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:

Lisa Perks, Administrator
Central Ohio Women's Clinic, Inc.
206 East State Street
Columbus, OH 43215

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X L Hutton ☐ Agent ☐ Addressee

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

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

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

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

2. Article ... *(Transf* 7010 0290 0003 0726 4683

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

Approved 3/28/11

PRINTED: 03/14/2011
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
	0530AS	A. BUILDING _____ B. WING _____	03/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL OHIO WOMEN'S CLINIC, INC	3255 EAST MAIN STREET COLUMBUS, OH 43213

Last Date 4/17/11

(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 CMu/KHo Inspection Inspection Administrator: Lisa Perks County: Franklin Capacity: 2 Operating Rooms The following violation was issued as a result of the inspection of an Ambulatory Surgery Center completed on 3/8/11.	C 000		
C231	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 a tour of the facility and staff interview it was determined that the facility failed to ensure that expired medications were not available for patient use. The patient census for 2010 was 1,412. Findings include: The facility tour was conducted on 03/08/11 at	C231	The expired medications have been disposed of in compliance with state and federal laws and regulations. Current procedures were reviewed, including the Risk and Quality Assurance Monthly Report Form, which includes a medication inventory. The Monthly Report From was deemed adequate and staff error was identified as the root problem. To eliminate this deficiency, a staff training was identified as the corrective action. Staff training will occur no later than April 17th, 2011 with all of Central Ohio Women's Center (COWC) direct care staff. The Risk and Quality Assurance Manager will review the proper use of the Monthly Report Form. For the next six months, a monthly audit will be conducted by the Health Center Manager to insure the correct use of the Monthly Report Form, which includes proper identification and disposal of expired medications. 4/17/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0530AS	A. BUILDING _____ B. WING _____	03/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL OHIO WOMEN'S CLINIC, INC	3255 EAST MAIN STREET COLUMBUS, OH 43213

(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
C231	Continued From page 1 10:20 AM with Staff A. The medication supply closet contained 23 bottles of an antibiotic that had expired on 10/1/10. This was confirmed with Staff A at 10:35 AM.	C231		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
0530AS	CENTRAL OHIO WOMEN'S CLINIC, INC

Type of Survey (select all that apply)

2								

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A								

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 25760	03/08/2011	03/08/2011	0.25	0.00	6.75	0.00	2.25	0.75
2. 27700	03/08/2011	03/08/2011	0.25	0.00	5.50	0.00	4.00	0.25
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 1.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 1.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

0590AS

Copy

Planned Parenthood®
of Central Ohio, Inc.

May 18, 1999

Edsel Cotter
Senior Operations Officer
Grant/Riverside Methodist Hospitals
Grant Medical Center Campus
111 South Grant Avenue
Columbus OH 43215

Dear Mr. Cotter:

Enclosed please find two copies of the revised Transfer Agreement between Grant Medical Center and Planned Parenthood of Central Ohio, Inc./Central Ohio Women's Center. The Agreement has been amended only to the extent of reflecting the new address of the joint PPCO/COWC facility.

If you see no additional changes that need to be made, please sign both copies and return them to us. I will then sign them and return a completed copy for your records.

Sincerely,

Judith B. Fountain
Executive Director

JBF:lhk

cc: Chet Porembski, Assistant General Counsel

206 EAST STATE STREET COLUMBUS, OHIO 43215 614/224-2235 FAX 614/224-2267

1932

TRANSFER AGREEMENT

Transfer Agreement made this May 25 day of _____, 1999, by and between Grant/Riverside Methodist Hospitals – Grant Medical Center Campus, hereinafter referred to as "The Hospital", a not-for-profit corporation and fully accredited hospital, created under the laws of the State of Ohio, with hospital facilities located in the County of Franklin and State of Ohio, and located at 111 South Grant Avenue, Columbus, Ohio; and Planned Parenthood of Central Ohio/Central Ohio Women's Center, hereinafter referred to as "PPCO/COWC", located at 3255 East Main Street, Columbus, Ohio.

WITNESSETH:

WHEREAS, PPCO/COWC is organized and operated as an ambulatory surgical facility under Ohio Administrative Code Section 3701-83-15; and

WHEREAS, PPCO/COWC desires to achieve such compliance and is required to enter into an appropriate transfer agreement for support services with a hospital that is registered with the Ohio Department of Health under Ohio Revised Code §3701.07; and

WHEREAS, The Hospital has the capacity of providing emergency back-up support services to PPCO/COWC, including, but not limited to medical, diagnostic, emergency, and other supportive services; and

WHEREAS, PPCO/COWC and the Hospital agree that it is to their mutual advantage, and the advantage of the community they serve, that they enter into an agreement whereby the Hospital provides support services to PPCO/COWC;

NOW, THEREFORE, in consideration of the foregoing and other good and valuable considerations hereinafter contained, the parties hereto agree as follows:

FIRST: TERM OF AGREEMENT

This Agreement, when signed by the Administrator of the Hospital and the Executive Director of Planned Parenthood of Central Ohio/COWC, shall become effective as of the date first above mentioned and shall continue in effect for a term of one (1) year from said date, and will automatically renew for one (1) year periods, unless either party to this Agreement gives notice to the other party at least thirty (30) days prior to the termination date at the business address first above written. This Agreement may also be terminated at any time by either party, with or without cause, upon 30 days advance notice to the other party.

SECOND: OBLIGATIONS OF GRANT/RIVERSIDE HOSPITALS, GRANT MEDICAL CENTER CAMPUS

1. The Hospital shall provide the required back-up support services to patients referred to the Hospital by PPCO/COWC when space is available for such patients and Hospital has the resources and expertise required to treat such patients.

2. In each instance of admission all usual reasonable established admission policies, procedures and conditions of the Hospital must be met.

3. With appropriate patient consent secured by PPCO/COWC, the Hospital shall provide to PPCO/COWC information regarding results of any diagnostic procedures and any such medical information as is appropriate and necessary in order to keep records updated. This includes, but is not limited to, timely returns of copies of PPCO/COWC referral forms.

4. The Hospital shall be entitled to, and PPCO/COWC shall in no way interfere with, the collection of fees from patients to whom the Hospital has rendered services pursuant to this Agreement.

5. The Hospital shall provide insurance or shall fund and maintain an adequate self insurance reserve as shall be necessary to insure the Hospital and its employees against any claim or claims for damage arising by reason of personal injury or death occasioned directly or indirectly in connection with the performance of any service by the Hospital.

6. The Hospital shall indemnify and hold PPCO/COWC harmless against any and all claims or liabilities resulting from any action by the Hospital, its staff physicians, or its employees, which arise out of services rendered by the Hospital to patients referred to the Hospital pursuant to this Agreement.

7. Non-discrimination: The Hospital agrees to comply with all applicable Federal, State, and Municipal laws and executive orders prohibiting discrimination. No person shall, on the grounds of race, creed, color, sex, national origin, age, marital status, disability, or ability to pay, be excluded from participating in, be denied the benefits of, or be otherwise subjected to discrimination under this Agreement.

THIRD: OBLIGATIONS OF CENTRAL OHIO WOMEN'S CENTER

1. PPCO/COWC shall identify and refer patients to the Hospital upon the recommendation of the patient's attending physician or PPCO/COWC's medical director that such transfer is medically appropriate. However, no

patient shall be admitted until such patient is accepted for care by a staff member of the Hospital with admitting privileges.

2. PPCO/COWC shall transfer promptly such medical and other information as is relevant to proper care by the Hospital including medical, social, nursing, and other care plans.

3. A release form will be obtained by PPCO/COWC from all patients referred by PPCO/COWC to facilitate the regular flow of information between the Hospital and PPCO/COWC.

4. PPCO/COWC shall provide insurance or shall fund and maintain an adequate self insurance reserve as shall be necessary to insure PPCO/COWC and its employees against any claim or claims of damage arising by reason of personal injury or death occasioned directly or indirectly in connection with the performance of any services by PPCO/COWC.

5. PPCO/COWC shall indemnify and hold the Hospital harmless against any and all claims or liabilities resulting from any action by PPCO/COWC or its employees, which arise out of services rendered by PPCO/COWC to patients referred to the Hospital pursuant to this Agreement.

6. Non-discrimination: PPCO/COWC agrees to comply with all applicable Federal, State, and Municipal laws and executive orders prohibiting discrimination. No person shall, on the grounds of race, creed, color, sex, national origin, age, marital status, disability, or ability to pay, be excluded from participating in, be denied the benefits of, or be otherwise subjected to discrimination under this Agreement.

FOURTH: WRITTEN NOTICE OF PROVISION

Any and all notices, designations, consents, offers, acceptances, or any other communication provided for herein shall be given in writing by registered or certified mail which, subject to change upon written notice, shall be addressed to the parties as follows:

Judith B. Fountain
Executive Director
Planned Parenthood of Central Ohio
206 East State Street
Columbus, Ohio 43215

Edsel Cotter
Senior Operations Officer
Grant/Riverside Methodist Hospitals
Grant Medical Center Campus
111 South Grant Avenue
Columbus, Ohio 43215

NOTWITHSTANDING any other provision in this Agreement, each facility remains responsible for ensuring that any service provided pursuant to this

Agreement complies with all pertinent provisions of Federal, State, and local statutes, rules, and regulations. The governing authority or operator of each facility shall maintain a written copy of this Agreement in the administrator's office and available to the Ohio Department of Health. For each admission to, or transfer or discharge from, either the Hospital or PPCO/COWC, the governing authority or operator of each such facility shall assure that:

a) The personal, alternate, or staff physician requests or agrees to the admission, transfer, or discharge unless the patient signs out or is signed out against medical advice; and
b) That admission information is obtained and transfer and discharge information is furnished as required by the provision of Ohio laws and regulations.

FIFTH: MISCELLANEOUS

1. The parties agree that all patient transfers will be made in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1986.

2. The parties specifically acknowledge that their relationship is one of independent contractors and nothing herein shall be construed as creating a relationship of employment, agency, joint venture, or partnership.

3. This Agreement may not be assigned by either party without the written consent of the other party.

IN WITNESS WHEREOF, the participants have hereunto set their hand and seals the date and year first above written.

Grant/Riverside Methodist Hospitals
Grant Medical Center Campus

BY: _____
Edsel Cotter
Senior Operations Officer

Planned Parenthood of Central Ohio
Central Ohio Women's Center

BY: _____
Judith B. Fountain
Executive Director

0530AS

Inspection Results
☑ Compliance ☐ Non Compliance
_____ Days to Comply

Division of State Fire Marshal
Code Enforcement Bureau
8895 East Main Street
Reynoldsburg, Ohio 43068
614-728-5460

COPY

Facility I.D. # 30-25-0530

County FRANKLIN

Fire Department Col. F.D.

Recommended Action (if necessary)
☐ Issue Notice of Violation
☐ Issue Fire Marshal Citation 41
☐ Issue Fire Marshal Citation 42
☐ Issue Notice of Opportunity for Hearing

☑ Annual
☐ Complaint
☐ One Time Inspection
☐ Permit No. _____

☐ State Facility
☐ New Construction
☐ Fire Equip. Test
☐ Call for Final-Not Ready

Fire Safety Inspection Report

Property Name: Central Ohio Women's Center			Telephone
Address/City/Zip: 3255 E. Main St Columbus 43213			Contact Person: Sarah Courtney
Responsible Person: Planned Parenthood of Central Ohio			Telephone: 614 222 3531
Date: 1-11-11	Time Arrived: 9:45	Time Departed: 10:45	Building No.: 1
Specific Property Use: Clinic	OBC Use Groups: B	Number of Stories: 1	Total Floor Area/Sq. Ft.
Maximum Occupant Load	Number of Exits: 3	Year of Construction/Renovation: 1999	

Portable Fire Extinguishers Operational: ☑ Yes ☐ No ☐ None — Date of Last Inspection: 8/10
Inspected by: R. Clafins — Certification No.: 54 651155

Special Hazard System Type: ☐ Dry Chemical ☐ Wet Chemical ☐ Other _____
Operational: ☐ Yes ☐ No ☒ None — Date of Last Inspection
Inspected by — Certification No.

Sprinkler System Type: ☑ Limited Area ☐ 13-Wet ☐ 13 Dry ☐ 13 Preaction ☐ 13 Deluge ☐ 13D ☐ 13R
Operational: ☑ Yes ☐ No ☐ None — Date of Last Inspection
Inspected by — Certification No.

Static Pressure ☐ Gauge ☐ Tag ☐ Report | Residual Pressure ☐ Gauge ☐ Tag ☐ Report | Air Pressure ☐ Gauge ☐ Tag ☐ Report

Trip Test Date Tripped _____ _____ seconds for water to outlet | Inspector Test ☐ Activated at Inspection ☐ Report _____ seconds to alarm | Standpipe _____ date last tested; Fire Pump _____ date last tested

Fire Alarm System Type: ☐ Manual ☒ Automatic Detection
Operational: ☒ Yes ☐ No ☐ None — Date of Last Inspection: 8/10
Inspected by: Stanley 8857628699 — Certification No.

Single Station Smoke Detectors Type: ☐ Battery ☐ Electric Operational: ☐ Yes ☐ No ☒ None
Inspected Weekly/Monthly ☐ Yes ☐ No

Fire Drills Documentation Available: ☒ Yes ☐ No — Conducted in Accordance with OFC ☒ Yes ☐ No
Tornado Safety Documentation Available: ☒ Yes ☐ No — Conducted in Accordance with OFC ☒ Yes ☐ No

Remarks/Violations Checked Drill records & maintence logs. Inspected patient waiting, exam & treatment rooms, storage, HVAC & offices. Checked electrical cords, switch/outlets, breaker panels, tested exit/emergency lights, fire/exit doors. Checked exitways, aisle ways & discharges.

☐ No Violations Noted at Time of Insp — Accompanied by: Dee Sec — ☐ Continuation Sheet Attached

Owner/Occupant Signature: _____ Date: _____
Inspector: Paige Andrews Date: 1-11-11 Certification No. 0040295
Supervisor: _____ Date: _____

Distribution: White-Office Yellow-Facility Pink-Inspector

10/28/2005 COM

Central Ohio Women's Clinic

10000435 05304S

CPT code

COPY

APPT TIME	
VISIT CODE	

ACCOUNT	PHONE	BIRTH	SEX	SERV.DATE

ADDRESS	FINANCIAL CLASS	PT. BALANCE	CODE

METHOD AT END OF VISIT	METHOD AT END OF VISIT	LANGUAGE
01 NONE	01 PREGNANT	1 LIMITED ENGLISH PR
02 ABSTINENCE	02 SEEKING PREGNANCY	2 ENGLISH
04 CONDOM	03 THINKS CAN'T GET	
05 DEPO PROVERA	05 PARTNER WON'T ALL	
08 IUD	06 SIDE EFFECTS FROM	
11 ORAL	07 RELYING ON PARTNE	
14 STERILIZATION FEM	08 NOT EXPECT TO HAV	
20 NUVARING		

EDUCATION/COUNSELING			
00365		000 NEW PATIENT EDUCATION	0.00
00337		99203 NEW PATIENT EDUCATIO	130.00
00375		76830 ULTRASOUND-INTERNAL	170.00
00322		36415 VENIPUNCTURE-RH FACT	0.00
00319		83036 HEMOGLOBIN	0.00
00364		00 PHYSICIAN CONSULT/24 HR	0.00
00366		0 ESTABLISHED PATIENT EDUC	0.00
00338		99213 ESTABLISHED PATIENT	90.00
00375		76830 ULTRASOUND-INTERNAL	170.00
00319		83036 HEMOGLOBIN	0.00
00364		00 PHYSICIAN CONSULT/24 HR	0.00
MEDICAL NEW			
00024		99201 NEW, LEVEL 1	55.00
00072		99202 NEW, LEVEL 2	90.00
00073		99203 NEW, LEVEL 3	130.00
00074		99204 NEW, LEVEL 4	200.00
MEDICAL ESTABLISHED			
00080		99212 EST, LEVEL 2	65.00
00081		99213 EST, LEVEL 3	90.00
00082		99214 EST, LEVEL 4	130.00
ADDITIONAL PROCEDURES			
00322		36415 VENIPUNCTURE-RH FACT	0.00
00370		0 VENIPUNCTURE-BETAS	0.00
00325		76816 ULTRASOUND-REPEAT	0.00
PREGNANCY TESTS			
00121		81025 PREG TEST NEGATIVE	20.00
00122		81025 PREG TEST POSITIVE	20.00
00379		81025 PREG TEST NEG NO CHA	0.00
00320		81025 PREG TEST 0 CHARGE	0.00

ABORTIONS			
00440		59840 AB TO 11.6	600.00
00441		59840 AB 12-12.6	700.00
00442		59840 AB 13-13.6	800.00
00339		01966 ANESTH, INDUCED AB P	200.00
00363		0 GONORRHEA AND CHLAMYDIA	0.00
00376		0000 DOXYCYCLINE #14-NO CH	0.00
00353		0 MEDICAL ABORTION PANEL	0.00
00317		S0199 MEDICAL ABORTION	600.00
00335		S0190 MIFEPRISTONE	0.00
00336		S0191 MISOPROSTOL	0.00
00363		0 GONORRHEA AND CHLAMYDIA	0.00
00376		0000 DOXYCYCLINE #14-NO CH	0.00
NO CHARGE VISITS			
00364		00 PHYSICIAN CONSULT/24 HR	0.00
00084		99024 POST SURGICAL ABORTI	0.00
00318		99024 POST MEDICAL ABORTIO	0.00
00372		59812L INCOMPLETE ABORTION	600.00
00373		59812C INCOMPLETE ABORTION	600.00
00374		59812M INCOMPLETE ABORTION	600.00
00384		59820L MISSED ABORTION LOC	0.00
00385		59820C MISSED ABORTION SED	0.00

IMPLANON VISITS			
00380		0 IMPLANON-LARC	0.00
00381		0 IMPLANON INSERT-NO CHARG	0.00
00382		0 IMPLANON REMOVAL-NO CHAR	0.00
00383		0 IMPLANON CHECK-NO CHARGE	0.00
IUC VISITS			
00328		58300 IUC INSERT-NO CHARGE	0.00
00332		58301 IUC REMOVAL-NO CHARG	0.00
00378		0000 IUC CHECK-NO CHARGE	0.00
00334		J7300 IUC-MIRENA-LARC	0.00
00333		J7300 IUC-PARAGARD-LARC	0.00
MEDICATIONS			
00341		X1400 AMOXICILLIN #21	15.00
00342		X1400 BACTRIM #6	15.00
00343		X1400 BACTRIM #14	15.00
00272		X1400 DOXYCYCLINE 14	15.00
00376		0000 DOXYCYCLINE #14-NO CH	0.00
00344		X1400 FLUCONAZOLE	10.00
00095		J7140 MTZ 500MG #4	15.00
00094		J7140 MTZ 500MG #14	20.00
00274		X1400 ZITHROMAX	60.00
00377		00000 ZITHROMAX-NO CHARGE	0.00
00437		96372 INJECTION	35.00
00369		0 RHOGAM PANEL	0.00
PPCOH PROVIDERS			
00405		0 MICHELLE ISLEY	0.00
00406		0 LISA KEDER	0.00
00407		0 CATHERINE CANSINO	0.00
00408		0 PABLO PONS	0.00

CURRENT	30 DAYS	60 DAYS	90 DAYS	120 DAYS

PREVIOUS DIAGNOSIS	RETURN: DAYS___ WEEKS___ MONTH_____ NEXT APPT:_____

CASH ____ CHECK ____ CREDIT CARD ____	COPAY	MISC. DATE	AFTERCARE DATE

PREVIOUS BALANCE	
TODAY'S CHARGE	
ADJUST	
TODAY'S PAYMENT	
TOTAL BALANCE	

OHIO DEPARTMENT OF HEALTH

246 North High Street
Columbus, Ohio 43215

614/466-3543
www.odh.ohio.gov

John R. Kasich / Governor

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

March 15, 2011

Lisa Perks, Administrator
Central Ohio Women's Clinic, Inc.
206 East State Street
Columbus, OH 43215

RE: Central Ohio Women's Clinic, Inc - License: 0530AS
Survey Completed on March 8, 2011

Dear Ms. Perks:

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.

FILE COPY

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/BSN

Wanda L. Iacovetta, R.N.
Non Long Term Care Unit Supervisor
Bureau of Community Health Care Facilities and Services
Division of Quality Assurance

WLI/cc

Enclosure: STATE FORM Licensure

FILE COPY

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	COWC				NPI 1568472207
Address	3255 E. Main Street				
City/County	Columbus / Franklin Co.				Zip +4: 43213
Mailing Address	206 E. State Street				
City/County	Columbus / Franklin Co.				Zip +4: 43215
E-Mail Address	LonnB@PPOH.org or PerksL@PPOH.org				
Administrator Name	Lisa Perks				
	Number:	Type:	Eff. Date:	Exp. Date:	Date Began Employment With Facility:
Other Information	Telephone: ( )			Fax: ( )	
	Provider No.: —	Licensure No.: 0530A5		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 N/A

Fiscal Year 12/31

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: 3-8-11	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:	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: Beth Lonn	Date: 3/8/11