 3 An environmental tour completed the afternoon of 06/05/13 revealed the facility's Operating Room (OR) #1 obstetrical examination table had a large strip of gold tone duct tape across the entire width of the examination table pad at the middle separation where the top and bottom pads met. Interview with Staff C at the time of tour verified the table pads had tears that were taped and unable to be properly cleaned and sanitized between uses secondary to the loss of product integrity. The equipment and supply drawer located on the foot end of the examination table was observed to contain a blue surgical pack whose sterile safety tape had been torn and contents consisting of surgical instruments were observed open to air. Interview with Staff C verified that he/she was unable to identify if the surgical instruments were soiled or not. Operating Room (OR) #1 was equipped with a hand-washing sink; however, there was no hand soap or paper towels observed in the room. A wooden wall cabinet was observed to contain two packs of sterile surgical instruments whose sterile color code indicated the items were no longer sterile or had failed the facility's heat sterilization process for surgical instruments. Interview with staff at the time of these findings indicated the instruments were stocked and ready to use in surgeries. Review of the facility's unnamed and undated procedure for "Handwashing Facilities", reviewed on 06/06/13, revealed that all handwashing	C 139	C 139 - Safety & Sanitation (Continued) 2. The following measures have been taken to ensure that the deficiency does not recur: a. Monthly Safety Inspection will include a section the requires the inspection of exam tables. b. All obsolete and unused equipment has been removed from OR and existing equipment has been inspected for correct dates. c. An in-service with staff members has been conducted to ensure proper compliance with company terminal cleaning procedures. d. Terminal cleaning procedures have been updated to ensure all hand washing facilities are properly stocked. 3. The performance will be monitored to ensure the solutions are permanent through: a. Monthly Safety Inspections will evaluate conditions of OR. b. Monthly Director inspections will evaluate staff's compliance to company policy and procedures. c. HR will monitor results of inspections to determine whether additional training or disciplinary action is required. 4. This deficiency was corrected on February 21, 2014.	02/21/2014

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C 139	Continued From page 4 locations are to be equipped with soap. A metal table in OR #1 used to hold supplies and equipment used in surgery was observed to contain a stainless steel lidded basin that was labeled Betadine (an iodine product used to cleanse skin prior to surgery), when the lid was removed the basin was observed to contain a dried brown Betadine stained strip of gauze. Interview with Staff C at the time of the observation verbalized the OR was clean and all equipment ready for upcoming surgeries scheduled later that week. Operating Room (OR) #2 was equipped with a hand-washing sink and handsoap; however, the plastic paper towel dispenser directly above the sink was observed to be empty. A stack of folded paper towels was placed approximately two feet away from the sink on the most distant part of the table from the sink. Two tubes of partially used surgical lubrication were placed on top of the stack of clean paper hand towels. Additionally, this table contained a stainless steel surgical tray used to hold medical instruments for surgical procedures adjacent to the sink. Interview with the Administrator, (Staff A) on 06/06/13 at 1:30 P.M. verified these findings. The sterile processing room was observed to have a plastic pan which contained three plastic hoses soaking in approximately two inches of clear unidentifiable liquid. Interview on 06/05/13 at 12:53 P.M. revealed the hoses were used with the facility's suction machine. Staff C verbalized he/she was unable to determine what the liquid was but the hoses should not have been there.	C 139		

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C 139	Continued From page 5 The above findings were all verified by Staff C during the tour completed on the afternoon of 06/05/13.	C 139		
C 141	O.A.C. 3701-83-10 (D) Hazmat Handling Each HCF shall label, store and dispose of all poisons, hazardous wastes and flammable materials in a safe manner, and in accordance with state and federal laws and regulations. This Rule is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to ensure oxygen was stored in a safe manner. This potentially affects all patients and staff at the facility. The facility provided services to 654 patients in the last 12 months. Findings include: A tour of the facilty was completed on 06/06/13. During tour on the afternoon of 06/05/13 two "E" tanks of oxygen were noted stored in the sterile processing room. There was no signage noted outside the room indicating the storage of a flammable material inside. Staff A confirmed this finding on 06/06/13 at 1:40 PM.	C 141	C 141 - Hazmat Handling 1. This deficiency will be corrected with the following measures: a. Room was properly placarded to reflect the presence of oxygen. 2. The following measures have been taken to ensure the deficiency does not recur: a. Monthly Safety inspection includes the inspection of signage regarding Hazmat materials. 3. The performance will be monitored to ensure solutions are permanent through: a. Completion of Monthly Safety inspection. 4. This deficiency was corrected on June 30, 2013	06/30/2013
C 146	O.A.C. 3701-83-11 (D) Medical Records Confidentiality	C 146	C 146 - Medical Records Confidentiality	02/21/2014

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C 146	Continued From page 6 The HCF shall maintain an adequate medical record keeping system and take appropriate measures to protect medical records against theft, loss, destruction, and unauthorized use. The HCF shall have policies and procedures to ensure the confidentiality of patient medical records. This Rule is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to ensure the medical records stored in the facility were secured against theft or unauthorized access and stored in a room safe from fire. This potentially affects all patients provided services from the facility. The facility provided services to 654 patients in the last 12 months. Findings include: A tour of the facility was completed on 06/06/13. During tour the afternoon of 06/05/13 it was noted that the medical records room door was not locked and no locking mechanism was found. Once inside the room, three cardboard boxes containing approximately 40 medical records each, was observed. The medical record room's walls and ceiling were constructed of wood. There were no sprinklers noted in the medical records room nor anywhere throughout the facility. This finding was confirmed with Staff C while on tour the afternoon of 06/05/13 and again with Staff A on 06/06/13 at 2:00 PM.	C 146	C 146 - Medical Records Confidentiality (Continued) 1. This deficiency will be corrected with the following measures: a. All cardboard boxes have been removed from the records room. b. Records room is secured with key access only. c. Inspections have been implemented to ensure compliance. d. Training has been conducted with all staff to ensure compliance. 2. The following measures have been taken to ensure the deficiency does not recur: a. Records room has been relocated to another room in the facility. b. Locksmith has re-keyed the locks to ensure security. c. Monthly Safety inspection requires the inspection of proper record handling procedures. d. In-service has been conducted with all staff to ensure compliance. 3. The performance will be monitored to ensure solutions are permanent through: a. Completion of Monthly Safety inspection. b. Completion of Monthly Director's inspection. c. Review of findings by the HR Manager to determine if additional training or disciplinary action is required. 4. This deficiency was corrected on February 21, 2014.	02/21/2014

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C 201	Continued From page 7	C 201		
C 201	O.A.C. 3701-83-16 (B) Governing Body Duties The governing body shall: (1) At least every twenty-four months review, update, and approve the surgical procedures that may be performed at the facility and maintain an up-to-date listing of these procedures; (2) Grant or deny clinical (medical-surgical and anesthesia) privileges, in writing and reviewed or re-approved at least every twenty-four months, to physicians and other appropriately licensed or certified health care professionals based on documented professional peer advice and on recommendations from appropriate professional staff. These actions shall be consistent with applicable law and based on documented evidence of the following: (a) Current licensure and certification, if applicable; (b) Relevant education, training, and experience; and (c) Competence in performance of the procedures for which privileges are requested, as indicated in part by relevant findings of quality assessment and improvement activities and other reasonable indicators of current competency. (3) In the case of an ASF owned and operated by a single individual, provide for an external peer review by an unrelated person not otherwise affiliated or associated with the individual. The external peer review shall consist of a quarterly audit of a random sample of surgical cases.	C 201	C 201 - Governing Body Duties 1. This deficiency will be corrected with the following measures: a. Another Governing Board approved doctor will review the paperwork of another doctor to ensure Peer Review is taking place. 2. The following measures have bee taken to ensure the deficiency does not recur: a. Monthly inspections of paperwork will include the peer review process to ensure compliance. b. All staff physicians have been informed of peer review requirements and established company protocol. 3. The performance will be monitored to ensure solutions are permanent through: a. Director will review all paperwork on a monthly basis to ensure compliance. b. Follow-up will be conducted with all staff physicians to ensure compliance. 4. This deficiency was corrected on February 21, 2014.	02/21/2014

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C 201	Continued From page 8 This Rule is not met as evidenced by: Based on review of facility documentation, physician credentialing file review and staff interview it was determined the facility failed to ensure the governing body provided for an external peer review of the medical director as part of the re-credentialing process. This potentially affects all patients provided services from the facility. The facility provided services to 654 patients in the last 12 months. Findings include: Review of the facility's quarterly medical record review was completed on 06/06/13. The facility's medical assistants, Staff C and D, were noted to have reviewed a sample of the medical records completed by the medical director on a quarterly basis. The surveyor interviewed Staff A and B on 06/06/13 at 1:00 PM to ascertain if the medical director's medical records were reviewed by another physician. Staff A and B could not produce evidence that this review was taking place. The medical director's reappointment for privileges was last approved by the governing body on 11/28/12.	C 201		
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 meet the following requirements:	C 225	C 225 - Nurse Duty Requirements 1. This deficiency will be corrected with the following measures: a. Elimination of intravenous sedation. b. Staff schedule review to ensure compliance.	02/21/2014

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C 225	Continued From page 9 (1) At least two nurses shall be 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 and 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, at leastone RN shall be readily available on an on-call basis; and (3) Sufficient and qualified additional staff to attend to the needs of the patients shall be present. This Rule is not met as evidenced by: Based on medical record review and staff interview it was determined the facility failed to ensure a RN was present in the recovery room when patients were present. This affected all patients reviewed who received intravenous sedation on 04/05/13 (Patient #'s 1, 2, 3, 4, 5, 6, 7 and 8) and has the potential to affect all patient's receiving intravenous sedation at the facility. The facility serviced 654 patients in the last 12 months. Findings include: Review of eight medical records of patients who had received intravenous (IV) sedation on 04/05/13 was completed on 06/06/13. All eight of the medical records revealed the same registered nurse (RN) provided care to all eight patients. The medical record review further revealed the portion of the surgical procedure flow sheet	C 225	C 225 - Nurse Duty Requirements (Continued) 2. The following measures have been taken to ensure the deficiency does not recur: a. ASF no longer provides intravenous sedation, alleviating any scheduling conflicts. b. In-service has been conducted with staff to ensure acclimation with required compliance pursuant to O.A.C. 3701-83-18 (F). 3. The performance will be monitored to ensure solutions are permanent through: a. Review of staff schedules will be conducted by the HR Manager to ensure proper staffing is schedule and all requirements are satisfied. b. All intravenous medications have been removed from the ASF, eliminating the possibility of scheduling conflicts. 4. This deficiency was corrected on February 21, 2014.	02/21/2014

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C 225	Continued From page 10 dedicated to the recovery room documentation was consistently initialed as being performed by Staff H. Staff H was identified by the facility as being a Licensed Practical Nurse (LPN). When the eight medical records were collectively reviewed it was determined the RN could not have been in the OR administering the IV sedation and at the same time be in the recovery room for post anesthesia care. Interview with Staff B on the afternoon of 06/06/13 revealed he/she was responsible for the staff schedule. Staff B verbalized the RN's were always scheduled in surgery with the physician for the administration of intravenous (IV) medications as well as to assist the physician with the surgical procedures. Staff B verified Staff H was always scheduled in the post surgical area as the RN's were needed in surgery.	C 225		
C 231	O.A.C. 3701-83-19 (B) Drug Control & Accountability The ASF shall: (1) Provide adequate space, equipment, and staff for storage and the administration of drugs in compliance with state and federal laws and regulations. (2) Establish and implement a program for the control and accountability of drug products throughout the facility and maintain a list of medications that are always available. This Rule is not met as evidenced by:	C 231	C 231 - Drug Control & Accountability 1. This deficiency will be corrected with the following measures: a. In-services will be conducted with all staff to ensure proper compliance to existing company Policy & Procedures. b. Operational security controls have been updated to include re-keying of any necessary locks, installation of a lock box system to store necessary keys. c. Inspections by company management to ensure all staff are adhering to all company policy and procedures.	07/30/2013

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C 231	Continued From page 11 Based on observation and staff interview it was determined the facility failed to secure medications. This potentially affects any patient who receives surgical procedures at the facility. The facility provided 654 procedures over the past twelve months. Findings include: During tour of the facility on the afternoon of 06/05/13, the supply room was observed to have unsecured wooden cabinet doors. In the cabinet there were three unopened boxes of 1% Lidocaine (injectable medication used to mask pain) each containing 25 vials and an open box of 21 vials. This represented a total of 96 vials of Lidocaine that were not contained in locked storage. Interview with Staff C at the time of the tour verified the medications were not contained in locked storage.	C 231	C 231 - Drug Control & Accountability (Continued) 2. The following measures have been taken to ensure the deficiency does not recur: a. Monthly Safety inspection includes the review of properly stored medications. b. In-service has been conducted with all staff to ensure they are knowledgeable of existing company policy and procedures and regulations regarding the proper storage of medications. 3. The performance will be monitored to ensure solutions are permanent through: a. Review of Monthly Safety inspections by the Director to ensure compliance. b. Review of findings by the HR Manager to determine if additional training or disciplinary action is required. 4. This deficiency was corrected on July 30, 2013.	07/30/2013