Approved Recommend

PRINTED 01/03/2017 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED 1081AS B. WING 11/29/2016 YAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NORTHEAST OHIO WOMEN'S CENTER 2127 STATE ROAD CUYAHOGA FALLS, OH 44223 SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL SDEE:X ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X5) COMPLETE TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) C 999 Initial Comments C 000 Licensure Compliance Inspection Administrator: Sheri Grossman County: Summit Number of ORs: One The following violations are issued as a result of the licensure compliance inspection completed on 11/29/16. C 104 O.A.C. 3701-83-03 (F) Governing Body C 104 C 104 - Governing Body 12/15/2016 The HCF shall have an identifiable governing body responsible for the following: 1. This deficiency will be corrected with (1) The development and implementation of the following measures: policies and procedures and a mission statement a. A template will be used to properly for the orderly development and management of the HCF: document meeting notes of the Governing Board. (2) The evaluation of the HCF's quality assesment and performance improvement program on an annual basis; and 2. The following measures have been taken to ensure that the deficiency does (3) The development and maintenance of a disaster preparedness plan, including evacuation not recur: procedures. a. The Clinic Manager will review all minutes and sign off for completion. Ohio Department of Health PUSUPPLIER PRESENTATIVE'S SIGNATURE LABORATORY DIRECTOR'S OF PROVIDE

Ohic Dept Health

PRINTED: 01/03/2017 **FORM APPROVED** Onio Dept Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 1081AS B. WING 11/29/2016 NAME OF PROMOER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD NORTHEAST OHIO WOMEN'S CENTER **CUYAHOGA FALLS, OH 44223** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) **T**43 CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) C 104 Continued From page 1 12/15/2016 C 104 C 104 - Governing Board (Continued) This Rule is not met as evidenced by: 3. The performance will be monitored Based on review of governing body minutes and to ensure solutions are permanent staff interview the facility failed to ensure the governing body evaluated the facility's quality through: assessment and performance improvement a. Quality assurance audits program (QAPI) on an annual basis. This could conducted by a 3rd party consulting potentially affect all patients receiving care in the facility. A total of 435 procedures were performed in the most recent twelve months. 4. This deficiency was corrected on Findings include: 12/15/2016. On 11/29/16 at 5:30 PM, a review was conducted of the governing body minutes, along with an interview of Staff A. According to this review of minutes, the last Governing Board meeting was on 02/03/15. There was no evidence of an annual review by the Governing Body of the facility's QAPI program plan policy in 2015 or 2016. This finding was confirmed with Staff A during an interview on11/29/16 at 5:30 PM. C 114 O.A.C. 3701-83-07 (A) Patient Care Policies C 114 C 114 - Patient Care Policies 12/23/2016 1. This deficiency will be corrected with The HCF shall develop and follow comprehensive the following measures: and effective patient care policies that include the following requirements: a. Policies will be developed regarding if the policy they sent is acceptable patient care including: treatment, privacy, (1) Each patient shall be treated with

Ohio Department of Health

dignity and

personal care needs:

consideration, respect, and full recognition of

individuality, including privacy in treatment and

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personal care, withdraw of consent,

records management, and financial

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records. (See Amendment B).

Ohio Dept Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED 1081AS B. WING 11/29/2016 WHE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NORTHEAST OHIO WOMEN'S CENTER 2127 STATE ROAD CUYAHOGA FALLS, OH 44223 (4) (D SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL odE-X ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X5) COMPLETE 743 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) C 114 Continued From page 2 C 114 C 114 - Patient Care Policies 12/23/2016 (2) Each patient shall be allowed to refuse or (Continued) withdraw consent for treatment; (3) Each patient shall have access to his or her 2. The following measures have been medical record, unless access is specifically taken to ensure that the deficiency does restricted by the attending physician for medical not recur: reasons. a. The Governing Board will review the policy and procedures manual on a (4) Each patient's medical and financial records shall be kept in confidence; and annual basis for approval. (5) Each patient shall receive, if requested, a 3. The performance will be monitored to detailed explanation of facility charges including ensure that the solutions are permanent an itemized bill for services received. through: a. The P&P will be audited on a quarterly basis by a 3rd party consulting firm for deficiencies. b. Any deficiencies identified will be This Rule is not met as evidenced by: Based on review of policies and staff interviews, referred to the Governing Board for the facility failed to develop comprehensive and development and review. effective patient care policies in regard to patients' treatment, a patients' refusal or 4. This deficiency was corrected on withdrawal of consent for treatment, for access to 12/23/2016. medical records, for maintaining patients' medical and financial information in a confidential manner, and for providing a detailed explanation of facility charges if requested by a patient. This could potentially affect all patients receiving care in the facility. A total of 435 procedures were performed in the most recent twelve months. Findings include: On 11/29/16 at 7:00 PM, a review of facility policies revealed the facility lacked policies in regard to patients' treatment, for patients' refusal or withdrawal of consent for treatment, for access

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STATEMENT OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE COMP	SURVEY
		1081AS	B. WING _		4415	0/2042
NAME OF PRO	MDER OR SUPPLIER	STREET AL	DRESS, CITY	STATE, ZIP CODE	11/2	9/2016
NORTHEAS	T OHIO WOMEN'S	S CENTER 2127 STA	TE ROAD GA FALLS,			
TA S	CAUD DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	AE-	(X5) COMPLETE DATE
C 114 Cc	ontinued From pa	ige 3	C 114	DEFICIENCY		
me me of Th at	edical and finance anner, and for profacility charges it is finding was co 7:00 PM.	ial information in a confidential oviding a detailed explanation requested by a patient.  onlined by Staff A on 11/29/16				
Ea cor ass for "G! My Sel RR evic sha	ch HCF shall deventrol plan that is to sessment of the fossessment shall be disease control audelines for Previous acterium tubettings, 2005," MN-17. The HCF steeping compliar	(B) T B Control Plan velop and follow a tuberculosis based on the provider's facility. The control and e consistent with the centers and prevention (CDC) venting the Transmission of erculosis in Health Care IWR 2005, Volume 54, No. hall retain documentation hace with this paragraph and becomentation to the director	C 120	C 120 - T B Control Plan  1. This deficiency will be corrected with following measures:  a. Nursing staff shall conduct TB on all employees.  2. The following measures have beetaken to ensure the deficiency does recur:  a. The Director of Nursing shall be responsible for maintaining a log that documents when each employee is of for their annual test.	with tests en not	12/30/2016
Bas revi facil con affe 435 rece	ed on personnel ew and staff intel lity failed to follov trol plan and poli ct all patients ser	t as evidenced by: file review, facility policy rview it was determined the v their TB (tuberculosis) cy. This could potentially ved by the facility. A total of e performed in the most s.		<ol> <li>The performance will be monitore ensure solutions are permanent thrown. Personnel files shall be review a quarterly basis to ensure all element of the established Infectious Control are being met.</li> <li>This deficiency was corrected on 12/30/2016.</li> </ol>	ugh: /ed on nts	

POPULAR SERVICES

Ohio Dept Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: \_\_\_\_ COMPLETED 1081AS B. WING 11/29/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD NORTHEAST OHIO WOMEN'S CENTER CUYAHOGA FALLS, OH 44223 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) C 120 Continued From page 4 C 120 Review of the facility TB Control Plan and the undated facility policy. "Quality Control," revealed facility employees "will be tested for TB on an annual basis," Review of the personnel files revealed Employees #1, #2, #3 and #6 had no record of TB testing in their personnel files; Employee #5's last TB testing was 6/30/15 and Employee #7's last recorded TB test was 12/19/14. This finding was confirmed during interview with Staff B at 7:10 PM on 11/29/16. C 122 O.A.C. 3701-83-08 (D) Job Descriptions C 122 C 122 - Job Descriptions 12/15/2016 Each HCF shall provide each staff member with a 1. This deficiency will be corrected with written job description delineating his or her responsibilities. the following measures: a. Job descriptions will be made part of the On-Boarding process. b. Existing staff shall be provided job descriptions for their current positions. This Rule is not met as evidenced by: 2. The following measures have been Based on review of the personnel files and staff taken to ensure the deficiency does not interview it was determined the facility failed to recur: provide each staff member a job description. This could potentially affect the patients served by a. Job descriptions have been made the facility. A total of 435 procedures were part of the new hire employment packet. performed in the most recent twelve months. b. Job descriptions have been developed for all existing positions. Findings include: Review of the personnel files noted Employees #1, #2, #6 and #7 did not have a signed job description or written acknowledgment of receipt

Ohio Dept Health **FORM APPROVED** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED 1081AS B. WING 11/29/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD NORTHEAST OHIO WOMEN'S CENTER CUYAHOGA FALLS, OH 44223 SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION 1D コンドン・メ PREFIX (X5) REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE 74G COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY Continued From page 5 C 122 - Job Descriptions C 122 12/15/2016 of their job description in their personnel files. (Continued) This finding was confirmed during interview with 3. The performance will be monitored to Staff B at 7:10 PM on 11/29/16. ensure solutions are permanent through: a. Personnel files shall be audited on a C 123 O.A.C. 3701-83-08 (E) Staff Orientation & C 123 quarterly basis for content. Training Each HCF shall provide an ongoing training 4. This deficiency was corrected on program for its staff. The program shall provide 12/15/2016. both orientation and continuing training to all staff members. The orientation shall be appropriate to the tasks that each staff member will be expected C 123 - Staff Orientation & Training 12/23/2016 to perform. Continuing training shall be designed to assure appropriate skill levels are maintained 1. This deficiency will be corrected with the and that staff are informed of changes in following measures: techniques, philosophies, goals, and similar matters. The continuing training may include a. All staff will be trained on Blood attending and participating in professional Bourne Pathogens, 1st-Aid & CPR, and meetings and seminars. general responsibilities and compliance. 2. The following measures have been taken to ensure the deficiency does not recur: This Rule is not met as evidenced by: a. A regular training format is being Based on review of personnel files and facility developed by a 3rd Party Consulting firm. policy and staff interview it was determined there b. All staff will complete various training was no evidence of an ongoing training program for staff. This could potentially affect all patients programs.

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months.

Findings include:

served by the facility. A total of 435 procedures were performed in the most recent twelve

Review of the undated facility policy, "Quality

Control" revealed, "....training is conducted on a

12/23/2016.

3. The performance will be monitored to

ensure solutions are permanent through: a. Quarterly reviews of personnel files.

4. This deficiency was corrected on

FORM APPROVED Onio Dept Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 1081AS B. WING 11/29/2016 VAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD NORTHEAST OHIO WOMEN'S CENTER CUYAHOGA FALLS, OH 44223 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ΙD ≃<del>P</del>EE:X EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 723 COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY C 123 Continued From page 6 C 123 regular basis and can include but is not limited to the following programs: CPR and first aid; Blood bome pathogens; OSHA safety guidelines; and Counseling/Communication skills." Review of the personnel files of facility employees #3 and #5 failed to reveal evidence of any ongoing training or competency assessment specific to their job tasks other than CPR/ACLS which they did not received through this facility. There was no evidence of blood-borne pathogens, OSHA or counseling/communications skills annual training. During interview at 6:40 PM on 11/29/16, Staff A stated, "Staff are so part-time....We have the documents, just haven't filled them out yet." On 11/29/16 at 7:00 PM, an interview was conducted with Staff A and Staff B regarding ongoing education and training of staff members. Staff B stated there were currently no ongoing inservices and continued training for staff related to their job duties and facility changes in policies. Staff A confirmed the facility did not have evidence of ongoing inservices and training for review, stating the facility administrative staff is working on putting together a plan for ongoing staff training. C 124, O.A.C. 3701-83-08 (F) Staff Orientation & 12/23/2016 C 124 - Staff Orientation & Training C 124 Training 1. This deficiency will be corrected with All staff shall have appropriate orientation and the following measures: training regarding the facility's equipment, safety guidelines, practices, and policies. a. All existing staff will undergo training

on equipment.

be developed.

b. A new hire orientation program will

" of the trace " He

PRINTED 01/03/2017 On o Dept Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED 1081AS B. WING 11/29/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NORTHEAST OHIO WOMEN'S CENTER 2127 STATE ROAD CUYAHOGA FALLS, OH 44223 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION בסבב א EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE 743 REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG DEFICIENCY C 124 Continued From page 7 C 124 C 124 - Staff Orientation & Training 12/23/2016 (Continued) This Rule is not met as evidenced by: Based on personnel file review and staff interview 2. The following measures have been it was determined the facility was unable to taken to ensure that the deficiency does

provide evidence of orientation regarding the facility's equipment, safety guidelines and/or policies and procedures for three (#1, #6 and #7) of seven employees. This could potentially affect all patients served by the facility. A total of 435 procedures were performed in the most recent twelve months.

Findings include:

Review of the personnel files revealed Staff #1 had no basic orientation to the facility equipment, safety guidelines or policies/procedures.

Review of the personnel files of Staff #6 and Staff #7 revealed no evidence of orientation to the facility, equipment, safety practices or policies/procedures.

This finding was verified during interview with Staff B at 7:10 PM on 11/29/16.

C 125 O.A.C. 3701-83-08 (G) Staff Performance Evaluation

> Each HCF shall evaluate the performance of each staff member at least every twelve months.

This Rule is not met as evidenced by: Based on personnel file review, facility policy review and staff interview, it was determined the not recur:

a. A new-hire orientation program has been developed to ensure all new employees have completed the orientation process.

- 3. The performance will be monitored to ensure solutions are permanent through:
- a. Quarterly reviews of all personnel files will be conducted to ensure compliance.
- 4. This deficiency was corrected on 12/23/2016.

C 125 - Staff Performance Evaluation

12/23/2016

- 1. This deficiency will be corrected with the following measures:
- a. The Clinic Director will conduct evaluations on all employees who have been employed for 12 or more months. (See Amendment E).

Ohio Department of Health

STATE FORM

C 125

**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 A..BUILDING: \_\_\_\_ 1081AS B. WING 11/29/2016 VAME OF PROMDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

MORTHEAST ONLY WOMEN'S CENTER

2127 STATE ROAD

MA 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES FEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	JO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 125	Continued From page 8	C 125	C 125 - Staff Performance Evaluation	12/23/201
	facility failed to perform annual performance evaluations. This finding could potentially affect all patients served by the facility. A total of 435 procedures were performed in the most recent twelve months.  Findings include:  Review of the undated facility policy, "Quality Control" revealed: "Each employee will be subject to annual performance evaluations as required by O.A.C. 3701-83-08 (G). Evaluations will be written by the individual employees' supervisor, and approved by Human Resources prior to reviewing the evaluation with the employee."  Review of the personnel files revealed Employees #3, #4 and #5, all employed greater than one year had no evidence of the completion or presentation of a performance evaluation.		(Continued)  2. The following measures have been taken to ensure the deficiency does not recur:  a. The Clinic Director shall document hiring dates for all employees.  b. Employee evaluations shall be conducted in the month of January to ensure compliance with O.A.C. 3701-83-08 (G).  3. The performance will be monitored to ensure solutions are permanent through:  a. Quarterly reviews of personnel files will be conducted by a 3rd party consulting firm to identify deficiencies.  4. This deficiency was corrected on 12/23/2016.	
	This finding was verified during interview with Staff B at 7:10 PM on 11/29/16.		12/23/2016.	
C 139.	O.A.C. 3701-83-10 (B) Safety & Sanitation	C 139	C 139 - Safety & Sanitation	12/23/2016
· · · · · · · · · · · · · · · · · · ·	The HCF shall be maintained in a safe and sanitary manner.  This Rule is not met as evidenced by:		This deficiency will be corrected with the following measures:     a. A log will be developed to record autoclave testing results.  (See Amendment F).     b. All staff will be trained on existing	
The second secon	Based on observations, review of facility documentation, and staff interviews, it was determined the facility failed to be maintained in a		refrigeration control logs.  c. A quality assurance audit will be completed to remove all expired items.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (	X3) DATE SURVEY COMPLETED
	1081AS	B. WING		44/20/2046
NAME OF PROVIDER OR SUPP	JER STREET AL	DDRESS, CITY	, STATE, ZIP CODE	11/29/2016
NORTHEAST OHIO WOM		TE ROAD	, - ,	
	CUYAHO	GA FALLS,	OH 44223	
, ERECX SEACH DEFICI	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BF COMPLETE
C 139 Continued From	n page 9	C 139	C 139 - Safety & Sanitation	12/23/2010
safe and sanita of surgical instr freezer contents blood. This cou- receiving care il procedures wer twelve months.  Findings include  1. A tour was of with Staff A and chest freezer we processing/p	ry manner in regard to sterilization uments, monitoring of stored s, and expired needles for drawing ld potentially affect all patients in the facility. A total of 435 e performed in the most recent		C 139 - Safety & Sanitation (Continued)  2. The following measures have been taken to ensure the deficiency does recur:  a. Clinic Director will conduct a maudit to ensure compliance with all QA protocols.  b. Completed audits will be submit to clinic ownership for review.  c. Staff will participate in ongoing training to ensure familiarity with QA protocols.  3. The performance will be monitore ensure the solutions are permanent through:  a. A 3rd party consulting firm will review all audits for compliance on a quarterly basis.  b. The consulting firm will also in staff and use results to recommend additional training.  4. This deficiency was corrected on 12/23/2016.	en not nonthly nitted
facility was mon	toring the temperature of the confirmed there was currently no			

FREEZERVAN FREEZE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  1081AS		1	LE CONSTRUCTION (X3	DATE SURVEY COMPLETED	
		B. WNG		11/29/2016	
VAME OF P	ROYIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
NORTHE	AST OHIO WOMEN'S	CENTER 2127 STA			
X4: /Đ	SHAMADY CTA		3A FALLS,	OH 44223	
=REF); =14G	EACH DEFICIENCY	Tement of deficiencies ( Must be preceded by full sc identifying information)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETE DATE
□ 139	Continued From pa	ge 10	C 139		
	process in place to temperatures.	monitor the freezer for correct			
	revealed expired pr needles in Room 1 needles was observ pre-packaged need 12/15. Staff B confir	9/16 at 2:30 PM with Staff B e-packaged blood collection (lab room). This open box of yed filled with expired les with expiration dates of med the date of expiration of eedles at the time of			
	(solution used to pe staff). The label on with wording of 1 m	tained expired Tubersol rform tuberculin testing on the container was observed (10 tests) and had an 1/04/16. This was confirmed me of observation.			
C 150	O.A.C. 3701-83-12 Program	(A) Q A & Improvement	C 150	C 150 - QA & Improvement Program	12/15/201
i i	and performance im to systematically mo of patient care, purs	ablish a quality assessment aprovement program designed onitor and evaluate the quality use opportunities to improve solve identified problems.		This deficiency will be corrected with the following measures:     a. A Quality Assurance Committee be developed to assess, review, and recommend QA based initiatives.	
	facility documentation facility lacked evider and performance im for monitoring and e	t as evidenced by: governing body minutes, on, and staff interviews, the nce of a quality assessment provement program (QAPI) valuating the quality of patient e patient care and resolve		2. The following measures have been taken to ensure that the deficiency does not recur:  a. Quality Assurance Committee we meet every two months.  b. Meeting minutes will be reviewed the Clinic Director.	ill

Ohio Dept Health

STATEME AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	SURVEY	
		IDENTIFICATION NUMBER:	A BUILDING:			COMPLETED	
		1081AS	B. WING		4475	29/2016	
WAKE OF	PROMDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE	11/2	13/2016	
NORTH	EAST OHIO WOMEN'S	CENTER 2127 STA	TE ROAD				
X4 ©	SUMMARY STA	TEMENT OF DEFICIENCIES	GA FALLS,	OH 44223			
TAG EAFETYX	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	1 RE	(X5) COMPLETE DATE	
	435 procedures werecent twelve month Findings include: On 11/29/16 at 5:30 of the governing boo documentation. An Staff A and Staff B a whether the facility is a reviews, peer review surveys; however, or conducting routine of findings to establish improve patient care Staff B confirmed the and program plan, si specifically in charge program. Staff A was with Staff B.	This could potentially affect g care in the facility. A total of re performed in the most his.  PM, a review was completed dy minutes and facility interview was conducted with at that same time regarding had a QAPI program. Staff B collecting data in record ys and patient satisfaction confirmed the facility was not part of the patient	C 150	C 150 - QA & Improvement Prograt (Continued)  3. The performance will be monito ensure solutions are permanent the a. Clinic Director will review comeeting minutes to ensure compliant. This deficiency was corrected of 12/15/2016.	red to rough: mpleted ince.		
	Each HCF shall deve describes the quality performance improv organization, scope, overseeing the effect	elop a written plan that assessment and ement program's objectives	0 101	C 151 - QA & Improvement Plan  1. This deficiency will be corrected to the following measures:  a. All staff will be trained regarding existing QA Program.  b. A Quality Assurance Committed to assess, review, and recommend new protocols.	with ng the	12/23/2016	
o Denortes	ent of Health						

PRINTED 01/03/2017 Ohio Dept Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING: COMPLETED 1081AS B. WING 11/29/2016 WANE OF PROMDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NORTHEAST OHIO WOMEN'S CENTER 2127 STATE ROAD CUYAHOGA FALLS, OH 44223 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION EACH DEFICIENCY MUST BE PRECEDED BY FULL SPERK (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) C 151 Continued From page 12 C 151 C 151 - QA & Improvement Plan 12/23/2016 This Rule is not met as evidenced by: (Continued) Based on review of governing body minutes, facility documentation, and staff interviews, the 2. The following measures have been facility failed to develop a written plan that taken to ensure that the deficiency does describes the quality assessment and performance improvement program's (QAPI) not recur: objectives, organization, scope, and mechanism a. A standard template will be used to for overseeing the effectiveness of monitoring, record Governing Board Meetings to evaluation, improvement and problem-solving activities. This could potentially affect all patients ensure QA is part of the documented receiving care in the facility. A total of 435 agenda. procedures were performed in the most recent b. Clinic Director will review Quality twelve months. Assurance Committee meeting minutes to ensure meetings are occurring on a Findings include: bi-monthly basis.

On 11/29/16 at 5:30 PM, a review was conducted of the governing body minutes and facility documentation.

An interview was conducted with Staff A and Staff B at that same time regarding whether the facility had a written plan that described the QAPI program. Staff B confirmed the facility currently lacks a written plan.

C 153 O.A.C. 3701-83-12 (D) Q A & Improvement -High-Risk Activities

> Each HCF shall implement a program for proactive assessment of high-risk activities related to patient safety and to undertake appropriate improvements.

This Rule is not met as evidenced by: Based on review of governing body minutes,

- 3. The performance will be monitored to ensure solutions are permanent through:
- a. The Clinic Director will perform monthly audits to ensure compliance.
- 4. This deficiency was corrected on 12/23/2016.

C 153 - QA & Improvement - High-Risk Activities

12/23/2016

- 1. This deficiency will be corrected with the following measures:
- a. The clinic will implement a pre-screening process developed to identify any high risk patients or situations. (See Amendment C).
- b. Staff will be trained to recognize indicating factors.

Ohio Department of Health

C 153

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PRINTED 01/03/2017 Onio Dept Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED 1081AS B. WING 11/29/2016 \*AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD **MORTHEAST OHIO WOMEN'S CENTER CUYAHOGA FALLS, OH 44223** SUMMARY STATEMENT OF DEFICIENCIES X4...) PROVIDER'S PLAN OF CORRECTION DEE X EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) C 153 Continued From page 13 C 153 - QA & Improvement - High-Risk 12/23/2016 C 153 facility documentation, and staff interviews, the Activities facility failed to implement a program for (Continued) preactive assessment of high-risk activities related to patient safety and to undertake 2. The following measures have been appropriate improvements. This could potentially taken to ensure the deficiency does not affect all patients receiving care in the facility. A total of 435 procedures were performed in the most recent twelve months. a. Staff will undergo routine training on high risk protocols. Findings include: b. Governing Board will review existing protocols as part of their QA review to On 11/29/16 at 5:30 PM, a review was completed of the governing body minutes and facility correct any deficiencies. documentation. An interview was conducted with Staff A and Staff B at that same time regarding 3. The performance will be monitored to whether the facility had implemented a program ensure solutions are permanent through: for proactive assessment of high-risk activities a. A monthly Audit will be conducted related to patient safety. to ensure compliance of all QA protocols. Staff B confirmed the facility currently lacks a written program. 4. This deficiency was corrected on 12/23/2016. C 202 O.A.C. 3701-83-16 (B (4) Governing Body -C 202 Infection Control C 202 - Governing Body - Infection Control 12/23/2016 Designate a qualified professional trained in 1. This deficiency will be corrected with the infection control to direct the infection control following measures: program required by paragraph (D) of rule 3701-83-09 of the Ohio Administrative Code. For a. A RN will train on Infectious Control the purpose of this rule, a qualified professional Protocols and will serve as the Training trained in infection control means a nurse or Coordinator for the clinic. physician as defined in rule 3701-83-01 of the b. All staff will undergo infectious Ohio Administrative Code, who has

documentation of completion of training in infection control, including, but not limited to, continuing education units, in-service training, or academic or vocational course completion.

This Rule is not met as evidenced by:

2229

control training.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		1081AS	B. WING		11/2	9/2016
name of i	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	•	
NORTHE	AST OHIO WOMEN'S	S CENTER 2127 STA				
	CSDALLOVATA		SA FALLS, (	<del>,</del>		
-X4 /5 PREF(X TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
0 232	Continued From pa	age 14	C 202	C 202 - Governing Body - Infection	Control	12/23/2016
	Based on review of	facility documentation and		(Continued)		
	staff interviews, the	Governing Body failed to				
	designate a qualific	ed professional trained in		2. The following measures have b	een	
	infection control to	direct the infection control		taken to ensure the deficiency doe	s not	
	program, and failed	to ensure the facility had an		recur:		
	affect all nationts re	ogram. This could potentially eceiving care in the facility. A		a. The Training Coordinator wil	l review	
	total of 435 procedu	ures were performed in the		the existing Infectious Control Prog		
	most recent twelve	months.		deficiencies for the Clinic Director		,
				review.		
	Findings include:			b. The Clinic Director will create	e new	
	On 11/20/16 at 5:3/	PM, a review was conducted		protocol based on the Training		
	of facility document	tation including Governing		Coordinator's recommendations.		
	Body minutes. An in	nterview was conducted with		c. The Governing Board will rev	view and	
	Staff A and Staff B	at that same time regarding		approve any new protocols submitt		
	whether the facility	had an infection control		approve any from processis submit		
	infection control D	lified professional trained in ouring this interview, Staff B		3. The performance will be monito	red to	
	confirmed the facility	ty does not have a current		ensure solutions are permanent the		
•	program in place as	nd does not have a qualified		a. The Governing Board shall re		
	professional trained	in infection control to direct		and approve the Infectious Control		
	an infection control	program.		Program on an annual basis.		
	Staff A was present	during this interview with Staff		l rogram on an armaar basis.		
	B.	during this interview with Stail		4. This deficiency was corrected o	_	
				12/23/2016,		
C 213	O.A.C. 3701-83-17 Instructions	(H) Receipt of Discharge	C 213	12/23/2010.		
i see spe dimensione	ensure that the pati acknowledge, in wr	iatrist, dentist, or a nurse shall ient or patient's representative iting, receipt of the physician's, ist's written discharge				
	This Rule is not me	et as evidenced by:				

Ohio Dept Health	_			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G:		SURVEY PLETED
	1081AS	B. WING			
NAME OF PROVIDER OR SUPPLIE	R STREET A	חחחבפפ מידי		1 11/2	29/2016
MODTUEACT AUTO MAN		ATE ROAD	STATE, ZIP CODE		
NORTHEAST OHIO WOME	VS CENTER CUYAHO	GA FALLS,	OH 44223		
X4 10 SUMMARY	TATEMENT OF DEFICIENCIES		<del></del>		<del>,</del>
TAB REGULATORY OF	ICY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICAL CROSS-REFERENCED TO THE APPROVIDERI	DRE	(X5) COMPLETE DATE
0.213 Continued From	page 15 Il record review and staff	C 213	C 213 - Receipt of Discharge Instr	uctions	12/23/2016
provide evidence discharge instruc This affected two surgical procedures v recent twelve mo Findings include:  Review of the me #3 revealed no evidescharge instruct	dical records of Patients #2 and idence of the provision of ions to the patient or the person		1. This deficiency will be corrected the following measures:  a. All staff will be retrained on procedures regarding documentation patient discharge instructions.  b. Charts will be reviewed at the completion of surgery days to ensure documentation is properly recorded (See Amendment D).  2. The following measures have be	proper ion of ne ure all d.	
During interview a verified there were written acknowled During interview a verified there were or written acknow #3 stating, "That's nurse so I'll have to the common acknowled C 222 O.A.C. 3701-83-1.  Each ASF shall have an RN with experiment own nursing care.	em for the procedure.  It 5:20 PM on 11/28/16 Staff A on discharge instructions or gment of receipt for Patient #2,  It 5:45 PM on 11/28/16 Staff A or also no discharge instructions edgment of receipt for Patient not the regular recovery room or go over that with her."  It 5:45 PM on 11/28/16 Staff A or also no discharge instructions edgment of receipt for Patient not the regular recovery room or go over that with her."  It is 6 (C) Director of Nursing who is ance in surgical and recovery the director of nursing shall staff and recovery the director of nursing shall sta	C 222	taken to ensure the deficiency doe recur:  a. Chart reviews will be complethe end of surgery days to ensure compliance. b. Clinic Director will retrain employees as needed.  3. The performance will be monitorensure solutions are permanent tha. Quarterly reviews will be comby a 3rd party inspector. b. Clinic will review at least 100 patient files.	es not eted at ered to rough: apleted	
This Rule is not m	the management of nursing et as evidenced by: el file review it was determined		4. This deficiency was corrected of 12/23/2016.	n	

	ept Health			,		I APPROVED
STATEM AND PLA	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE	SUPVEY PLETED
* ************************************		1081AS	B. WNG_		441	
· NAME O	F PROVIDER OR SUPPLIER	STREET A	DDRESS CITY	r, STATE, ZIP CODE	11/2	29/2016
NORTH	EAST OHIO WOMEN'S	CENTER 2127 ST	ATE ROAD DGA FALLS,			
X4 (D	SUMMARY STA	TEMENT OF DEFICIENCIES				
PDEF-X	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DE .	(X5) COMPLETE DATE
1 C 222	Continued From pa		C 222	C 222 - Director of Nursing	· · · · · · · · · · · · · · · · · · ·	12/15/2016
	This could potential the facility. A total of performed in the modern performed in the modern performed in the person personnel file to revisible experience. There is personnel file to revisible experience. Additional experience and was obtained to do in one evidence the che qualifications verified.	d. ified during interview at 7:10		1. This deficiency will be corrected the following measures:  a. The current Director of Nursir provide the Clinic Director proof of the experience, which includes over 3.5 as a nurse in an ambulatory surgical setting and 4 years as a Director of Nursing.  2. The following measures have be taken to ensure that the deficiency of not recur:  a. Staff files have been reviewed ensure evidence is present of prior very experience and training.	ng will heir i years il en does	
C 225	At all times when par or recovering from tr discharged, the ASF (1) Have at least two in the ASF, at least of and at least one of we advanced cardiac life present and on duty patients are present; (2) In addition to the (1) of this rule, have a readily available on a	nurses present and on duty one of whom shall be an RN chom is currently certified in a support who shall be in the recovery room when requirement of paragraph (F) at least one RN who shall be	C 225	3. The performance will be monitore ensure solutions are permanent throa. Quarterly reviews will be composed files to audit content.  b. Staff will be required to provid supporting documents as needed.  4. This deficiency was corrected on 12/15/2016.	ough: pleted le	
	(3) mave sufficient an	d qualified additional staff				1

Onic De	pt Health				FORM	APPROVE
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE COMP	SURVEY
		1081AS	B. WNG _		44/2	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS CITY	, STATE, ZIP CODE	11/2	372010
мортия	EAST OHIO WOMEN'		TE ROAD	, STATE, EF CODE		
1101(11)	AST ONO WOMEN	3 CENTER	GA FALLS,	OH 44223		
XA D PREFX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	(X5) COMPLETE DATE
C 225	Continued From pa	age 17	C 225	C 225 - Nurse Duty Requirements		12/01/201
	This Rule is not m Based on review o was determined the	o the needs of the patients.  The tas evidenced by: If the facility's "Nurse Logs" it to facility did not have two don duty at all times on		This deficiency will be corrected following measures:     a. A staff schedule will be creatensure two nurses are scheduled attimes during surgical procedures.     b. A policy has been developed requiring the retention of all staff schedules.	ted to at all	
	treatment days. The of the patients service only one nurse was	is could potentially affect any yed by the facility on days when a scheduled. A total of 435 erformed in the most recent		The following measures have be taken to ensure that the deficiency not recur:     a. All nursing staff and Clinic Dehave undergone training regarding	does	
	Findings include:			Nurse Duty Requirements.		
	one nurse was in the surgery and recover	ty's "Nurse Logs" revealed only he facility and worked both the ery room for the patients wing dates: 08/12/15;		b. Schedules will be audited on quarterly basis to ensure compliant maintained.		
	08/14/15; 09/06/15 04/06/16; 04/24/16	; 11/04/15; 11/09/15; 01/31/16; ; 05/03/16; 05/05/16; 05/22/16; ; 06/26/16; 11/08/16 and		The performance will be monito ensure solutions are permanent thrank. Monthly audits conducted by Clinic Director.	ough:	
	This finding was ve PM on 11/29/16 by	erifled during interview at 7:10 Staff B.		b. Quarterly audits conducted bard party inspector.	уа	
<b>C 226</b>	O.A.C. 3701-83-18 Schedules	(G) Copies of Licenses &	C 226	4. This deficiency was corrected or 12/01/2016.	ח	
	Each ASF shall ma	intain the following:				
	(1) An established the director to asce	system of records sufficient for rtain that all individuals				

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Ohio D	ept Health				FORM	APPROVED
STATEMI AND PLA	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE	SURVEY
		1081AS	B. WING _		1419	9/2016
NAMED	PROVICER OR SUPPLIER	STREET AC	DDRESS, CITY	, STATE, ZIP CODE	1 11/2	3/2010
HORTH	EAST OHIO WOMEN'S		TE ROAD	, emilia dobe		
		CUYAHO	GA FALLS,	OH 44223		
PREFIX	REGULATORY OR L	STEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D RE	(X5) COMPLETE DATE
<sup>2</sup> C 226	Continued From pa	ge 18	C 226	C 226 - Copies of Licenses and Si	chedules	12/15/2016
P company	including, but not lir Ohio license, regist required by law, and (2) Staffing schedul	F in a professional capacity applicable to that profession, mited to, possessing a current ration, or other certification des, time-worked schedules, and payroll records for at least		This deficiency will be corrected the following measures:     a. Clinic Director has received training on retention schedules and scheduling process.     b. A computer file has been created to help maintain compliance in reg	d with	
	it was determined the license status for the staff. This could posserved by the facility were performed in the months.  Findings include:	I file review and staff interview the facility failed to verify active eir RN (registered nurse) tentially affect all patients A total of 435 procedures the most recent twelve		to retention.  c. Copies of relevant licenses I been added to respective personn files.  2. The following measures have b taken to ensure that the deficiency not recur:  a. Monthly QA audits will samp personnel files for compliance.  b. Quarterly QA audits will take complete inventory of personnel files.	een does de	
	and #5 revealed verexpiration date of 8/sevidence to reveal liensure they were current action for the current This finding was veri	nnel files of RN Staff #3, #4, iffication of licenses with an 31/15. There was no censes had been checked to irrent and without disciplinary t period expiring 08/31/17.		3. The performance will be monitor ensure solutions are permanent the a. Quarterly audits conducted to 3rd party inspector.  4. This deficiency was corrected or the second seco	rough: by a	
C 286	Staff B at 7:10 PM o	n 11/29/16. Infection Control Program	C 266	12/15/2016.	161	
	intection control prod	cal facility shall maintain an gram by creating and designed to prevent, identify,				

Torrespondence and the contraction of the contracti

Onic Dept Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED 1081AS 8. WING NAME OF PROVIDER OR SUPPLIER 11/29/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NORTHEAST OHIO WOMEN'S CENTER 2127 STATE ROAD CUYAHOGA FALLS, OH 44223 SUMMARY STATEMENT OF DEFICIENCIES PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE TAG DATE DEFICIENCY) C 266 Continued From page 19 C 266 C 266 - Infection Control Program 12/23/2016 and manage infections and communicable diseases; ensure that the program is directed by 1. This deficiency will be corrected with a qualified professional trained in infection the following measures: control; ensure the program is an integral part of the ambulatory surgical facility's quality a. A template has been created to assessment and performance improvement document minutes for the Governing program; and implement in an expeditious Board meetings to ensure that the manner corrective and preventive measure that Infection Control Program is discussed. result in improvement. (See Amendment A). 2. The following measures have been This Rule is not met as evidenced by: taken to ensure that the deficiency does Based on review of facility documentation and not recur: staff interviews, the facility lacked evidence of an infection control program, and failed to ensure a a. Director of Nursing will assist in qualified professional trained in infection control developing a comprehensive Infection was present to ensure there was a program Control Program. which was an integral part of the ambulatory b. A 3rd party consulting firm will surgical facility's quality assessment and review the Infection Control Program for performance improvement program (QAPI). This could potentially affect all patients receiving care deficiencies and make recommendations. in the facility. A total of 435 procedures were performed in the most recent twelve months. 3. The performance will be monitored to ensure solutions are permanent Findings include: through: On 11/29/16 at 5:30 PM, a review was completed a. Governing Board will review and of facility documentation that included all of the approve the Infection Control Program Governing Body minutes. on an annual basis. b. Quarterly reviews of Governing An interview was completed with Staff A and Staff B at that same time regarding whether the facility Board meeting minutes will be conducted had an infection control program and a qualified to ensure the Infection Control Program professional trained in infection control. During was discussed. this interview, Staff B stated the facility does not c. Staff will be trained on all have a current infection control program in place Infection Control Program protocols. and does not have an employee designated and qualified to direct an infection control program. 4. This deficiency was corrected on

12/23/2016.

PRINTED: 01/03/2017

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Onio Dept Health					FOR	D: 01/03/20 MAPPROVE
STATEMENT OF DEFICIENT AND PLAN OF CORRECTION	CIES (X1) PROVIDER/SUP IDENTIFICATION	PLIER/CLIA NUMBER:	(X2) MULTIPLE A. BUILDING:	ECONSTRUCTION	(X3) DAT	E SURVEY IPLETED
	1081AS		B. WING			
NAME OF PROMOTER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		11,	29/2016			
NORTHEAST OHIO W	OMEN'S CENTER	2127 ST	ddress, city, s <sup>.</sup> <b>Ate road</b>	TATE, ZIP CODE		
		CUYAHO	GA FALLS, OI	H 44223		
PASTIX EACH DE	ARY STATEMENT OF DEFICIENT FICIENCY MUST BE PRECEDED	CIES	lD :	PROVIDER'S PLAN O	F 00000000	Ţ
	CK ESC IDENTIFYING INFOR	RMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE
C 266 Continued F	rom page 20		C 266			
Staff A was p B.	present during this intervie	ew with Staff				
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