SENDER: *COMPLETE THIS SECTION*

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Kelly Burden, Administrator
Toledo Women's Center
P O Box 6907
Toledo, OH 43612

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

☐ Agent
☐ Addressee

B. Received by (*Printed Name*)

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

Mail ☐ Express Mail
d ☐ Return Receipt for Merchandise
Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Art
(Tr 7007 0220 0001 4324 1722

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
0763AS	A. Building B. Wing	7/27/2011

Name of Facility	Street Address, City, State, Zip Code
CAPITAL CARE NETWORK	1160 WEST SYLVANIA AVENUE TOLEDO, OH 43612

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **C0132** Reg. # **3701-83-09 (D)** LSC	Correction Completed **07/27/2011**	ID Prefix **C0139** Reg. # **3701-83-10 (B)** LSC	Correction Completed **07/27/2011**	ID Prefix **C0152** Reg. # **3701-83-12 (C)** LSC	Correction Completed **07/27/2011**
ID Prefix **C244** Reg. # **3701-83-20 (E)** LSC	Correction Completed **07/27/2011**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By **State Agency**	**Reviewed By** KK	**Date:** 10/27/4	**Signature of Surveyor:** Don Leonard RN/PR	**Date:** 7/27/11
Reviewed By **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/14/2011

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Approved
ltr 10/20/11

PRINTED: 07/29/2011
FORM APPROVED

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 _____	R 07/27/2011

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

LD 7/30/11

(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 DL County: Lucas Administrator: Kelly Burden Type of survey: Licensure Number of operating rooms: Three The following violations were based on the post survey review completed on 07/27/11 from the licensure survey conducted on 04/14/11.	(C 000)		
(C 125)	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: This is a RE-CITE This rule was not met as evidenced by: Based on review of the facility's plan of correction, personnel files and staff verification, the facility failed to ensure that evaluations of staff performance was completed for each staff member at least every twelve months. This facility provided services to 1,454 patients in 2010. Review of the staff schedule took place on 07/27/11 for the months of June and July 2011. Staff C was observed to be scheduled as recovery nurse on 08/17/11, 06/25/11 and 07/2/11.	(C 125)	POC Staff C (owner of ASC) did not meet C125 due to no one held a higher position to evaluate her. After speaking 2 DON staff C now understands that if Staff C is working as an employee, then Staff C must have evaluation. The correction was made By Supervising Physician. Physician performed evaluation on staff C. Human Resource person has been hired to monitor Personnel records Staff C will be included	5/9/11 7-30-11

Ohio Department of Health

Thomas W. Michaelis MD

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 10/19/11

STATE FORM 1ZG812 If continuation sheet 1 of 3

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 _____	R 07/27/2011

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 125}	Continued From page 1 Staff C, registered nurse, is both owner and active nurse in this facility as revealed by staff B during an interview at 2:25 PM on 07/27/11. Review of the personnel record for staff C reveals no documentation of an annual performance evaluation. Interview with staff B on 07/27/11 at 2:25 PM reveals staff C has not had the June 2011 annual evaluation as stated in the facility's plan of correction submitted on 05/09/11. A request was made to staff B for the most recent annual evaluation for staff C on 07/27/11 at 3:35 PM. Staff B contacted the person who was able to get this information but informed this surveyor this was not available.	{C 125}	~~in the annual employee evaluations and monitored By human Resource personnel See attached.~~ In the annual employee evaluations and monitored By human Resource personnel See attached Quality assurance	
{C225}	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: (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.	{C225}		5/9/11

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 _____	R 07/27/2011

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
{C225}	Continued From page 2 This Rule is not met as evidenced by: This is a RE-CITE This rule was not met as evidenced by: Based on review of the facility's plan of correction, personnel files and staff verification, the facility failed to ensure that all registered nurses were Advanced Cardiac Life Support (ACLS) trained. This facility provided services to 1,454 patients in 2010. Review of the staff schedule took place on 07/27/11 for the months of June and July 2011. Staff C was observed to be scheduled as recovery nurse on 06/17/11, 06/25/11 and 07/2/11. Staff C, registered nurse, is both owner and active nurse in this facility as revealed by staff B during an interview at 2:25 PM on 07/27/11. Review of the personnel record for staff C reveals no documentation of ACLS certification although documentation within the personnel file along with a job description states the registered nurse must be ACLS trained. Interview with staff B on 07/27/11 at 2:25 PM reveals the ACLS certification for staff C had expired in September 2010. Review of the facility's plan of correction submitted on 05/09/11 states all registered nurses hired at this facility must obtain ACLS. During the interview with staff B at 2:25 PM on 07/27/11, staff B revealed this facility recently let one registered nurse go for refusing to obtain ACLS certification.	{C225}	~~7.29.2011~~ POC ACLS was obtained for staff C. See attachment Human Resource person has been hired to monitor personnel records. A quality assurance form has been devised to assure all personnel Records are reviewed every 6 months	7.29.11

Capital Care Network
Department: Administration
Subject: Quality Assurance
Effective: 5/03/11

Revised: 6/7/11 Reviewed: _____

Revised: _____ Reviewed: _____

Revised: _____ Reviewed: _____

Approved by _____ Date _____

PURPOSE

To maintain a high quality of patient care from both the medical and support staff, and identify areas for continuous improvement.

POLICY

The Quality Assurance Program monitors existing Clinic practices and staff performance in order to evaluate all aspects of care, resolve identified problems, and improve governance and management.

PROCEDURE

- Signed confidentiality statements by all employees and independent contractors.
- Daily review and analysis of Patient Feedback Surveys. This feedback from patients will be used to develop services and improve staff performance.
- A formal complaint response procedure is in place to gather information, investigate the situation, and resolve the problem. The Governing Board will conduct a review of patient complaints at their meetings and/or as dictated by the situation.
- Chart reviews of at least 10% of patient charts for each physician, are to be conducted at least monthly by the Director and/or his/her designee. The chart reviews must be signed by a physician.
- Annual Quality Assurance Reports will be submitted to the Governing Board to review complications, patient feedback surveys, performance of license personnel, in-house laboratory program, and drug logs.
- The Clinic Directors will meet every 8 weeks to establish expectations, develop plans, and implement procedures to assess and improve the quality of care. Annual QA Reports will be reviewed at this meeting. In addition, agenda for all staff meeting will be developed and scheduled to inform staff of all QA activities.
- The Governing Board will meet at least every 12 months to review/update procedures and review Quality Assurance issues.
- Routine, periodic equipment maintenance will be supervised by the facilities supervisor, under direction of the Director and/or Medical Director.
- In-Service training for the appropriate staff, as needed, to include: OSHA regulations, CLIA regulations, CPR, on-site machinery operation, customer service, emergency guidelines, and medical protocols. All employees will receive fire and safety training.
- Annual employee evaluations will be conducted as outlined in the employee manual. The goal of these evaluations is to keep employees performing up to the Clinic's expectations, as well as the employee's individual potential.

Semi-Annual Personnel Chart Review

Name	License Expiration for Certified Staff	ACLS,First Aid,CPR and Blood Bourn Path	CLIA Annual QA	Vaccine and Screening	Orientation performed	Physicians Signature	Evaluations performed annually

AH Form Approved
10/21/2011

DESK AUDIT

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
0763AS	A. Building B. Wing	10/20/2011

Name of Facility	Street Address, City, State, Zip Code
CAPITAL CARE NETWORK	1160 WEST SYLVANIA AVENUE TOLEDO, OH 43612

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

DESK AUDIT

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix C0125 Reg. # 3701-83-08 (G) LSC	Correction Completed 10/20/2011	ID Prefix C225 Reg. # 3701-83-18 (F) LSC	Correction Completed 10/20/2011	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
K	KK	10-27-11	Karen Honely [illegible]	10/20/2011
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/14/2011

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

OHIO DEPARTMENT OF HEALTH

246 North High Street
Columbus, Ohio 43215

614/466-3543
www.odh.ohio.gov

John R. Kasich / Governor

Theodore E. Wymyslo, M.D. / Director of Health

August 5, 2011

Kelly Burden, Administrator
Toledo Women's Center
P O Box 6907
Toledo, OH 43612

RE: Capital Care Network
License Number: 0763AS

Dear Kelly Burden:

The Ohio Department of Health surveys ambulatory surgery facilities to determine whether they meet State of Ohio licensing requirements. On 07/27/2011, the Non-Long Term Care Unit completed an inspection of your facility and cited the violations on the enclosed Form 2567, Statement of Deficiencies. In order for the Ohio Department of Health to recommend your facility for licensing with violations, we must receive an acceptable plan of correction (POC) **within five calendar (5) days** after you receive this notice.

Your PoC must contain the following:

What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice, if applicable;

How you will identify other patients having the potential to be affected by the same deficient practice and what corrective actions will be taken;

What measures will be put into place or what systemic changes you will make to insure that the deficient practice does not recur; and,

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

The projected date of correction must not exceed fourteen (14) days from the date of the inspection and cannot precede the inspection exit date. Please mail your Plan of Correction to me, Wanda Iacovetta, R.N., Non-Long Term Care Unit Supervisor; BCHCFS Division of Quality Assurance; 246 North High Street 2 Floor; Columbus, Ohio 43215. Failure to provide an acceptable plan of correction may result in revocation of your license.

The Plan of Correction must be written on the enclosed Statement of Deficiency form.

If you have any questions regarding this notice, please contact me at (614) 387-0801.

Sincerely,

Wanda L. Iacovetta, RN/pa

Wanda L. Iacovetta, R.N.
Non Long Term Care Unit Supervisor
Bureau of Community Health Care Facilities and Services
Division of Quality Assurance

WLI:cc

Enclosure: Form 2567 and Form 2567B

Tolido - pM.   PSR 7/27/11

POC REVIEW

Provider Name: Capital Care Network CCN: 0763 AS.

Facility Phone #: Kelly Burden 419 478-6801 Survey Exit Date: 7/27/11

POC Reviewed By: AS Date ~~Approved:~~ reviewed 9/21/11 [illegible] 10/20/11

Desk Audit: [illegible]

2567 signed and dated: ND Completed Date:

	Tag # 7-30	Tag # 7-29	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #
Correction date within timeframe?	C125	C225											
If POC refers to creating new policies/procedures, is a copy included?	✓	✓											
Does the plan address all of the deficient practice?	✓	✓											
Does the plan address who will monitor for compliance?	✓	✓											
Waiver/Variance requested?													

COMMENTS:

9/21 2567 not signed & dated
Kelly will not be in until afternoon
at this number.
re-cites - no desk audit AS

10/19 - called Kelly. said she faxed signed
& dated 2567.
Said she would fax again. AStine

10/19/11 Spoke c Kelly - She sent p1 of the
CLIA survey instead of ours

OHIO DEPARTMENT OF HEALTH

DIVISION OF QUALITY ASSURANCE
BUREAU OF COMMUNITY HEALTH CARE FACILITIES
NON LONG TERM CARE QUALITY UNIT

FACILITY INFORMATION DOCUMENT

~~NH # 07632A~~

*Facility Name	Capital Care Network of Toledo
*Address	1160 W. Sylvania Ave.
*City/County	Toledo — Zip +4: 43612
*Mailing Address	PO Box 6907
*City/County	Toledo / Lucas — Zip +4:
*E-Mail Address	twc frontdesk@gmail.com
*Administrator or Title	Kelly Burden Kellyb@capitalcarenetwork.com
*Other Information	Telephone: ~~419 381 1119~~ 4786801 Fax: 419 478 6968 Provider No.: Licensure No.: 07635 Medicaid No.:
	*FISCAL INTERMEDIARY/CARRIER: Name/Address/Phone # Our office does not deal with insurance. ~~Accept cash, moneyorder, visa or master card.~~ emorks

*Facility Type: ☑ ASC ☐ CAH ☐ CORF ☐ ESRD ☐ HHA ☐ HOSPICE ☐ PPS ☐ PTIP ☐ REHAB ☐ RURAL H ☐ X-RAY ☐ MLP

*ACCREDITED: ☐ Yes ☑ No By Which Accrediting Body: _____ Expiration Date: _____

*Maternity License Exp Date N / A

*Fiscal Year 12-31

*Action: ☐Certification ☐Licensure ☒ PCR (PSR) ☐ Complaint No._____ ☐Other: _____

*FACILITY Beds/Stations	Total	Hospital	Hospice	PPS Psych	PPS Rehab	Maternal Beds	N/B
Total Beds							
Total Census							

HEALTH SURVEYS:

*Survey Entry Date: 7-27-11	Entrance Time: A.M. P.M.
Day of the Week: M T (W) Th F Sat Sun	
Week of the Month: 1 2 3 (4)	
*Survey Exit Date: 7-27-11	Exit Time: A.M. P.M.

LSC SURVEYS:

*Survey Entry Date:	Entrance Time: A.M. P.M.
*Number of Buildings:	*Description of Construction Type/ Sprinklered and/or Hazardous areas
*Construction Dates (each bldg.):	
*Survey Exit Date:	Exit Time: A.M. P.M.

☐ *Additional Information On Back

*Completed By: D. Leone	*Date: 7-27-11

246 N. High Street
Columbus, OH 43215

To be completed by the District Office Reviewer

Facility Name	Capital Care Network
Facility/Provider Number	0763AS
Date of Survey	7-27-11 1st PSR & 10-20-11 2nd PSR to 4-4-11 Licensure survey

CONFIDENTIAL NOT FOR PUBLIC DISCLOSURE

T and S Management - Capital Care Network

Staff C

Employee Evaluation Form

Employee Name Terrie Hubbard Date July 30, 2011

Relationship to employee

- ☐ Co-worker
- ☐ Supervisor
- ☐ Other (explain) _____

Type of Evaluation

- ☐ Orientation
- ☐ Yearly
- ☐ Other (explain) _____

Which, of the jobs that this employee performs, do you observe?

- ☒ Answers phones
- ☐ Takes payments
- ☒ Counsels patients
- ☒ Performs ultrasounds
- ☒ Lab tasks
- ☒ Assists abortions
- ☐ Prepares medications
- ☒ Greets customers

Rate from 1 to 5
1 = Poor
2 = Fair
3 = Average
4 = Above average
5 = Excellent

Team Work / Cooperation Average score 5

1 2 3 4 (5) Strives to create and maintain positive work relationships with other staff
1 2 3 4 (5) Interacts with co-workers in a respectful manner
1 2 3 4 (5) Contributes to overall group/team success by helping where needed
1 2 3 4 (5) Is ready to start individual job at scheduled time
1 2 3 4 (5) Stays until work is finished
1 2 3 4 (5) Takes break at appropriate time and for the appropriate amount of time
1 2 3 4 (5) Receives feedback with an open mind
1 2 3 4 (5) Takes responsibility for own mistakes and learns from them
1 2 3 4 (5) Has the ability to be flexible and adapt to changes in procedures and services
1 2 3 4 (5) Sets a good example for others to follow

Comments and suggestions for improvement:

Patient Focus / Customer Service Average score 5

1 2 3 4 (5) Creates and maintains a climate of trust for patients
1 2 3 4 (5) Understands and demonstrates concern for the needs of patients
1 2 3 4 (5) Shows non-judgmental support, respect, empathy, patience and consideration for patients and their support persons
1 2 3 4 (5) Utilizes communication skills effectively to meet the needs of the patients and support persons in the clinic and the "potential customers" inquiring about our services (if applicable)
1 2 3 4 (5) Allows each patient the time and attention they need while still being mindful of waiting patients' time

Comments and suggestions for improvement:

Initiative Average score 5

1 2 3 4 (5) Contributes to and/or develops new ideas or methods
1 2 3 4 (5) Instead of complaining about policies/problems/procedures, works to change them
1 2 3 4 (5) Understands position/tasks and works independently
1 2 3 4 (5) Looks for ways to improve own job and services provided at IWC
1 2 3 4 (5) Works to increase knowledge related to IWC's services and improve question-answering ability
1 2 3 4 (5) Participates in meetings and shares ideas/opinions
1 2 3 4 (5) Addresses and/or fixes problems when s/he sees them

Comments and suggestions for improvement:

Professionalism Average score 5

1 2 3 4 (5) Uses a friendly tone when speaking to patients and support persons
1 2 3 4 (5) Uses proper language/terminology when speaking with patients and other persons with whom we do business
1 2 3 4 (5) Has a positive attitude about her/his job and the clinic
1 2 3 4 (5) Takes pride and care in her/his work
1 2 3 4 (5) Takes his/her work seriously
1 2 3 4 (5) Maintains patient confidentiality

1 2 3 4 (5) Maintains staff confidentiality
1 2 3 4 (5) Dresses appropriately
1 2 3 4 (5) Keeps private staff conversations away from patient areas
1 2 3 4 (5) Avoids gossiping about other staff
1 2 3 4 (5) Does not allow personal life to interfere with work
1 2 3 4 (5) Strives to achieve a level of excellence in the quality of services provided

Comments and suggestions for improvement:

Risk Management Average score 4.8

1 2 3 (4) 5 Documents accurately, appropriately, and thoroughly
1 2 3 (4) 5 Documentation is neat and legible
1 2 3 4 (5) Work area is clean
1 2 3 4 (5) Maintains a safe and functional work environment (follows OSHA)
1 2 3 4 (5) Demonstrates understanding of current medical and clinical protocol, keeps up to date with changes in protocol and is responsive to medical/legal issues
1 2 3 4 (5) Demonstrates proper judgment and decision making skills when necessary
1 2 3 4 (5) Demonstrates understanding and responsiveness to emergency response procedures
1 2 3 4 (5) Can be relied upon regarding task completion and follow-up

Comments and suggestions for improvement:

Efficiency Average score 5

1 2 3 (4) 5 Submits reports and/or completes work in a timely manner
1 2 3 4 (5) Appropriately prioritizes work and can manage multiple tasks
1 2 3 4 (5) Is able to produce a significant amount of work efficiently within a specified period of time
1 2 3 4 (5) Makes effort to find work during "downtime"
1 2 3 4 (5) Helps others improve efficiency by keeping distracting "chit-chat" to a minimum

Comments and suggestions for improvement:

Career Goals Average score 5

1 2 3 4 (5) Met career goals as identified in last review
1 2 3 4 (5) Maintained positive attitude regarding goals

Comments and suggestions for improvement, including specifics related to goals met or not met:

Goals for following year (Including Due Date when appropriate, initial after each goal to indicate acceptance and understanding):
1 Terrie has taken ownership of the facility as of 9/1/2010
2
3
4
5

Additional comments/suggestions:

Evaluator signature: _____ Date: 7/30/2011

Employee signature: _____ Date: 7.30.11

Capital Care Network
Department: Administration
Subject: Employee TB testing
Effective: 9/01/10

Revised:_____ Reviewed:_____

Revised:_____ Reviewed:_____

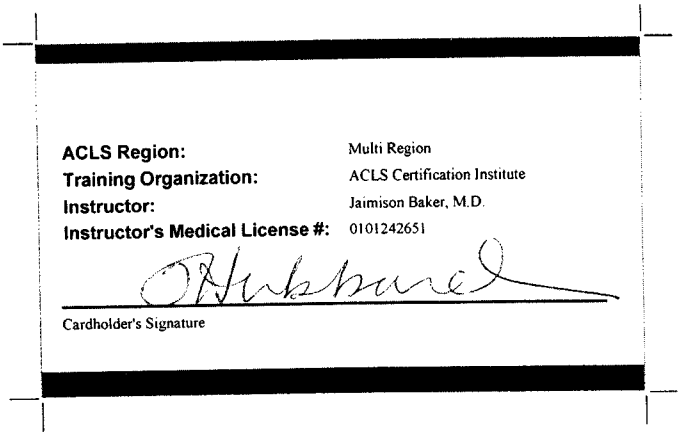
Revised:_____ Reviewed:_____

_____ _____

Approved by Date

PURPOSE

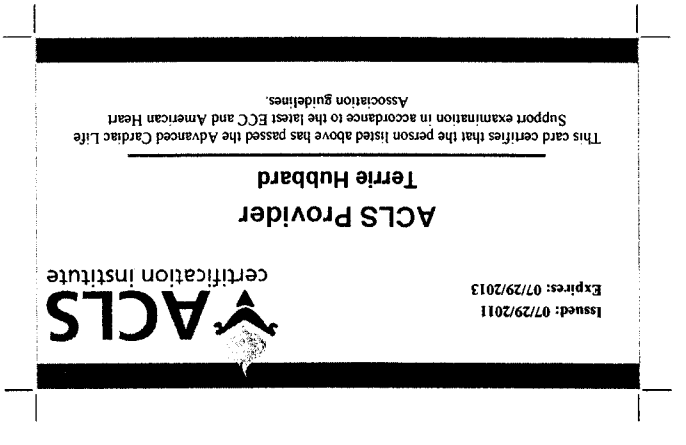
To ensure proper evaluation of TB status of employees.



ACLS Region: Multi Region
Training Organization: ACLS Certification Institute
Instructor: Jaimison Baker, M.D.
Instructor's Medical License #: 0101242651

Cardholder's Signature

Staff C



ACLS certification institute

Issued: 07/29/2011
Expires: 07/29/2013

ACLS Provider

Terrie Hubbard

This card certifies that the person listed above has passed the Advanced Cardiac Life Support examination in accordance to the latest ECC and American Heart Association guidelines.

OFFSITE SURVEY PREPARATION WORKSHEET

Ambulatory Surgical Centers

Surveyor Home: COLUMBUS Surveyor #: 21957 Discipline: HCFS

Facility Name: CAPITAL CARE NETWORK OF TOLEDO

Facility Address: 1160 W. SYLVANIA AVE. TOLEDO OH. 43612

Provider Number: 0763 AS Offsite Review Date: 7-27-11

Total Beds: Survey Begin Date: 7-27-11

List potential facility areas of concern and any potential residents to be reviewed during the survey. List any current complaints to be investigated onsite. LAST DATE: 5-8-11

PSR: ✓ FOR ANNUAL EVALUATIONS (C125)

(OK) — ✓ FOR MISSING P/P (C132)

REVIEW NEW P/P MANUAL

- SPECIFICS: PERSONAL PROTECTIVE EQUIPMENT
- STORAGE, MAINTENANCE, DISTRIBUTION OF STERILE SUPPLIES + EQUIPMENT
- DISPOSAL OF BIOLOGICAL WASTE INC. BLOOD, BODY TISSUE + FLUID
- CLEANING - SAFE + SANITARY ENVIRONMENT

(OK) TOUR FOR (C139): OBSERVE: - COUCH REMOVED, REPLACED & NEWER SET OF FURNITURE - CARPET CLEANED } 2ND WAITING AREA

VIEW WORK ORDERS +/OR RECEIPTS: - WALLS & NICKS/DENTS } BOTH WAITING AREAS

- DIRTY CEILING FANS IN 2 OR'S

SEE CLEANING SCHEDULE

(OK) — QA (C152) ✓ FOR PLANS IMPLEMENTED + MEETINGS HELD

NURSE DUTY REQUIREMENTS (C225)

✓ FOR RN'S ACLS (PERSONNEL FILES)

WORK SCHEDULE TO ASSURE RN' & ACLS TRAINING IS ON DUTY IN RECOVERY ROOM

(OK) ✓ EMERGENCY POWER - (C244) BATTERY BACK-UP INSTALLED?

* TRIPP LITE OMNISMART 1050

Surveyor/Discipline (list Team Coordinator first):

D. LEONARD

PREVIOUS MGT. KATHLEEN GLOVER G+H
TERRY HUBBARD T+S

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

SURVEYOR NOTES WORKSHEET

Facility Name: CAPITAL CARE NETWORK Surveyor Name: D. LEONARD
Provider Number: 0763 AS Surveyor Number: 21857 Discipline: HHCFS
Observation Dates: From 7-27-11 To 7-27-11

TAG / CONCERNS	DOCUMENTATION
A	KIM MAYS - MEDICAL ASSISTANT.
B	KELLY BURDEN - DIRECTOR K Kelly B
11:15A	TOUR OF FACILITY WITH STAFF B OBSERVED BOTH WAITING AREAS; NEW FURNITURE TO REPLACE COUCH. WALLS REPAIRED + PAINTED. CARPET CLEANED. BOTH ORs OBSERVED. NO DUST ON CEILING FANS OR OTHER ITEMS IN ROOM.
	PERSONNEL RECORDS
1)	SUZANNE MILLER-SPRUCING RN LIC EXP 8-31-11 ACLS EXP 6-2013 ANNUAL EVAL 5-21-11
2)	BECKY HENNE RN RN EXP 8-31-11 ACLS EXP 3-2012 ANNUAL EVAL 6-15-11
3)	KAREN BRACKBILL LPN ANNUAL EVAL 6-14-11 LIC EXP 8-31-12 MICHAEL KYDE LPN LIC EXP 8-31-12 ACLS EXP 12/2012 ANNUAL EVAL 6-29-11
C 4)	TERRIE HUBBARD RN RN EXP 8-31-11 ACLS EXP 10-2010 ANNUAL EVAL

FORM HCFA-807 (7-95)

SURVEYOR NOTES WORKSHEET

TAG / CONCERNS	DOCUMENTATION
	QA
1)	PT EVALUATIONS \ CURRENT PROJECT
	COMPLAINT PROCESS /
	ONGOING PROCESS ☆ 6 MONTH REPORTS TO GOV. BODY
2)	10% CLIENT CHARTS REVIEWED BY STAFF
	10% " " " " PHYSICIANS
	ONGOING PROCESS
3)	DIRECTOR'S MTGS. q 8 WKS
	SUMMARY IN MINS FORM IS PROVIDED TO ALL STAFF
	ONGOING PROJECT
4)	INSPECTION OF EQUIPMENT ANNUALLY & INTERNALLY
	PERIODICALLY
	P/P
	NEW POLICYS REVIEWED + SIGNED ON 5/17/11
	OLD " " " " 5/17/11
	CONTINUING ☆ REVIEW POLICIES FOR ENTIRE NETWORK
	ANNUALLY

*U.S. GPO: 1997-417-583/51027