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

APR 24 2013

Center for Choice
c/o Susan Postal
328 22nd Street
Toledo, Ohio 43604

Re: Proposed Civil Penalty
Proposed License Revocation and Proposed Refuse to Renew License
Facility Name: Center for Choice
License Number: 0629AS

Dear Ms. Postal:

You hereby are notified that I propose to issue an order revoking and refusing to renew the Health Care Facility license of Center for Choice located at 328 22nd Street, Toledo, Ohio 43604, to operate as an ambulatory surgical facility, for violations of Ohio Revised Code (R.C.) section 3702.30 and Chapter 3701-83 of the Ohio Administrative Code (O.A.C.). This action is taken under authority of R.C. section 3702.32, paragraph (C)(2) of O.A.C. rule 3701-83-05.1 and in accordance with R.C. Chapter 119.

Additionally, you are hereby notified that I propose to impose a civil penalty in the amount of twenty-five thousand dollars ($25,000.00) against Center for Choice for violations of R.C. section 3702.30 and Chapter 3701-83 of the O.A.C. This action is taken under authority of R.C. section 3702.32, paragraph (C)(4) of O.A.C. rule 3701-83-05.1 and in accordance with R.C. Chapter 119.

Representatives of the Ohio Department of Health conducted a licensure compliance inspection at Center for Choice, on April 10, 2013. A copy of the report is enclosed and incorporated into this notice by reference. The above listed actions are based on the violations found on the April 10, 2013, licensure compliance inspection.

You are hereby notified that you may request a hearing before me or my duly authorized representative regarding my Order prohibiting Center for Choice from performing medical, pharmaceutical, and anesthesia services and my proposal to revoke Center for Choice's license to operate. Such request must be made in writing and received within thirty days of receipt of this letter and should be directed to the Office of General Counsel, Ohio Department of Health, 246 North High Street, Seventh Floor, Columbus, Ohio, 43215. A request is considered timely if it is received by the Ohio Department of Health via facsimile, hand delivery, or ordinary United States mail within thirty days of the date of receipt of this letter.

At a hearing you may appear in person or be represented by an attorney. You may present evidence and you may examine witnesses appearing for and against you. You also may present your position, contentions or arguments in writing rather than appear in person for a hearing. If you are a corporation, you must be represented at the hearing by an attorney licensed to practice in the state of Ohio.

Please be advised that if you do not request a hearing within the thirty (30) days allowed, I will issue an adjudication order revoking Center for Choice's Health Care Facility license. Please call Kathryn Kimmet at (614) 644-6220 if you have any questions about this matter.

Sincerely,

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

Certified Mail Return Receipt Requested: 7012 3050 0002 1677 4290

c: Kathryn Kimmet, Chief, Bureau of Regulatory Compliance
Rachel Belenker, Office of the General Counsel
Tamara Malkoff, Assistant Bureau Chief, Bureau of Information and Operational Support

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0629AS	A. BUILDING: _____ B. WING _____	04/10/2013

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CENTER FOR CHOICE	328 22ND STREET TOLEDO, OH 43604

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C 000	Initial Comments County: Lucas Administrator: Susan Postal Type of survey: Licensure Compliance Inspection Number of operating rooms: Three The following violations were based on the License Compliance Inspection completed on 04/10/13.	C 000	COPY	
C 104	O.A.C. 3701-83-03 (F) Governing Body The HCF shall have an identifiable governing body responsible for the following: (1) The development and implementation of policies and procedures and a mission statement for the orderly development and management of the HCF; (2) The evaluation of the HCF's quality assesment and performance improvement program on an annual basis; and (3) The development and maintenance of a disaster prteparedness plan. This Rule is not met as evidenced by:	C 104	2013 APR 24 AM 11:01 REGULATORY COMPLIANCE	

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C 104	Continued From page 1 Based on review of the facility's policy and procedure manual and interview with the facility staff, the facility failed to ensure the governing body took responsibility for the development and implementation of the facility's policies and procedures to assure the orderly development and management of the facility. This had the potential to affect all patients cared for at this facility. The facility provided services for 1,451 patients in the past year. Findings included: The facility's policy and procedure manual was reviewed on 04/10/13. Included in the policy manual was a booklet entitled "Clinical Policy Guidelines" and dated 2013. Review of this booklet revealed guidelines for producing facility policies, but was not intended to replace facility policies and procedures. Further review of the policy manual revealed no policies and procedures in place for Nursing, Medical Staff, Quality Assurance, Laboratory, Surgical, Medical records, Pharmaceuticals, and Infection control. Interview with Staff A on 04/10/13 at approximately 2:50 PM revealed Staff A stating that the facility policy manual included the booklet titled "Clinical Policy Guidelines" as part of the facility policies and confirmed no specific facility polices were in place for the areas listed above.	C 104		
C 132	O.A.C. 3701-83-09 (D) Infection Control Policies & Procedures The HCF shall establish and follow written infection control policies and procedures for the	C 132		

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C 132	Continued From page 2 surveillance, control and prevention and reporting of communicable disease organisms by both the contact and airborne routes which shall be consistent with current infection control guidelines, issued by the United States centers for disease control. The policies and procedures shall address: (1) The utilization of protective clothing and equipment; (2) The storage, maintenance and distribution of sterile supplies and equipment; (3) The disposal of biological waste, including blood, body tissue, and fluid in accordance with Ohio law; (4) Standard precautions/body substance isolation or equivalent; and (5) Tuberculosis and other airborne diseases. This Rule is not met as evidenced by: Based on a review of the facility's policy and procedure manual and interview with the facility staff, the facility failed to establish and follow written infection control policies and procedures for the surveillance, control and prevention of post-operative infections. This had the potential to affect all patients cared for at this facility. The facility provided services for 1,451 patients in the past year. Findings included: The facility's policy and procedure related to	C 132		

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C 132	Continued From page 3 infection control was reviewed on 04/08/13. Review of the one page policy revealed the policy to be identified as being a low risk environment for certain communicable diseases. The policy did address air temperature and humidity in the operating and recovery room areas and hand hygiene and environmental cleaning; however, the policy did not address any surveillance for post-operative infections. Staff A was interviewed on 04/09/13 regarding the post-operative infection rate for patients. Staff A stated that only a portion of patients return for post surgical follow-up exam and the facility does not monitor those patients for post-surgical infections.	C 132		
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 surveyor observation during a tour of the facility and interview with the facility staff, the facility failed to ensure the operating room equipment was maintained in a safe and sanitary manner. This had the potential to affect all patients cared for at this facility. The facility provided services for 1,451 patients in the past year. Findings included: A tour of the facility was conducted during the morning of 04/09/13 with Staff A. The following observations were noted:	C 139		

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C 139	Continued From page 4 During tour of Operating Room #1, a vinyl covered exam chair was noted to have at least three cracks or splits in the vinyl, which could allow for bacterial growth or hibernation. In addition, a few discolored cotton balls held to the ceiling by a clear surgical dressing known as a Tegaderm was noted on the ceiling offset from the exam chair. Staff A was questioned on 04/09/13, at the time of the observation, as to what and why this was there. Staff A stated it was cotton balls held with tegaderm over an area, which had leaked in the past. During tour of each of the three operating rooms, the surveyor noted the stirrup mounting brackets attached to each of the three the exam chairs to have rust on both the right and left sides. During tour of the dirty/clean utility room, where instruments are processed and wrapped for future use, observation was made of an autoclave (sterilizer used to sterilize surgical tools), which had a glass bottle with distilled water sitting beside it. This bottle was noted to have a rubber tube approximately two foot long with one end of the tube attached to the top of the bottle and the other end pinched off with a paper clip to prevent water from leaking out. This bottle was filled from a larger container of distilled water, which sat on the floor and was then used to fill the reservoir of the autoclave. Closer observation of the rubber tubing revealed dark areas inside the tubing, which appeared to be mold. Staff A, at the time of the observation, agreed that this substance appeared to be mold and then removed the bottle with tubing from that area, taking it to the sink and pouring the water out. Final observation in each of the operating rooms and the dirty/clean utility room revealed rust on all	C 139		

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C 139	Continued From page 5 of the heater unit covers. Staff A verified the above observations at the time of the tour.	C 139		
C 140	O.A.C. 3701-83-10 (C) Disaster Planning The HCF shall develop a disaster preparedness plan including evacuation in the event of a fire. The HCF shall review evacuation procedures at least annually, and conduct practice drills with staff at least once every six months. This Rule is not met as evidenced by: Based on review of the facility's disaster preparedness plan, review of the facility's evacuation drills, and interview with the facility staff, the facility failed to ensure evacuation procedures were reviewed annually and practice evacuation drills with staff were conducted at least once every six months as required. This had the potential to affect all patients cared for at this facility. The facility provided services for 1,451 patients in the past year. Findings included: The facility's disaster preparedness plan and evacuation/fire drills were reviewed on 04/09/13. Review of the documentation revealed no evidence that the facility's disaster preparedness plan had been reviewed annually as required. Review of the facility's documentation of practice fire drills revealed fire drills had been conducted on 01/17/13, 02/17/13, 3/28/13 and 04/11/13 (current date is 04/09/13), and not every six months as required. Each of these sheets had been signed by those staff who had participated,	C 140		

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C 140	Continued From page 6 even the 04/11/13 drill which has not occurred as of the date of the review. In addition, the facility's documentation of the fire drills lacked any detail as to the time of the drill, evidence that evacuation was performed, or any evaluation of the drill. Interview with Staff A on 04/10/13 at approximately 10:40 AM confirmed this information.	C 140		
C 150	O.A.C. 3701-83-12 (A) Q A & Improvement Program Each HCF shall establish a quality assessment and performance improvement program designed to systematically monitor and evaluate the quality of patient care, pursue opportunities to improve patient care, and resolve identified problems. This Rule is not met as evidenced by: Based on review of the facility's quality assurance program policy and procedure, review of quality assurance program documentation, and interview with the facility staff, the facility failed to establish and follow a quality assessment and performance improvement program designed to systematically monitor and evaluate the quality of patient care, pursue opportunities to improve patient care, and resolve identified problems. This had the potential to affect all patients cared for at this facility. The facility provided services for 1,451 patients in the past year. Findings included: The facility's policy and procedure related to the their quality assurance program was reviewed on 04/08/13. Review of the one page policy	C 150		

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C 150	Continued From page 7 revealed the Director of Nursing was to maintain and implement the facility's quality assurance program. Review of information provided as part of the quality assurance program included quarterly peer review of medical records, patient medical record chart audits, and patient satisfaction surveys. Review of the peer review information and the patient medical record audits revealed no identified problems or areas needing improvement. Review of the patient satisfaction surveys revealed dissatisfaction with wait times prior to surgical procedures. Interview with Staff A on 04/09/13 regarding any identified quality assurance projects for 2012 and 2013 revealed no quality assurance projects were planned or completed in 2012 or 2013. Staff A stated that patient concerns related to wait times were addressed by informing the patients ahead of time there could be a four to six hour wait. Interview of Staff A on 04/09/13 regarding the amount of time the Director of Nursing spends on the facility's quality assurance program revealed that once every three to four months Staff A and the Director of Nursing work on the program.	C 150		
C 151	O.A.C. 3701-83-12 (B) Q A & Improvement Plan Each HCF shall develop a written plan that describes the quality assessment and performance improvement program's objectives, organization, scope, and mechanism for overseeing the effectiveness of monitoring, evaluation, improvement and problem-solving activities.	C 151		

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C 151	Continued From page 8	C 151		

This Rule is not met as evidenced by:
Based on review of the facility's quality assurance program policy and procedure, review of quality assurance program documentation, and interview with the facility staff, the facility failed to develop a written plan that described the quality assessment and performance improvement program's objectives, organization, scope, and mechanism for overseeing the effectiveness of monitoring, evaluation, improvement and problem-solving activities. This had the potential to affect all patients cared for at this facility. The facility provided services for 1,451 patients in the past year.

Findings included:

The facility's policy and procedure related to the their quality assurance program was reviewed on 04/08/13. Review of the one page policy revealed the Director of Nursing was to maintain and implement the facility's quality assurance program. The single page policy did not address the program's objectives, organization, scope or mechanism for overseeing the activities of the quality assurance program.

Interview of Staff A on 04/09/13 revealed there were no identified QA projects for 2012 or 2013. Review of information provided as part of the quality assurance program included quarterly peer review of medical records, patient medical record chart audits, and patient satisfaction surveys.

Review of the peer review information and the patient medical record audits revealed no identified problems or areas needing

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C 151	Continued From page 9 improvement. Review of the patient satisfaction surveys revealed dissatisfaction with wait times prior to surgical procedures. Interview of Staff A revealed that patient dissatisfaction with the pre-operative wait times was not presented as a quality assurance project. Interview of Staff A on 04/09/13 regarding the amount of time the Director of Nursing spends on the facility's quality assurance program revealed that once every three to four months Staff A and the Director of Nursing work on the program.	C 151		
C 152	O.A.C. 3701-83-12 (C) Q A & Improvement Requirements The quality assessment and performance improvement program shall do all of the following: (1) Monitor and evaluate all aspects of care including effectiveness, appropriateness, accessibility, continuity, efficiency, patient outcome, and patient satisfaction; (2) Establish expectations, develop plans, and implement procedures to assess and improve the quality of care and resolve identified problems; (3) Establish expectations, develop plans, and implement procedures to assess and improve the health care facility's governance, management, clinical and support processes; (4) Establish information systems and appropriate data management processes to facilitate the collection, management, and analysis of data needed for quality assessment and performance improvement, and to comply with the applicable data collection requirements of Chapter 3701-83 of the Administrative Code;	C 152		

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C 152	Continued From page 10 (5) Document and report the status of quality assessment and improvement program to the governing body every twelve months; (6) Document and review all unexpected complications and adverse events, whether serious injury or death, that arise during an operation or procedure; and (7) Hold regular meetings, chaired by the medical director of the HCF or designee, as necessary, but at least within sixty days after a serious injury or death, to review all deaths and serious injuries and report findings. Any pattern that might indicate a problem shall be investigated and remedied, if necessary. This Rule is not met as evidenced by: Based on review of the facility's quality assurance program policy and procedure, review of quality assurance program documentation, and interview with the facility staff, the facility failed to ensure that their quality assessment and performance improvement program monitored and evaluated all aspects of care including effectiveness, appropriateness, accessibility, continuity, efficiency, patient outcome, and patient satisfaction; established expectations, developed plans, and implemented procedures to assess and improve the quality of care and resolve identified problems; documented and reported the status of the quality assessment and improvement program to the governing body every twelve months; and held regular meetings, chaired by the medical director of the facility or designee. This had the potential to affect all	C 152		

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C 152	Continued From page 11 patients cared for at this facility. The facility provided services for 1,451 patients in the past year. Findings included: The facility's policy and procedure related to the their quality assurance program was reviewed on 04/08/13. Review of the one page policy revealed the Director of Nursing was to maintain and implement the facility's quality assurance program. Interview of Staff A on 04/09/13 revealed there were no identified quality assurance projects for 2012 or 2013. Review of information provided as part of the quality assurance program included quarterly peer review of medical records, patient medical record chart audits, and patient satisfaction surveys. Review of the peer review information and the patient medical record audits revealed no identified problems or areas needing improvement. Review of the patient satisfaction surveys revealed dissatisfaction with wait times prior to surgical procedures. The single page policy did not address the quality assurance program's mechanism to monitor and evaluate all aspects of care including effectiveness, appropriateness, accessibility, continuity, efficiency, patient outcome, and patient satisfaction. The policy did not establish expectations, develop plans, or implement procedures to assess and improve the quality of care or resolve identified problems. Interview of Staff A on 04/09/13 revealed that patient dissatisfaction with the pre-operative wait times was not presented as a quality assurance project.	C 152		

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C 152	Continued From page 12 Review of the facility's governing body meeting minutes revealed a meeting was held on 03/26/13. The very brief documentation of the meeting minutes revealed no discussion or evidence of the quality assurance program's activities or any quality assurance projects over the past 12 months. Further review of facility documentation revealed no evidence that regular meetings, chaired by the medical director or a designee were held that addressed quality assurance program activities. Interview of Staff A on 04/09/13 regarding the amount of time the Director of Nursing spends on the facility's quality assurance program revealed that once every three to four months Staff A and the Director of Nursing work on the program.	C 152		
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	C 201		

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C 201	Continued From page 13 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. This Rule is not met as evidenced by: Based on review of the facility's personnel files, review of the governing body's meeting minutes, and interview with the facility staff, the facility failed to ensure the governing body reapproved all physician's clinical privileges in writing as least every twenty four months as required. This had the potential to affect all patients cared for at this facility. The facility provided services for 1,451 patients in the past year. Findings included: The facility's personnel records were reviewed on 04/09/13. Review of Staff B's personnel record revealed no evidence that the governing body had reapproved the physician's clinical privileges in writing as least every twenty four months as	C 201		

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C 201	Continued From page 14 required. The governing body's meeting minutes, dated 03/26/13, were reviewed on 04/10/13. Review of the meeting minutes revealed Staff A and Staff C to be present at the meeting. The meeting minutes further revealed five topics of discussion, none of which included reappointments and clinical privileges of the facility's physicians. This document was signed by both Staff A and C. These finding were verified by Staff A during interview on 04/09/13 at approximately 3:50 PM. Staff A stated not knowing why this information was not in the file and would have a difficult time retrieving the necessary information on this day.	C 201		
C 227	O.A.C. 3701-83-18 (H) Ongoing Training for Staff Each ASF shall provide an ongoing training program for its personnel. The program shall provide both orientation and continuing training to all staff members. The orientation shall be appropriate to the tasks that each staff member will be expected to perform. Continuing training shall be designed to assure appropriate skill levels are maintained and that staff are informed of changes in techniques, philosophies, goals, and similar matters. The continuing training may include attending and participating in professional meetings and seminars. This Rule is not met as evidenced by: Based on review of the facility's personnel files and interview with the facility staff, the facility failed to ensure all staff were provided ongoing training, specifically related to infection control. This affected three of seven staff (Staff A, C, and	C 227		

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C 227	Continued From page 15 D) whose personnel files were reviewed. This also had the potential to affect all patients cared for at this facility. The facility provided services for 1,451 patients in the past year. Findings included: The facility's personnel files were reviewed on 04/09/13. Review of the personnel files revealed no documentation that Staff A, C, and D had received any ongoing training or review of infection control practices in order to assure appropriate skill levels were maintained and to inform staff of any changes in techniques. These findings were verified by Staff A during an interview on 04/10/13 at approximately 12:15 PM. Staff A verified no ongoing training had been completed for Staff A, C, and D.	C 227		
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: Based on surveyor observation during a tour of the facility and interview with the facility staff, the	C 231		

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C 231	Continued From page 16 facility failed to establish and implement a program for the control and accountability of drug products throughout the facility and to maintain a list of medications that are always available. This also had the potential to affect all patients cared for at this facility. The facility provided services for 1,451 patients in the past year. Findings included: A tour of the facility was conducted with Staff A on 04/09/13 between 8:30 A.M. and 10:30 A.M. The following observations were noted related to the accounting and storage of medications in the facility: 1. Surveyor observation during a tour of the facility revealed the facility's controlled substances to be in a locked cabinet. The accounting documentation was reviewed with Staff A. Staff A verified that the accounting of medication was completed by the RN, the physician and/or themselves, Staff A. Surveyor noted 156 ampules of Fentanyl on hand, each ampule containing 5 milliliters (250 micrograms per 5 milliliters). Review of the accounting information revealed a start count in micrograms at the beginning of the day and end count in micrograms at the end of the day. In addition, the physician documented the amount of Fentanyl in micrograms given to each patient. Those dosages ranged from 75 to 100 micrograms each patient. There was no documentation of the amount of Fentanyl wasted out of each ampule. The end count identified the amount of micrograms left after deducting the amount given to each patient. The end count and what was actually on hand did not match, because a large amount of Fentanyl was wasted after each patient, due to the ampules being single dose	C 231		

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C 231	Continued From page 17 ampules. Staff A verified the accounting of the Fentanyl was not correct. In addition to the controlled substances in the locked medication cabinet, the physician's prescription pads were also observed. The medication pad had three blank prescription pages, pre-signed with the physician's signature. Staff A verified the three pre-signed prescription pages. 2. Surveyor observation of a closet in Operating Room #3 revealed storage of medications used by the facility. The medications included two boxes of different antibiotics, an anti fungal, a bottle of analgesic oral medication, and 69 multi dose bottles of lidocaine 1%, with one of the 69 bottles of lidocaine being unsealed. There was no date as to when the lidocaine was opened or used. Additional medication was noted in the closet, which included a bottle of liquid acetaminophen. Staff A verified there was no listing or accounting of these medications maintained by the facility Also noted in the closet in Operating Room #3 was a box containing 44 syringes with needles attached containing 5 milliliters of an unidentified clear liquid. The syringes had no labels identifying the type of liquid, when the liquid was drawn up, or who drew up the liquid. Interview with Staff A, who accompanied the surveyor during the tour, was unable to tell the surveyor what was in the syringes, who drew it up, or when it was drawn up. 3. Surveyor observation in Operating Room #3 also revealed eleven intravenous (IV) bags of lactated ringers solution with expiration dates of February 2013. In addition there were 48 multi	C 231		

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C 231	Continued From page 18 dose bottles of lidocaine and epinephrine 1:100,000 which had expiration dates of March 2013. Staff A verified the expired medications were to have been discarded. Staff A verified the above observations at the time of the tour.	C 231		
C 234	O.A.C. 3701-83-19 (E) Transfer Agreement The ASF shall have a written transfer agreement with a hospital for transfer of patients in the event of medical complications, emergency situations, and for other needs as they arise. A formal agreement is not required in those instances where the licensed ASF is a provider-based entity of a hospital and the ASF policies and procedures to accommodate medical complications, emergency situations, and for other needs as they arise are in place and approved by the governing body of the parent hospital. This Rule is not met as evidenced by: Based on a review of the facility's documentation related to a transfer agreement and interview with the facility staff, the facility failed to have a written transfer agreement with a hospital for transfer of patients in the event of medical complications, emergency situations or for other needs as they arise. This had the potential to affect all patients cared for at this facility. The facility provided services for 1,451 patients in the past year.	C 234		

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C 234	Continued From page 19 Findings included: The facility's documentation related to a transfer agreement was reviewed on 04/08/13. The facility's documentation revealed that a transfer agreement with a local hospital obtained June 5, 2008 had been terminated 60 days after receiving a letter of termination from the hospital on May 17, 2010. Interview with Staff A on 04/08/13 revealed that the facility had been in discussions and attempted to obtain a transfer agreement with a local hospital, but currently the facility had reached no agreement with a local hospital. Staff A verified the facility had no transfer agreement in place and had not had one since the transfer agreement was terminated in 2010.	C 234		
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 surveyor observation during a tour of the facility, review of the facility's preventative maintenance record, and interview with the facility staff, the facility failed to ensure all medical	C 242		

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C 242	Continued From page 20 equipment was inspected, calibrated, and appropriate adjustments made in accordance with manufacturer's instructions. This had the potential to affect all patients cared for at this facility. The facility provided services for 1,451 patients in the past year. Findings included: A tour of the facility was conducted during the morning of 04/09/13 with Staff A. The following observations were noted: An ultrasound machine with an inspection tag attached indicating that the ultrasound machine had been visually inspected, dated 03/27/13, was noted in Operating Room #1. Another inspection tag indicating the equipment had been visually inspected, dated 03/27/13, was also noted on the blood pressure monitor. A culposcopy (a microscope used for visualization of the cervix) which had an inspection tag attached, indicating the culposcopy had been visually inspected, dated 03/27/13 was also noted in Operating Room #2. An ultrasound machine which had no inspection tag was noted in Operating Room #3. The facility's preventative maintenance record was reviewed on 04/09/13. The preventative maintenance record identified that inspections had been conducted for each medical device listed above with inspection tags, but confirmed no inspection had been conducted on the ultrasound machine in Operating Room #3. An interview with Staff A on 04/09/13 verified that the preventative maintenance log was silent to	C 242		

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C 242	Continued From page 21 the ultrasound machine being inspected in Operating Room #3 and that they had contacted the outside professional company and left a voice message requesting a return call in order to find out why the ultrasound machine had not been inspected.	C 242		