

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:	MA
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) # MA

TYPE (circle): ASC ESRD HCS HOSPICE

LICENSE# 0268AS 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	03284	C242								

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

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

SOD MAILED (Date/Initials) 3-6-12 CC
 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 3-6-12 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) 4-25-12 CC 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

OHIO DEPT OF HEALTH
 BQA-SACFS
 REC FEB 27 P 12 2011

NOTES: CLOSED IN ASPEN DATE/Initials _____

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> 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. 	<p>A. Signature <i>[Signature]</i> <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Print Name) <i>Gail Gubser</i> C. Date of Delivery</p>
<p>1. Article Addressed to:</p> <p>Connie Britton, Administrator Planned Parenthood Southwest Ohio Region 2314 Auburn Avenue Cincinnati, OH 45219</p>	<p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
<p>2. Article Number (Tr) 7007 0220 0001 4324 1104</p>	
<p>PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540</p>	

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 (Endorsement) _____

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

7007 0220 0001 4324 1104

PS Form 3800, August 2006 See Reverse for Instructions

disk audit approved 4/17/12 AS

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/22/2012
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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO	STREET ADDRESS, CITY, STATE, ZIP CODE 2314 AUBURN AVENUE CINCINNATI, OH 45219	<i>last date 3/14</i>
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(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
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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	<p>OHIO DEPT OF HEALTH DQA-BCHD/FS 2012 APR - 2 12:27</p> <p><i>Starting February 2012, Planned Parenthood SW Ohio Region Added our Ultra sound machines to our yearly Preventive Maintenance & Safety Inspection calendar</i></p> <p><i>We had both ultrasound machines inspected on February 27th 2012 in which they both passed (see attached)</i></p>	2-27-12

Ohio Department of Health

Tina Skrus

TITLE

(X6) DATE

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

MEDICAL DIR/LAB DIR

3/29/12

STATE FORM

6899

NDGW11

If continuation sheet 1 of 2

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/22/2012
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO		STREET ADDRESS, CITY, STATE, ZIP CODE 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	

Turner & K... 3/28/12

PLANNED PARENTHOOD
SUGERY SIDE
2314 AUBURN AVE
CINCINNATI OHIO 45219

YEARLY PREVENTIVE MAINTENANCE, 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 0286AS	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 4/17/2012
Name of Facility PLANNED PARENTHOOD SOUTHWEST OHIO REGION	Street Address, City, State, Zip Code 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 _____	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
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By State Agency <i>KK</i>	Reviewed By <i>KK</i>	Date: 4-25-12	Signature of Surveyor: <i>April Stone</i>	Date: 4/17/12
Reviewed By MS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/22/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567)		



Copy

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

March 2, 2004

Susan M. Momeyer
President & CEO
Planned 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,

A handwritten signature in black ink that reads 'Baha Sibai'.

Baha Sibai, M.D.
Professor and Director

POC REVIEW

SW Ohio

Provider Name: Planned Parenthood CCN: 0286 AS

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

POC Reviewed By: QuStone Date Approved: 4/17/12

Desk Audit: yes AS

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

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

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** for the violation(s) **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.

FILE COPY

Planned Parenthood Southwest Ohio Region
March 6, 2012
Page Two of Two

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, 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 SW Ohio PROVIDER NUMBER: 0286A5

COUNTY: _____ TYPE ACTION: _____

DATE	NAME & TITLE OF CONTACT--SUMMARY OF CONVERSATION	SIGNATURE
1305 3/26/12	Spoke to scheduler then left message on Tim Kreeb's	
	(medical director) voice mail regarding - Need to	
	know who will monitor that this is completed by	
	inspection company ^{yearly} annually. Do they have a	
	calendar or schedule? Need to fill in completion date /	Alice Datta



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	jnoeke@ppswoc.org		
Administrator Name	Connie Britton Sec		
Other Information	Telephone: 513 281-2635	Fax: 513 281-6496	
	Provider No.: 1567497270	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 <u>W</u> Th F Sat Sun	
Week of the Month: 1 2 <u>3</u> 4	
Survey Exit Date: 2-22-12	Exit Time: A.M. P.M.

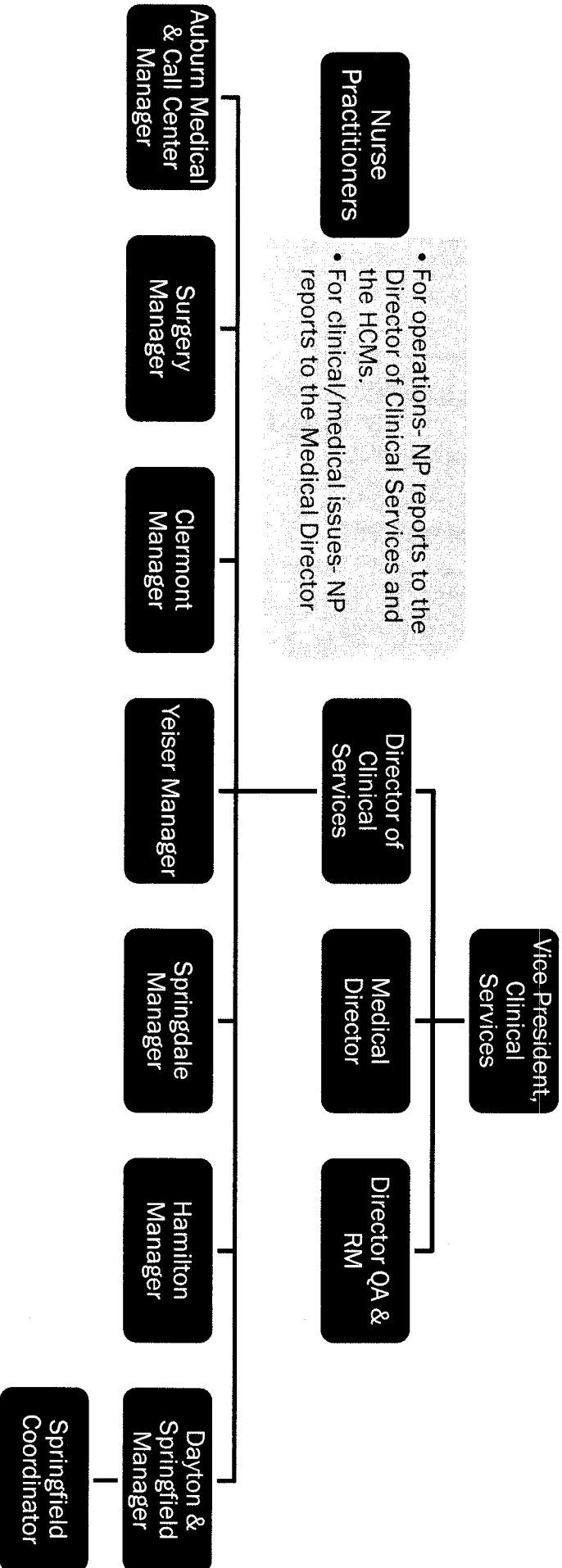
LSC SURVEYS

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: <u>Britton Sec</u>	Date: 2-22-12
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ORGANIZATIONAL CHANGES PATIENT SERVICES



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.

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