LICENSURE SURVEY PROCESSING CONTROL SHEET
NON LONG TERM CARE UNIT (NLTC)
PHONE: (614) 387-0801 FAX: (614) 387-2763

SURVEY HEALTH ENTRANCE	DATE: 2/22/12
SURVEY HEALTH EXIT	DATE: 2/22/12
LSC EXIT	DATE: NA
MAILED/TURNED IN	DATE: 2-23-12
FISCAL YEAR	6/30

PSR TO BE A DESK AUDIT? ☒ Yes ~~☐ No~~

Action (circle): INITIAL ANNUAL COMPLAINT(s) PSR (Onsite/Desk Audit)

COMPLAINT(S) # NA

TYPE (circle): ASC ESRD HCS HOSPICE

LICENSE# ~~02768AS~~ 0286AS NDG-W11

FACILITY NAME: Planned Parenthood

ADDRESS: 2314 Auburn Ave

CITY/COUNTY/ZIP Cincinnati, Oh 45219 (Hamilton)

Surveyor Initials	Oscar #	Tag #	Check if Condition	Check if Waiver	Recited	Oscar #	Tag #	Check if Condition	Check if Waiver	Recited
DL	21957	~~F33~~								
AA	03294	C242								

NLTC/Lic Cert Entered (Date/Initials) CERT 2-29-12CC ☐ 10/60 ☐ 10/45 CONDI ☐ 5/30 PSR LIC _____ ☐ 10/30 PSR ☐ 5/15 PSR

Draft To Supervisor By OA (Date/Initials) 2-29-12CC LTR. Signed (Date/Initials) 2/29/12 cm

SOD MAILED (Date/Initials) 3-6-12CC

2567 ~~2567B~~ 1601 ~~1601B~~ ~~LTR~~ ~~GUIDE~~ 1602 1666/CMS ☑ LOG ~~☐ CALENDAR~~ ☑ ACO ☑ Lic Cert

To ACTS (Date/Initials) _____

POC Due 5 Days or 10 Days 3-16-12 CC ☐ LOG ☐ CALENDAR ☐ ACO ☐ Lic Cert

POC Approved (Date/Initials) _____ File To Pending Drawer (Date/Initials) _____

File To Review (Date/Initials) _____ ☐ LOG ☐ Lic Cert

670 Completed (Date/Initials) 4-25-12cc All Final Info Entered Into Lic Cert (Date/Initials) _____

LIC LTR CMS NO DEF. LTR TO MAUST _____

File To Central Office (Date/Initials) _____ ☐ LOG ☐ ACO ☐ Lic Cert

RECEIVED FEB 27 PM 12 2012
OHIO DEPT OF HEALTH
BOA - SCANFS

NOTES: CLOSED IN ASPEN ☐ DATE/Intials _____

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:

Connie Britton, Administrator
Planned Parenthood Southwest Ohio Region
2314 Auburn Avenue
Cincinnati, OH 45219

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Gail Gubser ☑ Agent ☐ Addressee

B. Received by (Printed Name) Gail Gubser C. Date of Delivery

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7007 0220 0001 4324 1104

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

7007 0220 0001 4324 1104

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com

OFFICIAL

Postage $
Certified Fee
Return Receipt Fee (Endorsement Required)
Restricted Delivery Fee (Endorsement Required)

Connie Britton, Administrator
Planned Parenthood Southwest Ohio Region
2314 Auburn Avenue
Cincinnati, OH 45219

Street, Apt. No., or PO Box No.
City, State, ZIP+4

PS Form 3800, August 2006 See Reverse for Instructions

desk audit approved 4/17/12 as

PRINTED: 03/01/2012
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
	0286AS	A. BUILDING _____ B. WING _____	02/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD SOUTHWEST OHIO I	2314 AUBURN AVENUE CINCINNATI, OH 45219

last date 3/14

(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/AA Licensure Compliance Inspection Administrator: Connie Britton County: Hamilton The entrance conference was held with the administrator at 10:10 AM on 02/22/12. The following violation is a result of the licensure compliance inspection completed on 02/22/12. The facility has performed 2,735 procedures from 01/01/11 to 01/01/12. Three procedure rooms	C 000		
C 242	O.A.C. 3701-83-20 (C) Preventive Maintenance Each ASF shall establish and follow a preventive maintenance program which includes periodic calibration, cleaning and adjustment of all equipment in accordance with manufacturer's instructions. Each ASF using inhalation anesthesia shall develop and follow policies and procedures for monitoring the anesthesia machine which are consistent with the standards recommended by the American society of anesthesiologists. This Rule is not met as evidenced by: Based on equipment maintenance manual review, observation and staff interview it was determined this facility failed to ensure two ultrasound machines received preventative	C 242	Starting February 2012, Planned Parenthood SW Ohio Region Added our Ultrasound machines to our yearly Preventive maintenance & safety Inspection Calendar We had both Ultrasound machines inspected on February 27th 2012 in which they both passed (see Attached)	2-27-12

2012 APR -2 P 12:27
OHIO DEPT OF HEALTH
DDA-BCHCFS

Tullis Stokes — TITLE MEDICAL DIR/LAB DIR — (X6) DATE 3/29/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0286AS	A. BUILDING _____ B. WING _____	02/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD SOUTHWEST OHIO I	2314 AUBURN AVENUE CINCINNATI, OH 45219

(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 242	Continued From page 1 maintenance. This had the potential to affect all those who were treated with these medical devices. Total patients treated for the year of 2011 was 2,735. Findings include: During facility tour on 02/22/12 with staff A, observation was made of two ultrasound machines which failed to have the annual preventative maintenance sticker. The question was proposed to staff A as to when they were last calibrated and staff A stated according to staff B, they have not been calibrated since he/she has been with this facility and that has been six years. This interview confirmed this finding.	C 242	We plan to monitor that All Equipment will be inspected on A yearly basis by Precision Medical. Our Quality Assurance/ Risk mgmt Director will monitor & document that All Equipment on the yearly inspection Calendar has been inspected by the Above mentioned company during the month of MAY of Each year. Each inspected machine will be equipped with A sticker notating the completion of the inspection along with the Date. The inspection Reports will be housed by our QA/RM Director	

Tunia & Kra 3/29/12

PLANNED PARENTHOOD
SUGERY SIDE
2314 AUBURN AVE
CINCINNATI OHIO 45219

YEARLY PREVENTIVE MAINTENANACE,SAFETY AND RECALIBRATION OF EQUIPMENT
YEARLY Inspection schedule: MAY

ROOM 1

MIDMARK 104 EXAM TABLE'
BERKELEY 20-C SUCTION PUMP
GOOSENECK EXAM LIGHT

ROOM 2

MIDMARK 104 EXAM TABLE'
BERKELEY 20-C SUCTION PUMP
GOOSENECK EXAM LIGHT

ROOM 3

MIDMARK 104 EXAM TABLE'
BERKELEY 20-C SUCTION PUMP
GOOSENECK EXAM LIGHT
ULTRA SOUND SONOLNE - ADARA GM-6705A2A00

MISC

RITTER M-11 AUTOCLAVE S/N V403239
LOGAN DESK TOP LIGHT BOX
HEALTH-O-METER PHYSICIAN SCALE
HEWLETT PACKARD CODEMASTER XL + DEFIB
20 EACH ANEROID BP UNITS
NELLCOR N-100L PULSE OXIMETER S/N 100-02331041-C
CRITIKON DINAMAP 8100 MONITOR S/N 8100J6434
PURITAN BENETT NPB-40 PULSE OXIMETER S/N G00816468
BERKLEY SVGP 20-2 S/N 5464

LAB

HEMOCUE S/N 9248-011 249
THERMOLYNE LL16115 RH VIEW BOX S/N 187041131979

ULTRASOUND ROOM

RITTER MODEL D TABLE S/N 403D45X1915
ULTRA SOUND MACHINE SONOLINE PRIMA

INTERVIEW ROOMS 1-5

ABCO BLOOD PRESSURE UNIT

PRECISION MEDICAL EQUIPMENT REPAIR, LLC
Michael Gartner BMET

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisi
0286AS	A. Building B. Wing	4/17/2012

Name of Facility	Street Address, City, State, Zip Code
PLANNED PARENTHOOD SOUTHWEST OHIO REGION	2314 AUBURN AVENUE CINCINNATI, OH 45219

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. 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 C0242 Reg. # O.A.C. 3701-83-20 (C) LSC	Correction Completed 04/17/2012	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correcti Complet
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correctior Complete
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: 4-25-12	Signature of Surveyor:		Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:		Date: 4/17/12
Followup to Survey Completed on: 2/22/2012			Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567)		

D2688c MAR 0 8 2004

UNIVERSITY OF Cincinnati

College of Medicine

Department of Obstetrics and Gynecology
University of Cincinnati Medical Center
PO Box 670526
Cincinnati OH 45267-0526

231 Albert B. Sabin Way
Phone (513) 558-8440
Fax (513) 558-6138

Copy

March 2, 2004

Susan M. Momeyer
President & CEO
Panned Parenthood-Cincinnati Region
2314 Auburn Avenue
Cincinnati, Ohio 45219-2802

Dear Susan:

The Department of Obstetrics and Gynecology will continue its agreement to provide medical backup for emergencies that may arise in the course of patient care at Planned Parenthood. These patients should be taken to the University Hospital Emergency Room where our in-house faculty physician will coordinate the necessary care. Our department has 24-hour in-hospital attending coverage by both attending and resident physicians. The appropriate contact person for such emergencies can be found by calling University Hospital Labor and Delivery (594-3999) and asking to be connected to the faculty member who is on call.

If there are any questions or clarifications, please refer them to Dr. Arthur Ollendorff who will act as a liaison between the OB/GYN department and Planned Parenthood.

Sincerely,

Baha Sibai, M.D.
Professor and Director

POC REVIEW

Provider Name: Planned Parenthood SW Ohio CCN: 0286 AS

Facility Phone #: _____ Survey Exit Date: 2/22/12

POC Reviewed By: [signature] Date Approved: 4/17/12

Desk Audit: yes AS

2567 signed and dated: yes Completed Date: 3/14/12

	Tag # 2452	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #
Correction date within timeframe?	3/14												
If POC refers to creating new policies/procedures, is a copy included?													
Does the plan address all of the deficient practice?	Y												
Does the plan address who will monitor for compliance?	Y												
Waiver/Variance requested?													

COMMENTS:

Desk audit approved.

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

March 6, 2012

Connie Britton, Administrator
Planned Parenthood Southwest Ohio Region
2314 Auburn Avenue
Cincinnati, OH 45219

RE: Planned Parenthood Southwest Ohio Region - License: 0286AS
Survey Completed on February 22, 2012

Dear Ms. Britton:

The Ohio Department of Health, under the authority of Chapter 3702 of the Ohio Revised Code, inspects Health Care Facilities to determine compliance with the licensure requirements set forth in Chapter 3701-83 of the Ohio Administrative Code. To attain and maintain licensure, a health care facility must be in compliance with each licensure requirement and not have any violations that jeopardize the patients' health and safety or seriously limit the facility's capacity to provide adequate care and services.

On the date noted above, we completed an inspection of your facility and cited the violation(s) annotated on the enclosed form. Therefore, in order to recommend your agency for licensure, we must receive an acceptable plan of correction **signed and dated within ten (10) calendar days** after you receive this notice. **Failure to provide an acceptable plan of correction may result in denial, revocation, or non-renewal of your license.**

This plan of correction must contain the following at a minimum:

What action(s) will be accomplished to correct the situation(s) or condition(s) causing or contributing to the noncompliance.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.

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

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

The projected date of correction must not exceed 30 days from the date of inspection exit date unless approval for an extended period for correction is obtained from this office.

Where documentary evidence of corrective action is appropriate, such evidence should accompany the plan of correction wherever possible. When this is not possible, these documents should be provided not later than the latest correction date submitted in your plan of correction **and accepted by this office**. Evidence of compliance may include documentation of facility monitoring, in-service training records, consultant reports, work orders, purchase orders, invoices, photographs, or other information that would confirm compliance.

Normally, an onsite revisit will be conducted to verify corrective action has been taken per the plan of correction. However, after our review of the plan of correction and any evidence of compliance, it is possible that an onsite visit will not be required. If this is the case, you will be advised by phone that your plan of correction was accepted and that the appropriate licensure action will be recommended to the licensure administrator.

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

Sincerely,

Wanda L. Iacovetta

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: STATE FORM Licensure

FILE COPY

REPORT OF CONTACT

FACILITY: Planned Parenthood Of S.W. Ohio PROVIDER NUMBER: 0286AS

COUNTY: ______________ TYPE ACTION: ______________

DATE	NAME & TITLE OF CONTACT--SUMMARY OF CONVERSATION	SIGNATURE
1325 3/26/12	Spoke c̄ schedule then left message on Tim Kress (medical director) Voice mail regarding - Need to know who will monitor that this is completed by inspection company ~~annually~~ yearly. Do they have a calendar or schedule? Need to fill in completion date	Alice Dottai, RN

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

FACILITY INFORMATION DOCUMENT

Facility Name	Planned Parenthood of South West Ohio Region
Address	2314 Auburn ave
City/County	Cinti Ohio Zip + 4: 45219
Mailing Address	2314 Auburn Ave
City/County	Cinti Ohio Zip + 4: 45219
E:Mail Address	Snoeke@ppswo.org
Administrator Name	Connie Britton SCC
Other Information	Telephone: (513) 721-7635 Fax: (513) 287-6496 Provider No.: 156749720 Licensure No.: 35082315 Medicaid No.: 2128500
	Fiscal Intermediary/Carrier: Name/Address/Phone No. In house

Facility Type: ☒ASC ☐CAH ☐CORF ☐ESRD ☐HHA ☐HOSPICE ☐PPS ☐PTIP
☐REHAB ☐RURAL H ☐X-RAY ☐MLP ☐HOSP ☐HCS

ACCREDITED: ☐ Yes ☐ No Maternity License Expiration Date:_____

Fiscal Year: 6/30

Action: ☐Certification ☒Licensure ☐PCR/PSR ☐Complaint No._____ ☐Other_____

FACILITY BEDS	TOTAL	HOSPITAL	HOSPICE	PPS PSYCH	PPS REHAB	MATERNAL BEDS	N/B
Total Beds							
Total Census							

HEALTH SURVEYS

Survey Entry Date: 2-22-12	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: 2-22-12	Exit Time: A.M. P.M.

LSC SURVEYS

Survey Entrance Date:	Entrance Time: A.M. P.M.
Number of Buildings:	Description of Construction Type:
Construction Dates (each bldg):	
Survey Exit Date:	Exit Time: A.M. P.M.

☐ Additional Information On Back

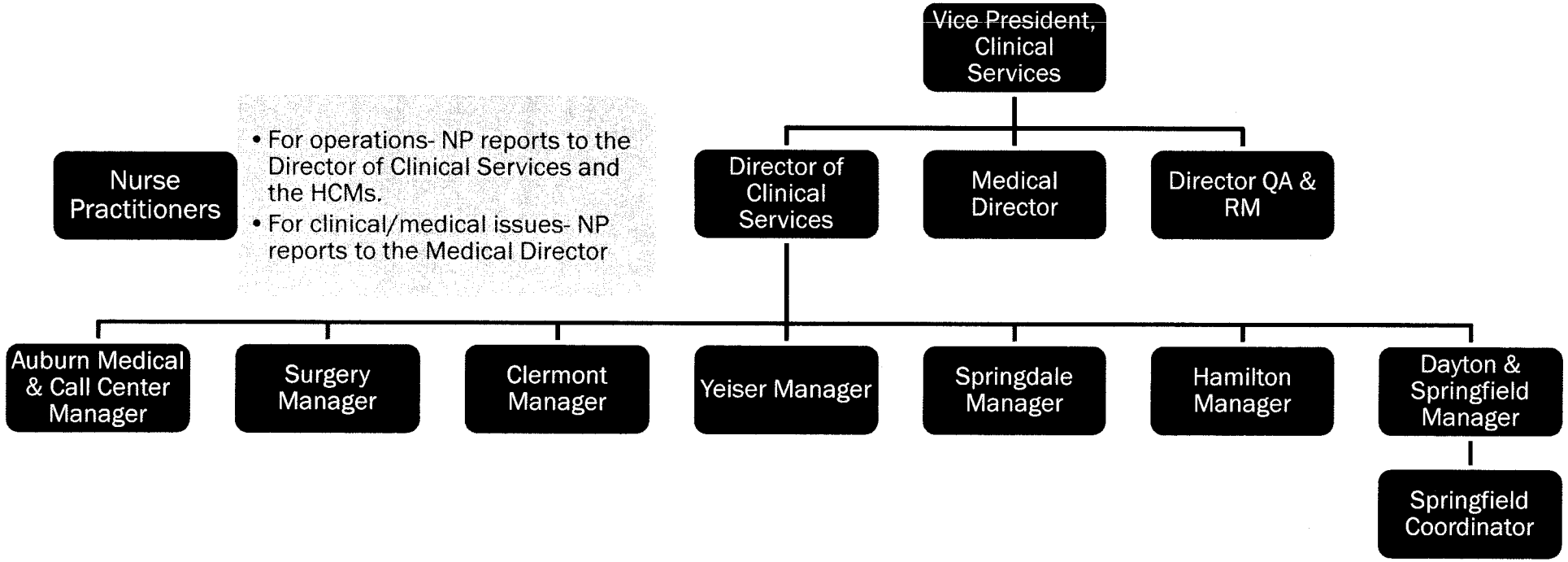
Completed By: Britton SCC	Date: 2-22-12

#5

0268 A5

ORGANIZATIONAL CHANGES

PATIENT SERVICES



Planned Parenthood®
Southwest Ohio Region

0268 AS

PLANNED PARENTHOOD SOUTHWEST OHIO REGION

PROCEDURE FOR HANDLING COMPLAINTS

As part of PPSWO's quality assurance activities, we record and monitor complaints of patients or other individuals in order to improve our customer service or adapt our procedures to better meet patients needs or expectations.

A. If a patient or other individual indicates a wish to make a complaint, either by phone or in person, that person should be transferred to the Center Manager or other person in charge of the center. Complaints will be referred in order of Center Manager, Regional Manager, Director of Patient Services.

B. A complaint form is completed as fully as possible, including an indication of how the complaint was resolved or will be followed up on.

C. Staff handling complaints will respond non-defensively, listen objectively, and try to turn the complaint into an opportunity to satisfy the customer.

D. The manager will assess the validity of the complaint, discuss the situation with appropriate staff and take whatever action seems warranted. Discussion with the Regional Manager, Quality Improvement Manager, or Director of Patient Services may be appropriate. It may also be an opportunity to examine systems and initiate improvements if indicated.

E. If a complaint regarding services at a center comes directly to administrative staff, the same process will be followed but the matter of accessing implications for center staff or systems will be given to the manager of that center.

F. If the complaint arrives in the form of a letter, the center manager will follow up with the person making the complaint and forward the letter with the completed complaint form as below.

G. All complaint reports will be sent to the Director of Patient Services for review. They will be maintained in a file by the Quality Improvement Manager. They will be reviewed immediately for the need to file an occurrence report with PPFA and periodically for patterns or indicators of the need for an audit or a change in protocol or procedure or other system wide action. If an action plan is deemed necessary, the Action Plan document will be completed.

H. The surgical department will maintain a duplicate file of complaint reports on site to meet the requirements of an Ambulatory Surgical Facility.

I. The toll free number for patients to call the Ohio Department of Health with a complaint will be posted in the surgical center as required.

0268 AS

PLANNED PARENTHOOD SOUTHWEST OHIO REGION

Patient Complaint/Incident Report Form

This form must be used when you have had an interaction with a patient, which you feel may result in a patient complaint or legal action. All information is treated with strict confidence.

Please describe the details of the incident, including time and date of the incident, the name of the persons involved, and your observations and concerns.

Date of Incident:_____ Time:_____ Center/Location:_____

Patient Name:_____ Birthdate:_____Pt. Number:_____

Nature of Complaint:

Intervention or Resolution offered:

Outcome:

Date:_____ Staff Signature & Title:_____

Forward original documents to the Director of Patient Services

****

PPSWO Action: (to be completed by QIM or DPS)

_____ PPFA Occurrence Report Sent Date:_____ Sent By:_____

_____ Action plan required, see attached Action Plan document

_____ Other _____

_____ No further action required