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

SURVEY HEALTH ENTRANCE	DATE: 5-16-12
SURVEY HEALTH EXIT	DATE: 5-16-12
LSC EXIT	DATE:
MAILED/TURNED IN	DATE: 5-16-12
FISCAL YEAR	

PSR TO BE A DESK AUDIT? ☐ Yes ☐ No

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

COMPLAINT(S) # _____

TYPE (circle): (ASC) ESRD HCS HOSPICE

2Z6N12

LICENSE# 0288AS

FACILITY NAME: Preterm

ADDRESS: 12000 Shaker Boulevard

CITY/COUNTY/ZIP Cleveland / Cuyahoga / 44120

Surveyor Initials	Oscar #	Tag #	Check if Condition	Check if Waiver	Recited	Oscar #	Tag #	Check if Condition	Check if Waiver	Recited
CB	21521	Ø								

NLTC/Lic Cert Entered (Date/Initials) CERT 5-17-12 CB ☐ 10/60 ☐ 10/45 CONDI ☐ 5/30 PSR LIC _____ ☐ 10/30 PSR ☐ 5/15 PSR

Draft To Supervisor By OA (Date/Initials) 5-17-12 CB LTR. Signed (Date/Initials) 5/17/12 ~~5/17/12~~ DH

SOD MAILED (Date/Initials) _____

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 _____ ☐ LOG ☐ CALENDAR ☐ ACO ☐ Lic Cert
POC Approved (Date/Initials) _____ File To Pending Drawer (Date/Initials) _____

File To Review (Date/Initials) 5-22-12 CB ☐ LOG ☑ Lic Cert

670 Completed (Date/Initials) 5-22-12 CB 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

NOTES: CLOSED IN ASPEN ☐ DATE/Intials _____

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

OHIO DEPT OF HEALTH
BOA-BCHCFS
2012 MAR 26 P 12:58

SURVEY HEALTH ENTRANCE	DATE: 2-21-12
SURVEY HEALTH EXIT	DATE: 3-21-12
LSC EXIT	DATE: NA
MAILED/TURNED IN	DATE: 3-23-12
FISCAL YEAR	

PSR TO BE A DESK AUDIT? ☐ Yes ☐ No

EVENT ID 226N11

AST

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

COMPLAINT(S) # _____

TYPE (circle): (ASC) ESRD HCS HOSPICE

226N11

LICENSE# 0288AS

FACILITY NAME: Peterm

ADDRESS: 12000 Shaker Boulevard.

CITY/COUNTY/ZIP Cleveland Cuyahoga Ohio 44120

Surveyor Initials	Oscar #	Tag #	Check if Condition	Check if Waiver	Recited	Oscar #	Tag #	Check if Condition	Check if Waiver	Recited
JS	03180	C211								
CS	02432									

NLTC/Lic Cert Entered (Date/Initials) CERT 3-27-12 ☐ 10/60 ☐ 10/45 CONDI ☐ 5/30 PSR LIC _____ ☐ 10/30 PSR ☐ 5/15 PSR

Draft To Supervisor By OA (Date/Initials) 3-27-12CC LTR. Signed (Date/Initials) 3/29/12

SOD MAILED (Date/Initials) 4-2-12CC

(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) 4-12-12CC ☐ LOG ☐ CALENDAR ☐ ACO ☐ Lic Cert

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

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

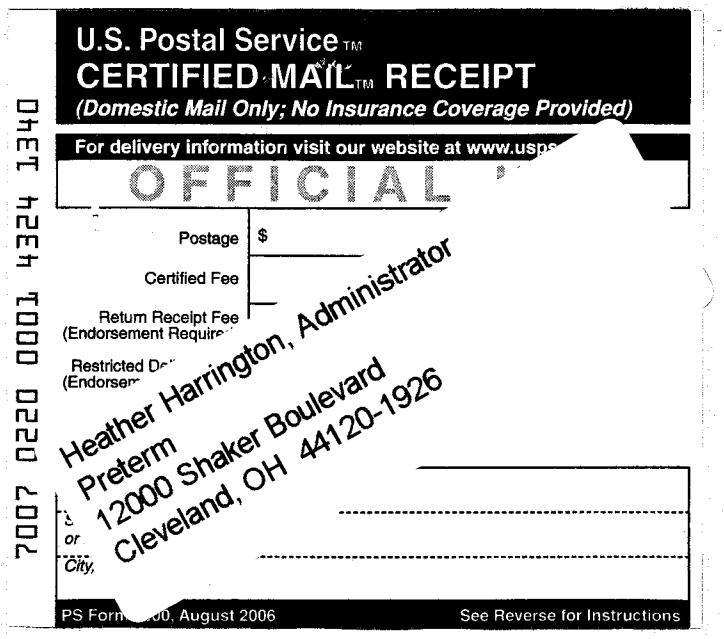
670 Completed (Date/Initials) 5-22-12KH All Final Info Entered Into Lic Cert (Date/Initials) _____

LIC LTR CMS NO DEF. LTR TO MAUST _____

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

NOTES: CLOSED IN ASPEN ☐ DATE/Intials _____

Revised 10/26/07
SURVEY_CONTROL_SHEET.doc



U.S. Postal Service™
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For delivery information visit our website at www.usps

OFFICIAL

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

Heather Harrington, Administrator
Preterm
12000 Shaker Boulevard
Cleveland, OH 44120-1926

or
City,

7007 0220 0001 4324 1340

PS Form 3800, August 2006 See Reverse for Instructions

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:

Heather Harrington, Administrator
Preterm
12000 Shaker Boulevard
Cleveland, OH 44120-1926

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X James Collier ☐ Agent ☐ Addressee

B. Received by *(Printed Name)* C. Date of Delivery 4-4-12

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

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

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

2. A (T 7007 0220 0001 4324 1340

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

Approved 5-15-12

PRINTED: 03/27/2012
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
	0288AS	A. BUILDING _____ B. WING _____	03/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRETERM	12000 SHAKER BOULEVARD CLEVELAND, OH 44120

(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 JS/CS Type of inspection: Licensure Compliance Inspection Administrator: Heather Harrington. County: Cuyahoga Number of Operating Rooms: Five Services Provided: Surgical & Medical Abortion License: Current: Yes License Expiration Date: March 2012 The following violation is issued as a result of the licensure compliance inspection completed on 03/21/12.	C 000	(1) We cannot go back and add documentation to the medical record of Patient#1. It should be noted that the patient did not require further medical intervention at the hospital and that her follow-up examination at Preterm was fully documented. (2) All of the practicing physicians, the Director of Nursing, and the Director of Clinic Operations have been re-educated regarding the necessary documentation in the medical record. (See attachment 1)	
C 211	O.A.C. 3701-83-17.(F) MR With Patient Transport Patients transported to a hospital shall be accompanied by their medical records that are of sufficient content to ensure continuity of care. This Rule is not met as evidenced by: Based on patient medical record review, review of facility policy and staff interview and verification, the facility failed to ensure that patients transported to a hospital were accompanied by their medical records and that sufficient content was provided to ensure continuity of care. One of 6 patient medical records (Patient#1) was affected. The facility provided 4747 procedures in the past 12 months.	C 211		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0288AS	A. BUILDING _____ B. WING _____	03/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRETERM	12000 SHAKER BOULEVARD CLEVELAND, OH 44120

(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 211	Continued From page 1 Findings included: On 03/21/12 the medical record for Patient #1 was reviewed. Patient #1 was admitted to the facility on 07/06/11 for a surgical procedure. Review of the medical record revealed that near the completion of the procedure the physician noted some increased bleeding. The physician noted observations of the surgical area in the medical record. Documentation ended with the physician's note. The medical record had no documentation that addressed the physician's decision to send the patient to the hospital, the patient's status prior to the transport and at the time of transport, as well as how the patient was transported to the hospital and who accompanied the patient. There was no documentation which noted if any of the patient's medical record was sent with the patient. Review of the facility policy regarding emergency transfer to the hospital revealed the director of nursing or charge nurse was to obtain transfer information, obtain physician charting, provide the medical record to the administrator for copying and provide the medical record to the nurse for charting of medications, vital signs, times, etc. The policy indicated that a patient support person was to accompany the patient to the hospital and be supportive of the patient and be a patient advocate at the hospital. Further review of the medical record revealed the hospital provided discharge information to the facility which described the patients condition at the time of discharge from the hospital. The record also included a summary of the event,	C 211	③ Responsibility for ensuring that the proper documentation is placed in the medical record has been added to our Emergency Transfer Protocol. (See attachments 2/3) ④ Ongoing performance monitoring will be carried out by the QA/QI Complication Review Committee, headed by the Director of Clinic Operations. (see attachment 1)	4/10/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0288AS	A. BUILDING _____ B. WING _____	03/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRETERM	12000 SHAKER BOULEVARD CLEVELAND, OH 44120

(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 211	Continued From page 2 written by the administrator after the patient's discharge and follow-up with the physician one week later. Interview of Staff A on 03/20/12 verified the medical record did not reflect the patient's condition and the preparation for the patient's transfer to the hospital. It was also verified the facility policy was not followed with regards to emergency transfer procedure.	C 211		

EMERGENCY TRANSFER TO UNIVERSITY HOSPITALS

The Director of Nursing (or charge nurse in her absence) will:

1) Inform the MR that there is an emergency and a possible patient transfer.
2) Consult the physician and assess the patient's need for immediate care.
3) Act as liaison between the MR, physician, patient and Director managing the situation.
4) Ensure that the medical record is complete, containing the physician's reason for transfer, patient's status prior to and at the time of transfer, how she is being transported and who is accompanying her, and that a copy of the record is accompanying the patient.
5) Direct the MR to call 911. The DON should be prepared to give information to the 911 dispatcher.
6) Direct the MR to notify staff (overhead page: "Attention all staff. Disposition T.R.") and initiate transfer checklist.
7) Call the emergency room triage nurse of the admitting hospital and give report.
    a. UH Adult ED Nurses Station: 216-844-7007
8) Control the chart flow to :
    a. MR for transfer information
    b. Physician for charting
    c. Administrator for copying of chart (Facesheet, labs, screening, sedation/anesthesia, procedure/recovery are to be copied. Procedure page should not leave the 3rd floor.)
    d. Nurse for charting (meds, vitals, times, etc.)
9) After consultation with the physician, tell the MR when to page "Attention all staff. All clear disposition" and begin procedures again.

The Emergency Team will:

1) Report to the Director of Nursing (or charge nurse in her absence) in the room where the event is occurring as soon as possible upon hearing the "disposition T.R." page.
2) Perform any duties as assigned by the DON or physician.
3) Leave the area and resume her normal duties as soon as directed to do so by the DON.

Emergency Team

a. Angel
b. Marty, if here
c. Sedation Nurse
d. Dana
e. La'Toya

The Medical Receptionist will:

1) Inform the Director of Nursing, Director of Clinic Operations, Director of Counseling Services, or other Administrator, of the possibility of a patient transfer to the hospital.
2) For emergency transfers where the MD or CRNA need to be at bedside continually, stop all procedures and traffic in the procedure area until the Director of Nursing says it is okay to start procedures again. For non-emergent transfers, procedures do not need to be suspended, as long as the MD or CRNA do not need to be at bedside. This should be determined by the MD/Director of Nursing. Stop flow to the third floor until patient has been transferred.
3) After the Director of Nursing has notified the MR of the transfer, she will call 911 and initiate transfer checklist. Overhead page: "Attention all staff. Disposition T.R.".

Pursuant to O.A.C. 3701-83-17(F): "Patients transported to a hospital shall be accompanied by their medical records that are of sufficient content to ensure continuity of care."

If a patient under my care at Preterm must be transferred to a hospital for further treatment or evaluation, I understand that I must clearly document in the medical record my rational for transport, her status prior to and at the time of transport, how she was transported to the hospital, who accompanied her, and the fact that her medical record was sent to the hospital with her.

Justin Lappen, M.D.

Rebecca Lowenthal, M.D.

Lisa Perriera, M.D.

Mitch Reider, M.D.

Mohammad Rezaee, M.D.

(Dr. Burkons does not treat patients at Preterm, therefore is not a signatory)

If a patient receiving treatment at Preterm is transported to a hospital for further treatment or evaluation, I will be responsible for ensuring that the above-mentioned documentation is present and complete in the patient's medical record. The Director of Clinic Operations will assume this responsibility in my absence.

Angel Rucker, RN, BSN
Director of Nursing

Heather Harrington, BA, CNM
Director of Clinic Operations

As part of our already established QA/QI procedure of review of any potential complication at the quarterly Complication Review Meeting, complete documentation as noted above will henceforth be one of the factors examined.

Heather Harrington, BA, CNM
Director of Clinic Operations

0288AS

COPY

PATIENT TRANSFER AGREEMENT

This Patient Transfer Agreement ("Agreement") is made and entered into as of the 15th day of February, 2005 ("the "Effective Date"), by and between University Hospitals of Cleveland ("UHC"), located at 11100 Euclid Avenue, Cleveland, Ohio 44106 and Preterm-Cleveland, located at 12000 Shaker Boulevard, Cleveland, Ohio 44120 ("Facility").

RECITALS

WHEREAS, UHC and Facility operate health care institutions that provide health care services for the Patients ("Patients") of their respective facilities.

WHEREAS, the parties are deeply concerned with elevating the quality of health care of their patients, and therefore desire to enter into a Patient Transfer Agreement to promote expeditious and safe transfers between the two institutions.

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, and for other valuable considerations, the sufficiency of which is hereby acknowledged, UHC and Facility agree as follows:

1. Term. This agreement shall commence on the day and year first above written and shall continue for a period of one (1) year. Thereafter this Agreement shall be renewed automatically for successive periods of one (1) year each, unless sooner terminated as provided in Section 11.

2. Patient Transfer. The Patient's attending physician shall determine the need for transfer of a Patient. When such a determination has been made, the transferring institution shall determine the Patient's medical status, acuity, and risk assessment and shall immediately notify the receiving institution of the impending transfer and provide medical and administrative information necessary to determine the appropriateness of the placement and to enable continuing care of the Patient.

3. Transferring Institution's Responsibilities. The transferring institution initiating the transfer shall have the following responsibilities:

(a) Medical Screening and Stabilization. The transferring institution is responsible for ensuring, as applicable, that all transfers are in compliance with the Emergency Treatment and Active Labor Act (commonly referred to as the "COBRA anti-dumping law"), 42 U.S.C. § 1395dd, et seq.

(b) Patient Authorization. The attending physician and the transferring institution will be responsible for obtaining any necessary Patient authorization and consent for transfer prior to the transfer.

(c) Transfer Information. The transferring institution shall assure that the receiving institution receives, upon transfer, appropriate and applicable information with regard to current medical findings, diagnosis, rehabilitation potential, a summary of the course of treatment followed in the transferring institution, nursing and dietary information, ambulation status, pertinent administrative and social information, and documented consent for treatment. In addition, the transferring institution shall include the name, address and phone number of the individual designated by Patient to notify in case of medical emergency, or a statement that there is no known individual to be informed in such case. With the Patient's consent, the transferring

institution shall notify that individual of the transfer.

(d) Mode of Transport. The transferring institution shall have the responsibility for arranging for and effecting the transportation of the Patient to the receiving institution, including the selection of the mode of transportation and, where indicated, the provision of appropriate health care personnel and equipment to accompany the Patient.

(e) Coordination with Receiving Institution. The transferring institution shall be responsible for contacting and confirming prior to transfer that the receiving institution is willing to and can accept the transfer of the Patient and provide the appropriate treatment. The attending physician at the transferring institution shall be responsible for communicating directly with the physician at the receiving institution to ensure that adequate space and personnel are available for the Patient and to resolve any questions concerning the transfer.

(f) Personal Effects and Valuables. The transferring institution will be responsible for the transfer or other appropriate disposition of personal effects, particularly money and valuables, and information relating to these items. The status of such disposition shall be made in a writing and forwarded to the receiving institution.

(g) Death of Patient after Transfer. In the event a Patient dies after transfer, the parties agree to cooperate in determining the Patient's next-of-kin or such other persons as may be required to be notified of the Patient's death.

4. Receiving Institution's Responsibilities. The receiving institution shall have the following responsibilities:

(a) Admission. If the Patient transfer is accepted, the receiving institution agrees to admit the Patient, provided that the medical staff, facilities and personnel are available to accommodate that Patient. The receiving institution's responsibility for the Patient's care shall begin when the Patient arrives at the receiving institution.

(i) Consultation. Upon request by the transferring institution and/or attending physician, the receiving institution will provide consultation prior to, during or following transfer. The receiving institution, however, will provide no confidential Patient information to the transferring institution unless the Patient has given prior written consent for such exchange of information.

(ii) Reverse Transfer. Upon request by the transferring institution, an attending, and/or the Patient, the receiving institution may return the Patient to the transferring institution or transfer the Patient to another appropriate institution.

5. Patient Records. The transferring institution shall provide all pertinent and necessary medical information and records which shall accompany the Patient, including current medical and social history, diagnosis, treatment summary, prognosis and other pertinent information. The transferring institution agrees to supplement the above information as necessary for the maintenance of the Patient during transport and treatment upon arrival at the receiving institution. Once the Patient is admitted to the receiving institution ongoing oral or written confidential Patient information may be provided with the Patient's or responsible party's consent. Such exchange of information shall be done in compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

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6. Outpatient Services. UHC shall make available its diagnostic and therapeutic services on an outpatient basis as requested by the Facility attending physician and as ordered by a UHC physician. UHC agrees to provide, according to UHC's policies, available outpatient services as may be required by the Patient of Facility when the services are not available at Facility. Outpatient services may include, but are not limited to laboratory, x-ray, physical services or any other form of services necessary for appropriate treatment care of the Patient; provided, however, that nothing contained herein shall require UHC to provide such services unless Patient has demonstrated the ability to reimburse UHC or cause UHC to be reimbursed for such services.

7. Payment for Services. The Patient is primarily responsible for payment for care received at either institution and for payment of transport costs. Each institution shall be responsible for collecting payment for services rendered in accordance with its usual billing practices. Nothing in this Agreement shall be interpreted to authorize either institution to look to the other institution to pay for services rendered to a Patient transferred by virtue of this Agreement, except to the extent that such liability may exist separate and apart from this Agreement.

8. Independent Contractor Status. Both institutions are independent contractors. Neither institution is authorized or permitted to act as an agent or employee of the other. Nothing in this Agreement is intended to or shall be construed to create any relationship between the institutions other than that of independent contractors. Neither party, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other party to this Agreement.

9. Liability. Each institution shall be responsible for its own acts and omissions and shall not be responsible for the acts and omissions of the other institution.

10. Insurance. Each institution, either through insurance contracts or by self-insurance, shall secure and maintain with respect to itself, its agents and employees, during the term of this Agreement, comprehensive general liability insurance coverage and professional liability insurance coverage with limits not less than $250,000 per occurrence/$750,000 in the aggregate. Facility shall provide UHC with evidence of such insurance coverage within fifteen (15) days following the effective date each renewal of such insurance coverage. Each party shall immediately notify the other of any notice from its insurance carrier of intent to modify or cancel such insurance coverage, or of either party's cancellation of required insurance coverage.

11. Modification or Termination.

(a) This Agreement may be modified or amended from time to time by a written agreement signed by the parties hereto.

(b) Any modification or amendments shall be in writing and shall become a part of this Agreement.

(c) This Agreement shall be effective as of the Effective Date and shall continue in effect until terminated as hereinafter provided.

(d) Either party may terminate this Agreement without cause by giving thirty-(30) days' notice in writing to the other party of its intent to terminate.

(e) During the 30-day notice period, the terminating institution will be required to

meet its commitments under this Agreement with respect to all Patients for whom the other institution has begun the transfer process in good faith.

(f) This Agreement shall be immediately terminated should either party fail to maintain its state licensure or registration requirements, if any, or (if applicable) should either party's certification as a Medicare or Medicaid provider be revoked.

(g) All disputes arising under the Agreement shall first be discussed directly by the designated authorities of the UHC and Facility.

(h) If the dispute cannot be resolved at this level, it will be referred to the chief executive officers of the Facility and the UHC for discussion and resolution prior to termination of the Agreement.

12. Notice. Any notice required or allowed to be given hereunder shall be deemed to have been given upon hand delivery or upon deposit in the United States mail, registered or certified, with return receipt requested and addressed to the following.

a. All notices to UHC shall be addressed to:

University Hospitals of Cleveland
11100 Euclid Avenue
Cleveland, Ohio 44106

Attn: Senior Vice President, Women's Services

With a copy to:

General Counsel
University Hospitals of Cleveland
11100 Euclid Avenue
Cleveland, Ohio 44106

b. All notices to Facility shall be addressed to:

Preterm-Cleveland
12000 Shaker Boulevard
Shaker Heights, Ohio 44120

Attn: President or Executive Director

13. HIPAA Compliance. During the term of this Agreement, the parties shall take such actions and revise this Agreement as is necessary or advisable to comply fully with all laws, rules and regulations applicable to the performance and discharge of such services, including without limitation the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) ("HIPAA") and the rules and regulations promulgated thereunder, as well as guidance issued by the United States Department of Health and Human Services (the "HIPAA Regulations").

14. Use of Name. Neither party shall use the name of the other party in any promotional, marketing or advertising media without prior written approval of the other party.

Copy 0288AS

15. Entire Agreement. This Agreement constitutes the entire agreement between the parties and contains all of the agreements between them with respect to the subject matter hereof and supersedes any and all other agreements, either oral or in writing, between the parties hereto with respect to the subject matter hereof.

IN WITNESS WHEREOF, the authorized representatives of the parties hereto have caused this Agreement to be executed as of the day and year first above written.

University Hospitals of Cleveland

By: [signature]

Print Name: Meri Arnold

Its: Sr VP & GM

Preterm-Cleveland

By: [signature]

Print Name: Chrisse France

Its: Executive Director

AH Form Approved
5/22/2012

DESK AUDIT

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
0288AS	A. Building B. Wing	5/16/2012

Name of Facility	Street Address, City, State, Zip Code
PRETERM	12000 SHAKER BOULEVARD CLEVELAND, OH 44120

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 C0211 Reg. # O.A.C. 3701-83-17 (F) LSC	Correction Completed 05/16/2012	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

Reviewed By State Agency X	Reviewed By [initials]	Date: 5-22-12	Signature of Surveyor: Chris Sanders, RD	Date: 5-16-12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/21/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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	Meterm				NPI 1326048182
Address	12000 Shaker Blvd.				
City/County	Cleveland Cuyahoga				Zip +4: 44120 1922
Mailing Address	same as above				
City/County					Zip +4:
E-Mail Address	hhartington@preterm.org				
Administrator Name	Heather Hartington				
	Number:	Type:	Eff. Date:	Exp. Date:	Date Began Employment With Facility:
					07/1995
Other Information	Telephone: (216) 991-4000			Fax: (216) 991-4571	
	Provider No.:	Licensure No.: 0288AS		Medicaid No.:	
	FISCAL INTERMEDIARY/CARRIER: Name/Address/Phone #				

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

ACCREDITED: ☒ Yes ☐ No Maternity Lic Exp Date _____

Fiscal Year ~~6/30/2011~~ 6/30/14 AAAHC 5 OR

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: 3-~~28~~-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: 3-21-12	Exit Time: A.M. P.M.

LSC SURVEYS:

Survey Entry 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:	Date: ~~3/15/11~~ 3/21/12

POC REVIEW

Provider Name: Preterm
CCN: _____
Facility Phone #: 216-472-3245
Survey Exit Date: 3-21-12
POC reviewed by: _____
Date approved: 5-15-12
Desk Audit _____

2567 signed and dated ✓
Completion date 4-20-12

	Tag #211	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #	Tag #
Correction date within timeframe?	✓												
Does the plan address all elements of the deficient practice?	✓												
If in-servicing is provided is all pertinent staff to attend identified?	✓												
Waiver/Variance requested?													

COMMENTS
2567 not signed. LJman on 5-15-12 @ 2135 pm

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

April 2, 2012

Heather Harrington, Administrator
Preterm
12000 Shaker Boulevard
Cleveland, OH 44120-1926

RE: Preterm - License: 0288AS
Survey Completed on March 21, 2012

Dear Ms. Harrington:

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, RN

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

preterm
12000 shaker boulevard
cleveland, ohio 44120 1922

April 10, 2012

Wanda L. Iacovetta, R.N.
Non Long Term Care Unit Supervisor
Bureau of Community Health Care Facilities and Services
Division of Quality Assurance
Ohio Department of Health
246 North High Street
Columbus, OH 43215

Dear Ms. Iacovetta,

Enclosed please find our Plan of Correction on the Statement of Deficiency form and supporting documents.

We are committed to full compliance with all regulatory requirements and to providing the highest quality of care to our patients. Thank you for assisting us in meeting these goals.

If you have any questions or concerns regarding this submission, please do not hesitate to contact me.

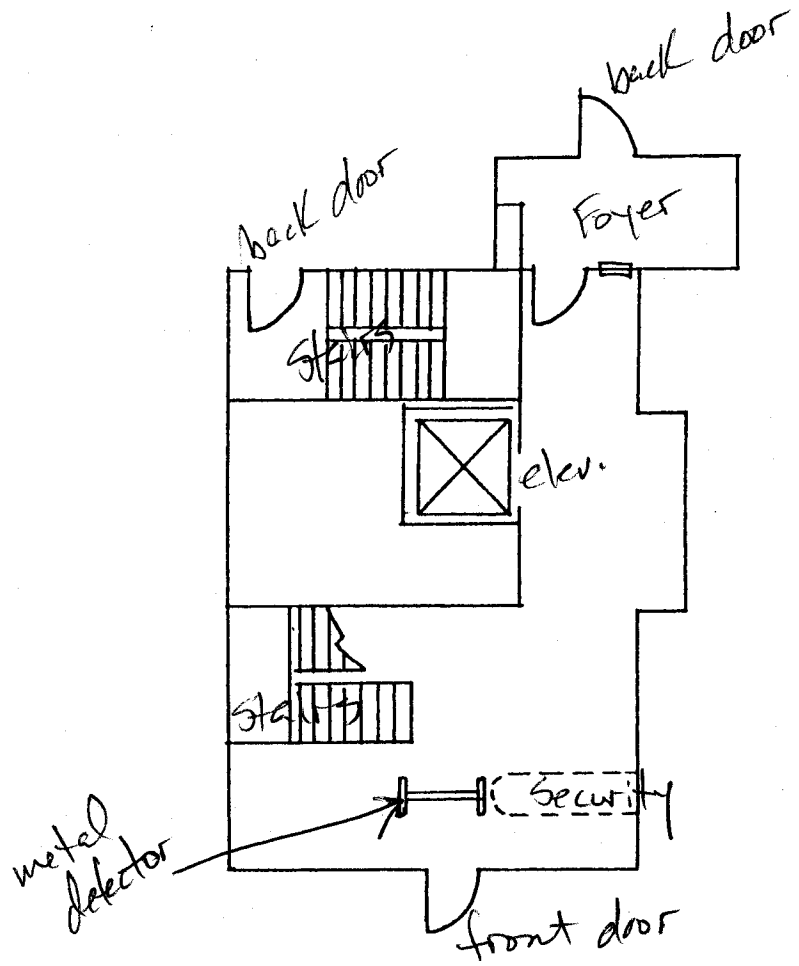
Sincerely,

Heather Harrington
Director of Clinic Operations
(216) 472-3215
hharrington@preterm.org

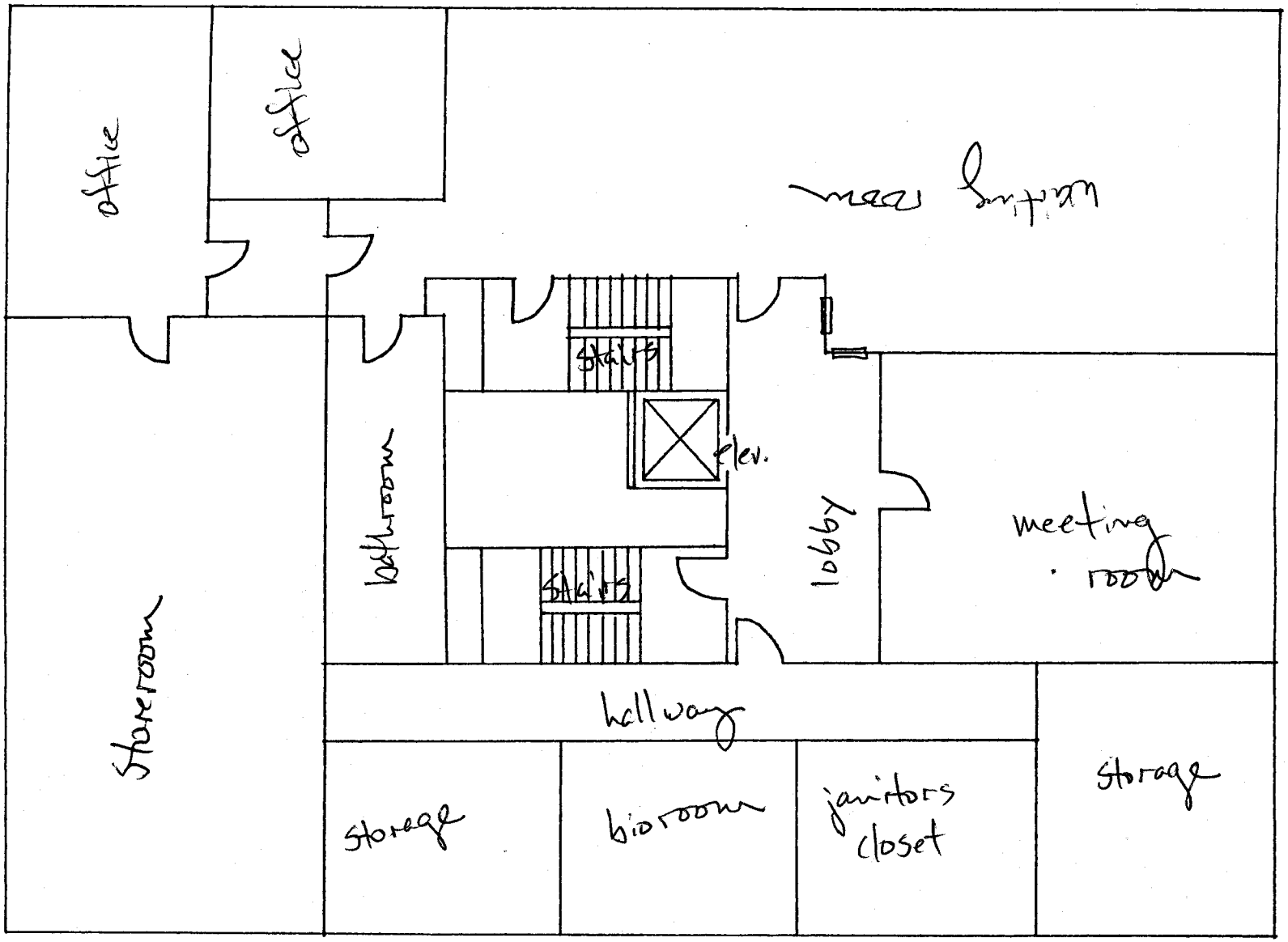
phone . 216.991.4000
fax . 216.991.4571
email . info@preterm.org
www.preterm.org

a member of Greater Cleveland Community Shares

Preterm 02884S

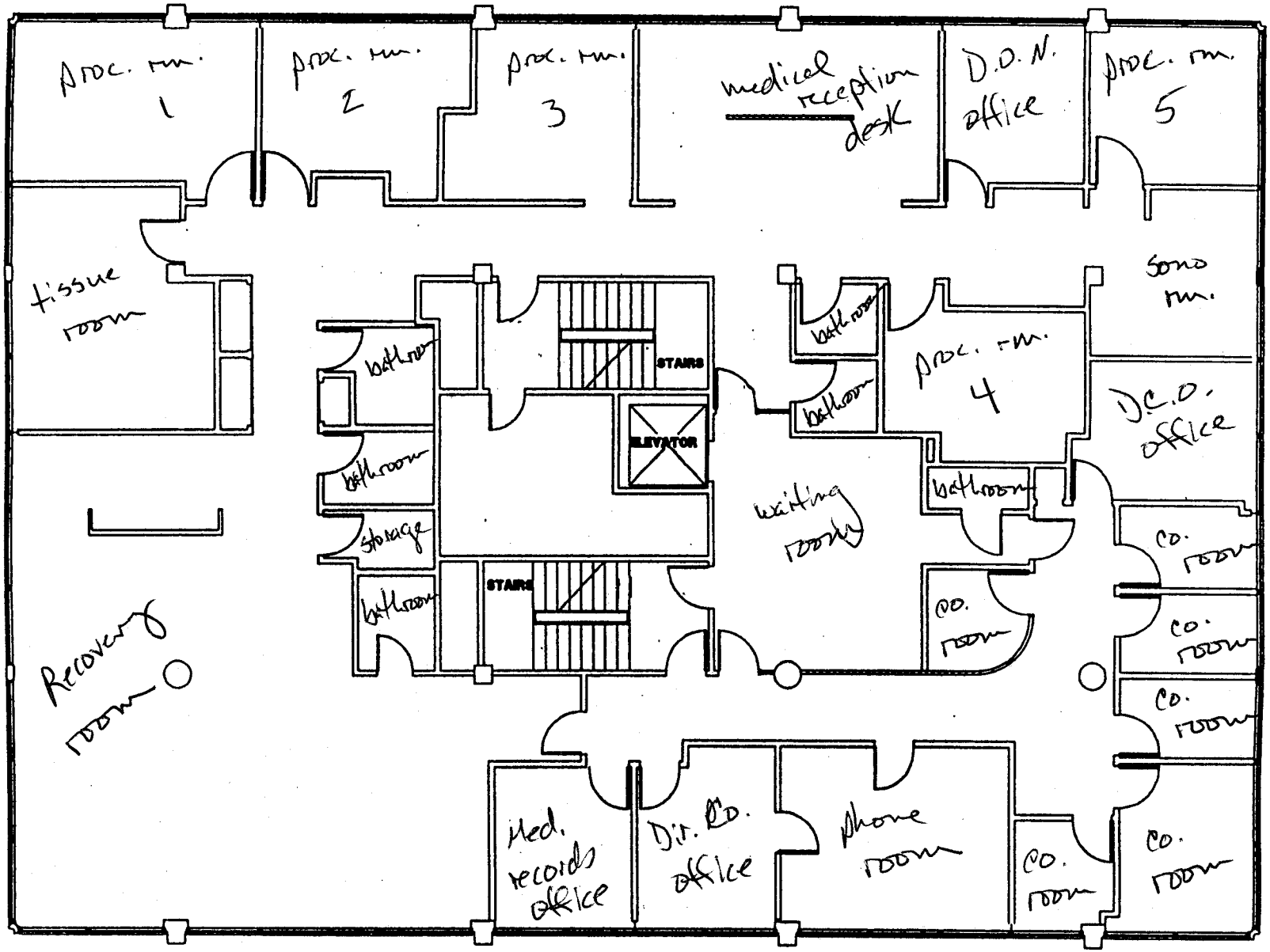


FIRST FLOOR



SECOND FLOOR

Preterm 0288A3

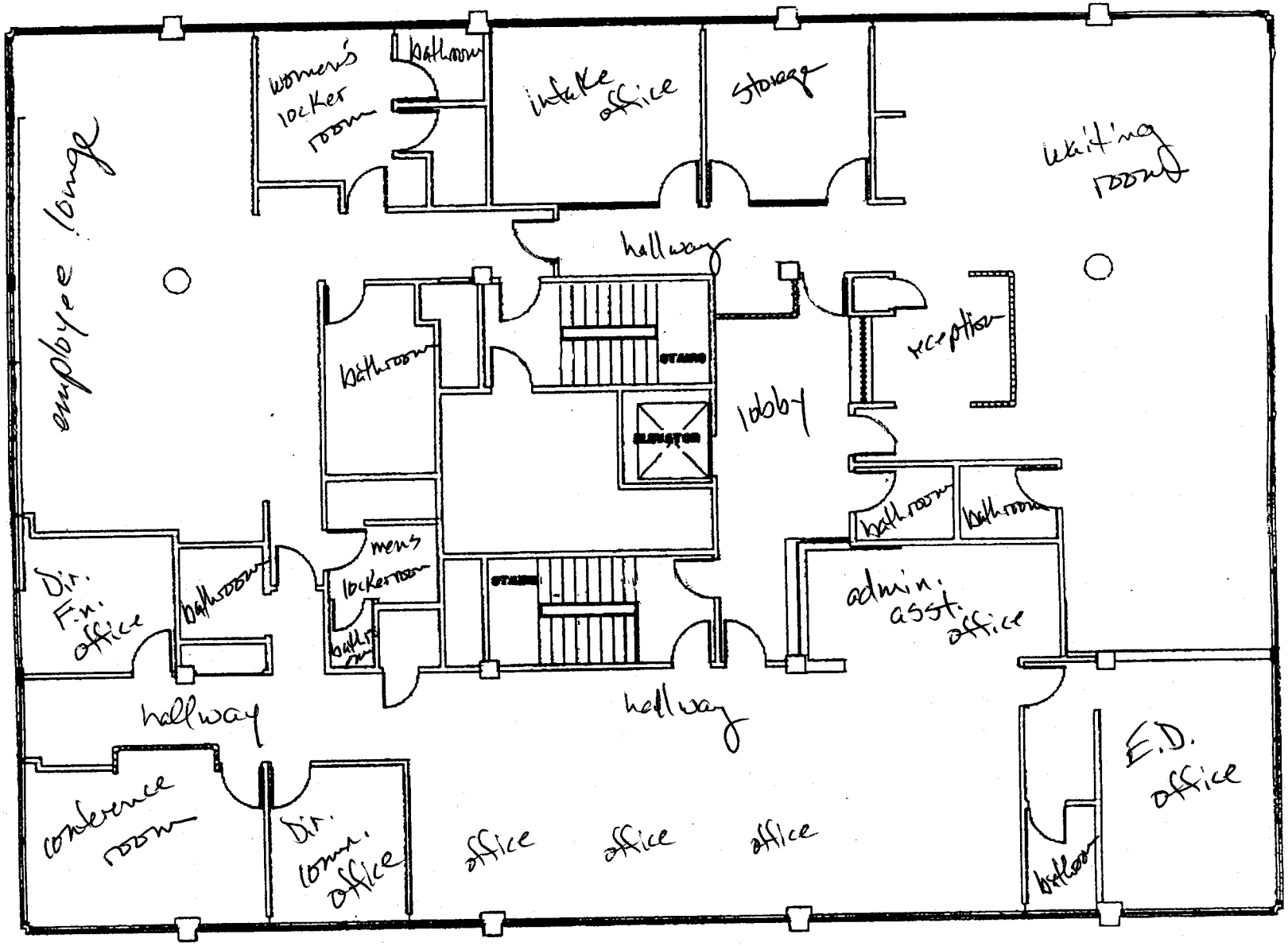


THIRD FLOOR
PRETERM

02884S

IN CASE OF FIRE USE STAIRS

Preterm

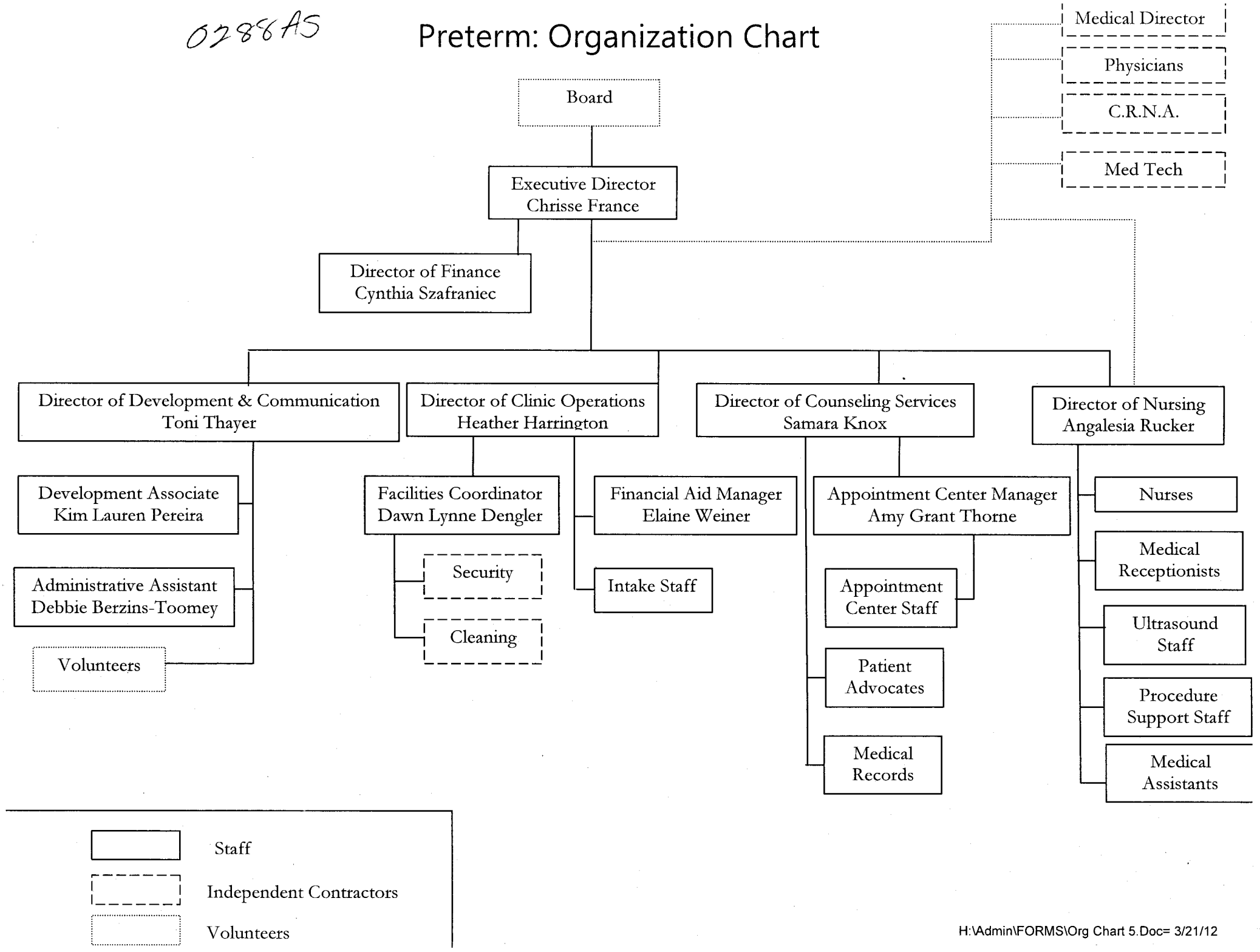


EMERGENCY EXIT ROUTES

FOURTH FLOOR

0286AS

Preterm: Organization Chart



H:\Admin\FORMS\Org Chart 5.Doc= 3/21/12