RECEIVED JAN 31 2013 Approved 3/12/13 Slovdebaker RN

PRINTED: 01/18/2013
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
	1014AS	A. BUILDING _____ B. WING _____	01/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD BEDFORD HEIGHTS	25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146 RECEIVED JAN 31 2013

(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 Licensure Compliance Inspection Administrator: Miriam Hernandez County: Cuyahoga Capacity: Six Operating Rooms The following violations are issued as a result of the licensure compliance inspection completed on 01/11/13.	C 000		
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 facility observation and staff interview and verification, the facility failed to ensure a safe and sanitary environment. Potentially all patients, visitors and staff could be affected. The facility provided services for 3618 patients in the year 2012. Findings included: On 01/10 and 01/11/13 the facility was observed and documentation was reviewed during the compliance inspection. The following observations were noted regarding safety and sanitation of the facility; 1. Upon entrance to the first floor waiting area, an automatic door release for the secured waiting room door was noted. The cover to the automatic release was noted to be out of place,	C 139	The automatic door release for the first floor waiting room has been reset and is in standard working order. Please see enclosed photographs (Appendices A & B) as evidence that the release has been reset. Information of how (continued)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE VP of Health Services (X6) DATE 1/31/13

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C 139	Continued From page 1 exposing the inside of the box. Staff A present at the observation on 01/10 and 01/11/13 revealed the release for the secured door of the waiting area was designed especially for handicapped patients. The door was equipped with an electronic eye which would release if a person was standing in front of the door. The electronic eye may not release the door if a wheelchair patient was present, thus the need for the manual release button. Staff A verified the automatic release was not in working order and in need of repair. The door did release in case of emergency. 2. Observation of the fire extinguishers on the first and second levels of the facility revealed the facility fire extinguishers had not been inspected monthly as evidenced by lack of documentation on the back of the tag on the extinguishers. In addition, two extinguishers, one on the first floor and one on the second floor, had not been inspected on an annual basis. The tag on the two extinguishers revealed the last annual inspection was in September 2011. Staff A present at the time of the observation verified that no monthly inspection of the extinguishers had been conducted and further verified the two fire extinguishers had not been serviced in 2012. 3. Observation of the second floor surgical waiting area revealed very lightly colored walls. Observation of the seating area revealed darkened and discolored walls behind the chairs in the waiting areas. The discolored areas looked consistent with dirty areas left behind by persons sitting in the chairs who may had leaned or rested against the wall. Staff present on the tour verified the observation. Review of facility documentation on 01/11/13	C 139	to reset the release is on site in the facility and available to the staff in the event it is released again. Corrected 1/28/13. Center Manager will be responsible for Ensuring all doors are functioning as required. Two fire extinguishers, not in use, were located at another facility that had been serviced in 2012. These were put in place of the two extinguishers that were serviced in 2011 (see appendicies C&D). Additionally the service company has scheduled to visit the facility on February 1, 2013 to service the two fire extinguishers in need of service which will be moved to storage. There is now a list of all of the extinguisher locations on file at the site so that future service inspections will include all fire extinguishers in the facility. Corrected by 2/1/13. The cleaning company ~~has~~ cleaned the walls in the facility ~~were cleaned~~ on January 31st. 2013. The cleaning company is adding wall cleaning to their contracted services (cont)	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 139	Continued From page 2 revealed the failure to check fire extinguishers had been identified during a safety check conducted by staff in 2012. Review of the contracted cleaning staff duties revealed cleaning of the waiting area walls was not listed.	C 139	(cont.) for the facility and will begin this service regularly in February 2013. Corrected by 2/1/13. The staff of the ASF were trained on January 17, 2013 on how to do monthly ~~of~~ safety checks by the charge clinician	
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 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	C 201	Monthly safety Checks of the fire extinguishers began in January 2013 and Monthly safety audits of the ASF will ensure that the fire extinguisher checks are happening as required. Item to be corrected by 2/1/13. Maintinance and safety compliance of the fire extinguishers and facility upkeep will be the responsibility of the Center Manager to ensure compliance.	

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C 201	Continued From page 3 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 physician credentialing files and staff interview and verification, the facility failed to ensure the governing body at least every twenty-four months reviewed, updated, and approved the surgical procedures that may be performed at the facility. Two of four physician credentialing files (Staff CC and Staff DD) were affected. The facility provided services for 3618 patients in the year 2012. Findings included: On 01/10/13, Staff A provided four credentialing files for physicians who provided surgical services at the facility. Review of the four credentialing files on that date revealed the following: 1. Review of the credentialing file for Staff CC revealed that privileges were last reviewed and approved by the governing body in November 2010. Interview of Staff A revealed that Staff CC no longer provided services for the facility but had not been released as no longer practicing there. Staff A verified the governing body had taken no action regarding credentialing and approval of privileges for Staff CC. 2. Review of the credentialing file for Staff DD revealed there was no documented evidence of a list of requested and approved procedures to be	C 201	The ASF Governing Body for Planned Parenthood of Greater Ohio is scheduled to meet on February 7, 2013. At that time, Staff CC will be released from providing services at the facility. Also at that meeting the status of Staff DD as the Medical Director will be documented and her privledges will be reviewed based on all of the required criteria. The surgical privledeges at the ASF for Staff DD will be approved or denied. Please see Appendix E as an example of the privledging form that will be used by the ASF Governing Body. Additionally at the February 7th meeting the current surgical procedures performed at the facility will be reviewed and approved. (continued)	

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C 201	Continued From page 4 performed in the facility. Interview of Staff A regarding the lack of requested procedures and approval by the governing body revealed Staff DD was the current medical director. The credentialing file contained no documented evidence to indicate that Staff DD acquired the duties of the medical director. On 01/10/13 at 4:30 P.M. Staff A verified there was no delineation of privileges and indication of governing body approval.	C 201	Going forward, the policy will be in place that the ASF Governing Body will follow this review process at least every 24 months. Items corrected by 2/8/13. The Vice President of Health Services will ensure compliance with the ASF Governing Body policy as part of the PPGOH RQM program.	
C 243	O.A.C. 3701-83-20 (D) Ventilation & Humidity Levels Each ASF shall have appropriate ventilation and humidity levels in order to minimize the risk of infection and to provide for the safety of the patient. This Rule is not met as evidenced by: Based on facility observation and staff interview and verification, the facility failed to ensure appropriate ventilation and humidity levels in order to minimize the risk of infection and to provide for the safety of the patients. The facility provided services for 3618 patients in the year 2012. Findings included: On 01/10/13 tour of the facility was conducted with Staff A and B. Observation of the facility revealed the surgical and recovery areas was located on the second floor of the building. Staff A and B verified the facilities utilized only conscious sedation of the patients and no general anesthesia was used.	C 243		

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C 243	Continued From page 5 Interview of Staff A regarding temperature and humidity levels for the surgical and recovery areas revealed the levels were not monitored by staff. Staff A revealed the corporate policy was that humidity levels were to be monitored. A portable electric heater was observed in the patient recovery area.	C 243	Humidity and temperature ~~meter~~ monitors were purchased and installed in the facility in surgical and recovery areas on January 30, 2013. Staff were trained how to monitor the devices on that day by the VP of Health Services. Daily monitoring of the devices will begin February 1, 2013. Monthly facility safety audits will ensure the regular monitoring of temperature and humidity is happening in the facility as required. See Appendecies F - I for documentation of the purchase and instalation of these devices. The portable electric heater has been removed from the surgical floor. On January 17, 2013 the staff were informed by charge clinician to not bring portable heaters onto the surgical floor or use them in the facility. Item to be corrected by 2/1/13. The center manager will be responsible for ensuring humidity and temperature monitoring is compliant. ~~ser~~	

Appendix A


EXIT
Appendix B

Appendix C


Appendix D
2012

Appendix E

PLANNED PARENTHOOD OF GREATER OHIO

Bedford Heights Surgery Center
25350 Rockside Road
Bedford Heights, OH 44146

East Columbus Surgery Center
3255 East Main Street
Columbus, OH 43213

The Governing Body of Planned Parenthood if Greater Ohio's ambulatory surgical facilities grants privileges to provide abortions up to ____ weeks gestation including medication abortion to _____ M.D.

Privileges are granted for a 24 month period from __ / __ / 20__ through __ / __ / 20__, unless terminated for cause. Privileges are restricted to the services provided at the ASF:

☐ located at 3255 East Main Street Columbus, Oh 43213

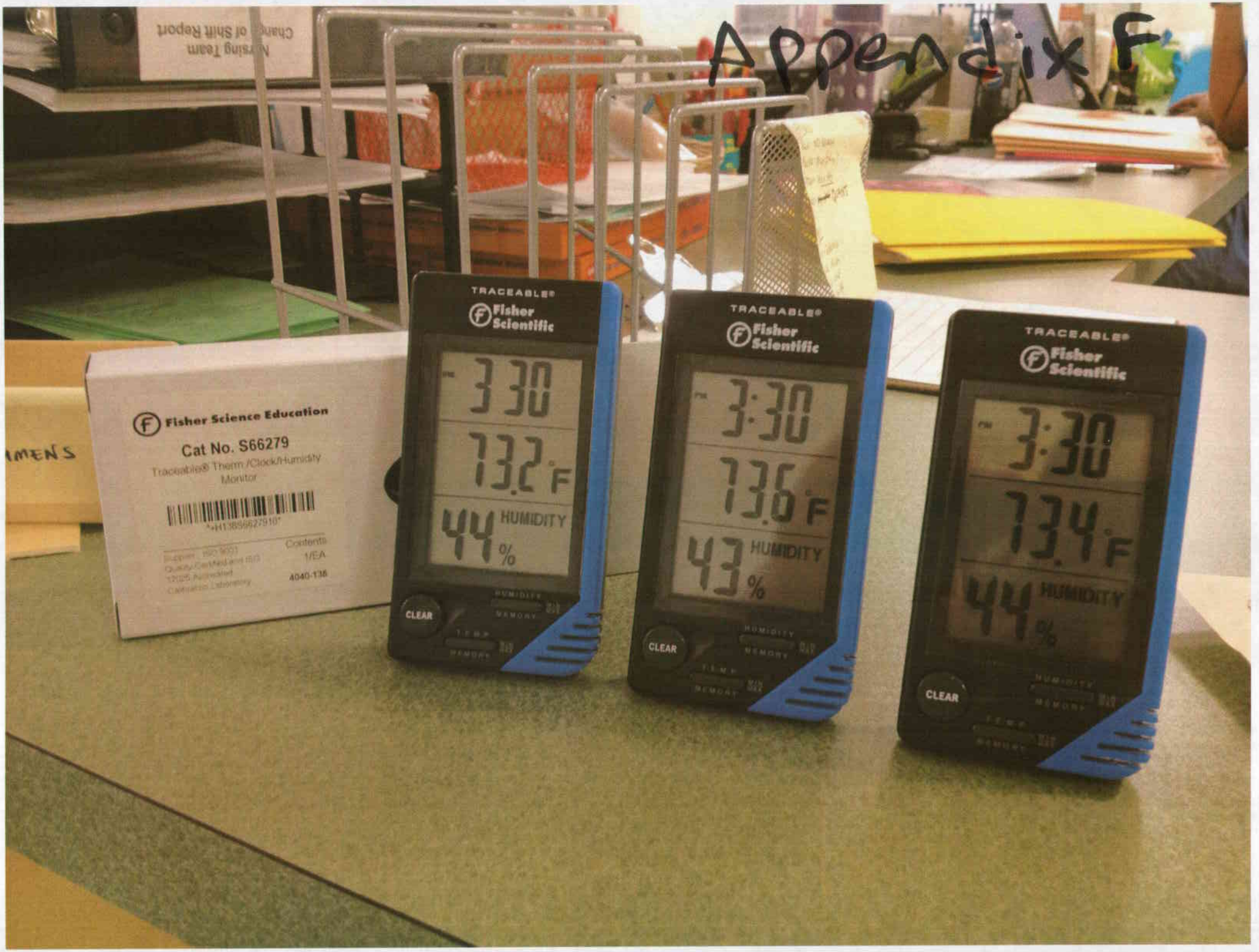
☐ located at 25350 Rockside Road Bedford Heights, Ohio 44146

_____ _____
Authorized Representative of ASF Governing Body — Date

_____
Printed Name

_____
Title

REV 1.31.13


Appendix F
Fisher Science Education
Cat No. S66279
Traceable® Therm /Clock/Humidity Monitor
TRACEABLE®
Fisher Scientific
3:30
73.2 °F
44 HUMIDITY %
CLEAR
TRACEABLE®
Fisher Scientific
3:30
73.6 °F
43 HUMIDITY %
CLEAR
TRACEABLE®
Fisher Scientific
3:30
73.4 °F
44 HUMIDITY %
CLEAR

Appendix G

Appendix H

ilac-MRA ACCREDITED Calibration Certificate No. 1750.01

Calibration complies with ISO/IEC 17025, ANSI/NCSL Z540-1, and 9001

Cert. No.: 4040-4537628

Traceable® Certificate of Calibration for Therm./Clock/Humidity Monitor

Manufactured for and distributed by: Fisher Scientific, P.O. Box 1768, Pittsburgh, PA 15230

Instrument Identification:

Model: S66279 S/N: 122444558 Manufacturer: Control Company

Standards/Equipment:

Description	Serial Number	Due Date	NIST Traceable Reference
Chilled Mirror Hygrometer	31874/H2048MCR	5/24/13	10100
Digital Thermometer	90969500	9/14/12	4000-3893285
Non-contact Frequency Counter	26.6 2025	3/06/13	1000313632

Certificate Information:

Technician: 104 Procedure: CAL-17 Cal Date: 8/03/12 **Cal Due: 8/03/14**

Test Conditions: 26.0°C 41.0 %RH 1012 mBar

Calibration Data: (New Instrument)

Unit(s)	Nominal	As Found	In Tol	Nominal	As Left	In Tol	Min	Max	±U	TUR
°C		N.A.		23.56	23.6	Y	22.6	24.6	0.06	>4:1
%RH		N.A.		41.840	43	Y	34	50	1.300	>4:1
Sec/24hr		N.A.		0.000	0.300	Y	-8.640	8.640	0.130	>4:1

This Instrument was calibrated using Instruments Traceable to National Institute of Standards and Technology.

A Test Uncertainty Ratio of at least 4:1 is maintained unless otherwise stated and is calculated using the expanded measurement uncertainty. Uncertainty evaluation includes the instrument under test and is calculated in accordance with the ISO "Guide to the Expression of Uncertainty in Measurement" (GUM). The uncertainty represents an expanded uncertainty using a coverage factor k=2 to approximate a 95% confidence level. In tolerance conditions are based on test results falling within specified limits with no reduction by the uncertainty of the measurement. The results contained herein relate only to the item calibrated. This certificate shall not be reproduced except in full, without written approval of Control Company.

Nominal=Standard's Reading; As Left=Instrument's Reading; In Tol=In Tolerance; Min/Max=Acceptance Range; ±U=Expanded Measurement Uncertainty; TUR=Test Uncertainty Ratio; Accuracy=±(Max-Min)/2; Min = As Left Nominal(Rounded) - Tolerance; Max = As Left Nominal(Rounded) + Tolerance; Date=MM/DD/YY

Nicol Rodriguez, Quality Manager

Wallace Berry, Technical Manager

Maintaining Accuracy:

In our opinion once calibrated your Therm./Clock/Humidity Monitor should maintain its accuracy. There is no exact way to determine how long calibration will be maintained. Therm./Clock/Humidity Monitors change little, if any at all, but can be affected by aging, temperature, shock, and contamination.

Recalibration:

This device was calibrated using a single test point. Should additional test points be required, please contact Control Company for factory calibration and re-certification traceable to National Institute of Standards and Technology.

CONTROL COMPANY 4455 Rex Road Friendswood, TX 77546 USA
Phone 281 482-1714 Fax 281 482-9448 service@control3.com www.control3.com

HENRY SCHEIN®

Appendix I

INVOICE#	INVOICE DATE
9763679-01	1/29/13

CUSTOMER#	BOX#	PAGE
318080	1 of 1	

CUSTOMER PO#
BDADT24012813

HSI ORDER#	ORDER DATE
06870864	01/29/13

BOX CONTENT LIST

SS
HO
IL Planned Parenthood
PD 25350 Rockside Rd
TT Greater OH
OO Bedford Heights OH 44146-7110

B
I
L Planned Prnthd Of Grtr OH
L 444 W Exchange St
T Greater OH
O Akron,OH 44302-1711

LOCATION CODE	SHIPPED QTY	EXP. CODE	UNIT SIZE	DESCRIPTION & STRENGTH	ITEM CODE	LINE NO.
E-74-08-5U	3		EA	THERMOMETER/CLOCK/HUMIDIT MONITOR S66279	116-5313	1
				MIDWEST D.C. Dea#: RH0162494		
				HENRY SCHEIN INC. 5315 WEST 74TH STREET INDIANAPOLIS,IN 46268		

MH
013013

OFFICE USE ONLY

BATCH# 46201-002

Size:# 2

WT - 1

FREIGHT INSTRUCTIONS OH3 3679

DESK AUDIT

AH Form Approved
4/1/2013

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
1014AS	A. Building B. Wing	4/1/2013

Name of Facility	Street Address, City, State, Zip Code
PLANNED PARENTHOOD BEDFORD HEIGHTS REGIONAL MEI	25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix C0139 Reg. # O.A.C. 3701-83-10 (B) LSC	04/01/2013	ID Prefix C0201 Reg. # O.A.C. 3701-83-16 (B) LSC	04/01/2013	ID Prefix C0243 Reg. # O.A.C. 3701-83-20 (D) LSC	04/01/2013
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

FILE COPY

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
✓	TLU	4/4/13	[illegible]	4/1/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
1/11/2013

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

Planned Parenthood® of Greater Ohio | WE'RE HERE.℠

January 31, 2013

OHIO DEPT OF HEALTH
DQA-BCHCFS
2013 FEB -5 P 1:26

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

Dear Wanda,

Planned Parenthood of Greater Ohio received the ODH inspection report for our ambulatory surgery center located at 253530 Rockside Road, Bedford Heights, Ohio on January 24th, 2013. The site review was conducted on January 11, 2013.

Enclosed is our Plan of Correction written on the required Statement of Deficiency form. We have also enclosed documentary evidence of corrective action as appropriate. We hope that this evidence of corrective action will be sufficient and that a repeat onsite visit will not be required.

Please notify me by phone at 216-961-8804 x 1201 at your earliest convenience about the acceptability of our plan of correction. We hope that you can recommend the appropriate licensure action to the licensure administrator as soon as possible.

Sincerely,

Regan Clawson
Vice President, Health Services

Enclosures