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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF HEALTH CARE SERVICES

MIKE ZIMMER
ACTING DIRECTOR

October 7, 2014

Women's Center of Southfield (636949)
C/O Pam DiMaggio
28505 Southfield Road
Lathrup Village, MI 48076

SUBJECT: State Licensure Survey Findings for Above-Referenced Agency

Dear Pam DiMaggio:

A fourth post annual follow up survey was conducted on September 30, 2014 at Women's Center of Southfield located at 28505 Southfield Road, Lathrup Village, MI 48076. (Please refer to previous survey letters dated January 8, 2014, April 29, 2014, July 3, 2014, and August 8, 2014.)

Participants included:

- Pam DiMaggio, Office Manager, Women's Center of Southfield
- Dr. Jacob Kalo MD, Medical Director, Women's Center of Southfield
- Andrew Schefke, State Health Care Surveyor, MDLARA
- Pam Lindsey RN, State Health Care Surveyor, MDLARA

After observance of provision of patient care, along with a thorough examination of documents provided, the surveyors found the facility had made corrections related to rules R325.3840 and R325.3847. However, additional survey findings found the facility to not be in compliance with the following state licensing rules:

R325.3825

- No hand hygiene was observed being performed by Dr. Kalo. (Not before or after ultrasound exam, Not before gloving for procedure or after removing gloves at end of procedure)
- No vaginal prep done. (Betadine was available in OR)
- No inspection of the POC (Productions of Conception) was observed by Dr. Kalo or qualified person assisting the physician prior to disposing of the pathologic specimen by the medical assistant.
- Patient's belongings-purse, shoes, and clothing stored in an open plastic basket in OR during procedure.
- During procedure the RN was observed going into the medication supply cupboard with contaminated gloves. The RN drew medication from a multidose vial into an unlabeled syringe and gave it to Dr. Kalo who administered it, without the RN showing him the vial for verification of medication provided.

- No hand hygiene observed by Medical Assistant after removing gloves after washing dirty instruments used during the procedure.
- At end of procedure the Medical Assistant used a common bucket (kept in the OR) containing tap water to suck fluid through the bloody used suction aspiration tubing from the procedure. (Staff confirmed the bucket contained no disinfectant, and the bucket was being used for multiple patients.)
- Following the procedure Dr. Kalo was observed handling the bloody used suction tip and tubing in the instrument cleaning sink without gloves or proper PPE.

R325.3828

- Failure of Dr. Kalo to fulfill requirements of MCL 333.17015, Subsection 10 (6) a through ii related to patient's signature on acknowledgement and consent form and (8) related to ultrasound exams.
- No oral discussion with patient occurred. (No discussion of consent, risks, complications or other requirements of MCL 333.17015, Subsection 10 (6) a-ii occurred prior to the procedure)
- (8) Failure of Dr. Kalo to provide patient with an opportunity to view the active ultrasound image.

R325.3831

- Failure of facility to maintain a transfer log with documentation of post op care & case outcome
- Case identified on previous survey of patient post procedure transfer due to suspected uterine perforation. Should be in transfer log. No log established or provided to surveyors.

R325.3832

- Failure to obtain written hospital transfer agreement for patients requiring transfer for emergency care

R325.3836

- Failure to develop facility policies regarding History & Physicals, Medical Record Retention, and Verbal/Standing orders

R325.3838

- Failure of medical director to make arrangements for impartial medical surveillance and review of quality of care provided at the facility
- Failure of facility to have an infection control program or quality program and failure to track infections.

R325.3842

- Failure to remove opened expired vial of medication from medication supply cupboard
- Failure to remove defibrillator & ventilator not being maintained from OR

R325.3843

- Failure to offer and provide beverages and light nourishments to patients

R325.3844

- Patient restroom adjacent to PACU was marked out of order. Staff indicated that the toilet was not working. No work order to repair the toilet could be provided.

R325.3860

- Failure to provide a nurse call system in the PACU

R325.3877

- Failure to remove a Biohazard Storage Bin from OR when greater than 2/3 full

Based on survey findings, it was determined that the facility is not in compliance with MCL 333.20801 through 333.20821 and/or the Michigan Administrative Rules for freestanding surgical outpatient facilities R325.3801 through R325.3877. Please note that any enforcement actions due to repeated surveys with continuous citations will be sent under a separate cover.



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