Approved Recommend revisit

Ohio Dept Health

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FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1081AS	A. BUILDING: _____ 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

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C 000	Initial Comments 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 000	2017 JAN 31 AM 11:44 ODH/OHAL COMMUNITY HEALTH CARE	
C 104	O.A.C. 3701-83-03 (F) Governing Body The HCF shall have an identifiable governing body responsible for the following: (1) The development and implementation of policies and procedures and a mission statement for the orderly development and management of the HCF; (2) The evaluation of the HCF's quality assesment and performance improvement program on an annual basis; and (3) The development and maintenance of a disaster preparedness plan, including evacuation procedures.	C 104	C 104 - Governing Body 1. This deficiency will be corrected with the following measures: a. A template will be used to properly document meeting notes of the Governing Board. 2. The following measures have been taken to ensure that the deficiency does not recur: a. The Clinic Manager will review all minutes and sign off for completion.	12/15/2016

Ohio Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

K C Mally MD 1/27/17 LAB DIRECTOR

TITLE

DATE

STATE FORM 5899 XN5211

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C 104	Continued From page 1 This Rule is not met as evidenced by: Based on review of governing body minutes and staff interview the facility failed to ensure the governing body evaluated the facility's quality assessment and performance improvement program (QAPI) on an annual basis. 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 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 104	C 104 - Governing Board (Continued) 3. The performance will be monitored to ensure solutions are permanent through: a. Quality assurance audits conducted by a 3rd party consulting firm. 4. This deficiency was corrected on 12/15/2016.	12/15/2016
C 114	O.A.C. 3701-83-07 (A) Patient Care Policies The HCF shall develop and follow comprehensive and effective patient care policies that include the following requirements: (1) Each patient shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and personal care needs;	C 114	C 114 - Patient Care Policies 1. This deficiency will be corrected with the following measures: a. Policies will be developed regarding patient care including: treatment, privacy, personal care, withdraw of consent, records management, and financial records. (See Amendment B).	12/23/2016

ask Lea Ann if the policy they sent is acceptable

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C 114	Continued From page 2 (2) Each patient shall be allowed to refuse or withdraw consent for treatment; (3) Each patient shall have access to his or her medical record, unless access is specifically restricted by the attending physician for medical reasons, (4) Each patient's medical and financial records shall be kept in confidence; and (5) Each patient shall receive, if requested, a detailed explanation of facility charges including an itemized bill for services received. This Rule is not met as evidenced by: Based on review of policies and staff interviews, the facility failed to develop comprehensive and effective patient care policies in regard to patients' treatment, a patients' refusal or withdrawal of consent for treatment, for access to 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 to medical records, for maintaining patients'	C 114	C 114 - Patient Care Policies (Continued) 2. The following measures have been taken to ensure that the deficiency does not recur: a. The Governing Board will review the policy and procedures manual on a annual basis for approval. 3. The performance will be monitored to ensure that the solutions are permanent 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 referred to the Governing Board for development and review. 4. This deficiency was corrected on 12/23/2016.	12/23/2016

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C 114	Continued From page 3 medical and financial information in a confidential manner, and for providing a detailed explanation of facility charges if requested by a patient. This finding was confirmed by Staff A on 11/29/16 at 7:00 PM.	C 114		
C 120	O.A.C. 3701-83-08 (B) T B Control Plan Each HCF shall develop and follow a tuberculosis control plan that is based on the provider's assessment of the facility. The control and assessment shall be consistent with the centers for disease control and prevention (CDC) "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings, 2005," MMWR 2005, Volume 54, No. RR-17. The HCF shall retain documentation evidencing compliance with this paragraph and shall furnish such documentation to the director upon request. This Rule is not met as evidenced by: Based on personnel file review, facility policy review and staff interview it was determined the facility failed to follow their TB (tuberculosis) control plan and policy. 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:	C 120	C 120 - T B Control Plan 1. This deficiency will be corrected with the following measures: a. Nursing staff shall conduct TB tests on all employees. 2. The following measures have been taken to ensure the deficiency does not recur: a. The Director of Nursing shall be responsible for maintaining a log that documents when each employee is due for their annual test. 3. The performance will be monitored to ensure solutions are permanent through: a. Personnel files shall be reviewed on a quarterly basis to ensure all elements of the established Infectious Control Plan are being met. 4. This deficiency was corrected on 12/30/2016.	12/30/2016

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C 120	Continued From page 4 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 120		
C 122	O.A.C. 3701-83-08 (D) Job Descriptions Each HCF shall provide each staff member with a written job description delineating his or her responsibilities. This Rule is not met as evidenced by: Based on review of the personnel files and staff interview it was determined the facility failed to provide each staff member a job description. This could potentially affect the 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 noted Employees #1, #2, #6 and #7 did not have a signed job description or written acknowledgment of receipt	C 122	C 122 - Job Descriptions 1. This deficiency will be corrected with 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. 2. The following measures have been taken to ensure the deficiency does not recur: a. Job descriptions have been made part of the new hire employment packet. b. Job descriptions have been developed for all existing positions.	12/15/2016

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C 122	Continued From page 5 of their job description in their personnel files. This finding was confirmed during interview with Staff B at 7:10 PM on 11/29/16.	C 122	C 122 - Job Descriptions (Continued) 3. The performance will be monitored to ensure solutions are permanent through: a. Personnel files shall be audited on a quarterly basis for content. 4. This deficiency was corrected on 12/15/2016.	12/15/2016
C 123	O.A.C. 3701-83-08 (E) Staff Orientation & Training Each HCF shall provide an ongoing training program for its staff. The program shall provide both orientation and continuing training to all staff members. The orientation shall be appropriate to the tasks that each staff member will be expected to perform. Continuing training shall be designed to assure appropriate skill levels are maintained and that staff are informed of changes in techniques, philosophies, goals, and similar matters. The continuing training may include attending and participating in professional meetings and seminars. This Rule is not met as evidenced by: Based on review of personnel files and facility policy and staff interview it was determined there was no evidence of an ongoing training program for staff. 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 undated facility policy, "Quality Control" revealed, "....training is conducted on a	C 123	C 123 - Staff Orientation & Training 1. This deficiency will be corrected with the following measures: a. All staff will be trained on Blood Bourne Pathogens, 1st-Aid & CPR, and general responsibilities and compliance. 2. The following measures have been taken to ensure the deficiency does not recur: a. A regular training format is being developed by a 3rd Party Consulting firm. b. All staff will complete various training programs. 3. The performance will be monitored to ensure solutions are permanent through: a. Quarterly reviews of personnel files. 4. This deficiency was corrected on 12/23/2016.	12/23/2016

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C 123	Continued From page 6 regular basis and can include but is not limited to the following programs: CPR and first aid; Blood borne 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 123		
C 124	O.A.C. 3701-83-08 (F) Staff Orientation & Training All staff shall have appropriate orientation and training regarding the facility's equipment, safety guidelines, practices, and policies.	C 124	C 124 - Staff Orientation & Training 1. This deficiency will be corrected with the following measures: a. All existing staff will undergo training on equipment. b. A new hire orientation program will be developed.	12/23/2016

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C 124	Continued From page 7 This Rule is not met as evidenced by: Based on personnel file review and staff interview it was determined the facility was unable to 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 124	C 124 - Staff Orientation & Training (Continued) 2. The following measures have been taken to ensure that the deficiency does 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.	12/23/2016
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	C 125	C 125 - Staff Performance Evaluation 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).	12/23/2016

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C 125	Continued From page 8 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. This finding was verified during interview with Staff B at 7:10 PM on 11/29/16.	C 125	C 125 - Staff 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.	12/23/2016
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 observations, review of facility documentation, and staff interviews, it was determined the facility failed to be maintained in a	C 139	C 139 - Safety & Sanitation 1. 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 refrigeration control logs. c. A quality assurance audit will be completed to remove all expired items.	12/23/2016

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C 139	Continued From page 9 safe and sanitary manner in regard to sterilization of surgical instruments, monitoring of stored freezer contents, and expired needles for drawing blood. 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: 1. A tour was conducted on 11/29/16 at 6:50 PM with Staff A and Staff B. An autoclave and a chest freezer were observed in the instrument processing/products of conception (POC) room. Instructions for operating the autoclave were posted on the top of the machine. The autoclave model was observed as Tuttnauer 2340 M. Manufacturer's guidelines for this model contained the following instructions: "Place a sterilization indicator in each tray or inside each wrapped pack." When both Staff A and Staff B were interviewed as to how they knew the autoclave was functioning properly to sterilize the surgical instruments, both staff replied they knew it was working properly by checking the tape on the outside of the instrument packaging, if it turned a dark color, the instruments were processed correctly. Per these interviews, both staff confirmed there was no process in place to maintain documentation of the processing procedure. 2. A chest freezer was observed in the autoclave room during this tour. Staff B stated the freezer was used to store POC and "pathology" specimens. When interviewed as to whether the facility was monitoring the temperature of the freezer, Staff B confirmed there was currently no	C 139	C 139 - Safety & Sanitation (Continued) 2. The following measures have been taken to ensure the deficiency does not recur: a. Clinic Director will conduct a monthly audit to ensure compliance with all QA protocols. b. Completed audits will be submitted to clinic ownership for review. c. Staff will participate in ongoing training to ensure familiarity with QA protocols. 3. The performance will be monitored to 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 interview staff and use results to recommend additional training. 4. This deficiency was corrected on 12/23/2016.	12/23/2016

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C 139	Continued From page 10 process in place to monitor the freezer for correct temperatures. 3. The tour on 11/29/16 at 2:30 PM with Staff B revealed expired pre-packaged blood collection needles in Room 1 (lab room). This open box of needles was observed filled with expired pre-packaged needles with expiration dates of 12/15. Staff B confirmed the date of expiration of the pre-packaged needles at the time of observation. The refrigerator contained expired Tubersol (solution used to perform tuberculin testing on staff). The label on the container was observed with wording of 1 ml (10 tests) and had an expiration date of 11/04/16. This was confirmed with Staff B at the time of observation.	C 139		
C 150	O.A.C. 3701-83-12 (A) Q A & Improvement Program Each HCF shall establish a quality assessment and performance improvement program designed to systematically monitor and evaluate the quality of patient care, pursue opportunities to improve patient care, and resolve identified problems. This Rule is not met as evidenced by: Based on review of governing body minutes, facility documentation, and staff interviews, the facility lacked evidence of a quality assessment and performance improvement program (QAPI) for monitoring and evaluating the quality of patient care, and to improve patient care and resolve	C 150	C 150 - QA & Improvement Program 1. This deficiency will be corrected with the following measures: a. A Quality Assurance Committee will be developed to assess, review, and recommend QA based initiatives. 2. The following measures have been taken to ensure that the deficiency does not recur: a. Quality Assurance Committee will meet every two months. b. Meeting minutes will be reviewed by the Clinic Director.	12/15/2016

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C 150	Continued From page 11 identified problems. 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 5:30 PM, a review was completed 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 QAPI program. Staff B stated the facility is collecting data in record reviews, peer reviews and patient satisfaction surveys; however, confirmed the facility was not conducting routine QAPI meetings to use these findings to establish goals or use the data to improve patient care. Staff B confirmed the lack of a QAPI committee and program plan, stating there was no one specifically in charge of a quality assurance program. Staff A was present during this interview with Staff B.	C 150	C 150 - QA & Improvement Program (Continued) 3. The performance will be monitored to ensure solutions are permanent through: a. Clinic Director will review completed meeting minutes to ensure compliance. 4. This deficiency was corrected on 12/15/2016.	12/15/2016
C 151	O.A.C. 3701-83-12 (B) Q A & Improvement Plan Each HCF shall develop a written plan that describes the quality assessment and performance improvement program's objectives, organization, scope, and mechanism for overseeing the effectiveness of monitoring, evaluation, improvement and problem-solving activities.	C 151	C 151 - QA & Improvement Plan 1. This deficiency will be corrected with the following measures: a. All staff will be trained regarding the existing QA Program. b. A Quality Assurance Committee will be formed to assess, review, and recommend new protocols.	12/23/2016

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C 151	Continued From page 12 This Rule is not met as evidenced by: Based on review of governing body minutes, facility documentation, and staff interviews, the facility failed to develop a written plan that describes the quality assessment and performance improvement program's (QAPI) objectives, organization, scope, and mechanism for overseeing the effectiveness of monitoring, evaluation, improvement and problem-solving activities. 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 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 151	C 151 - QA & Improvement Plan (Continued) 2. The following measures have been taken to ensure that the deficiency does not recur: a. A standard template will be used to record Governing Board Meetings to ensure QA is part of the documented agenda. b. Clinic Director will review Quality Assurance Committee meeting minutes to ensure meetings are occurring on a bi-monthly basis. 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.	12/23/2016
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,	C 153	C 153 - QA & Improvement - High-Risk Activities 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.	12/23/2016

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C 153	Continued From page 13 facility documentation, and staff interviews, the facility failed to implement a program for proactive assessment of high-risk activities related to patient safety and to undertake appropriate improvements. 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 5:30 PM, a review was completed 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 implemented a program for proactive assessment of high-risk activities related to patient safety. Staff B confirmed the facility currently lacks a written program.	C 153	C 153 - QA & Improvement - High-Risk Activities (Continued) 2. The following measures have been taken to ensure the deficiency does not recur: a. Staff will undergo routine training on high risk protocols. b. Governing Board will review existing protocols as part of their QA review to correct any deficiencies. 3. The performance will be monitored to ensure solutions are permanent through: a. A monthly Audit will be conducted to ensure compliance of all QA protocols. 4. This deficiency was corrected on 12/23/2016.	12/23/2016
C 202	O.A.C. 3701-83-16 (B (4) Governing Body - Infection Control Designate a qualified professional trained in infection control to direct the infection control program required by paragraph (D) of rule 3701-83-09 of the Ohio Administrative Code. For the purpose of this rule, a qualified professional trained in infection control means a nurse or physician as defined in rule 3701-83-01 of the 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:	C 202	C 202 - Governing Body - Infection Control 1. This deficiency will be corrected with the following measures: a. A RN will train on Infectious Control Protocols and will serve as the Training Coordinator for the clinic. b. All staff will undergo infectious control training.	12/23/2016

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C 202	Continued From page 14 Based on review of facility documentation and staff interviews. the Governing Body failed to designate a qualified professional trained in infection control to direct the infection control program, and failed to ensure the facility had an infection control program. 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 5:30 PM, a review was conducted of facility documentation including Governing Body minutes. An interview was conducted with Staff A and Staff B at that same time regarding whether the facility had an infection control program and a qualified professional trained in infection control. During this interview, Staff B confirmed the facility does not have a current program in place and does not have a qualified professional trained in infection control to direct an infection control program. Staff A was present during this interview with Staff B.	C 202	C 202 - Governing Body - Infection Control (Continued) 2. The following measures have been taken to ensure the deficiency does not recur: a. The Training Coordinator will review the existing Infectious Control Program for deficiencies for the Clinic Director to review. b. The Clinic Director will create new protocol based on the Training Coordinator's recommendations. c. The Governing Board will review and approve any new protocols submitted. 3. The performance will be monitored to ensure solutions are permanent through: a. The Governing Board shall review and approve the Infectious Control Program on an annual basis. 4. This deficiency was corrected on 12/23/2016.	12/23/2016
C 213	O.A.C. 3701-83-17 (H) Receipt of Discharge Instructions The physician, podiatrist, dentist, or a nurse shall ensure that the patient or patient's representative acknowledge, in writing, receipt of the physician's, podiatrist's, or dentist's written discharge instructions. This Rule is not met as evidenced by:	C 213		

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C 213	Continued From page 15 Based on medical record review and staff interview it was determined the facility failed to provide evidence of the provision of written discharge instructions prior to leaving the facility. This affected two patients (#2 and #3) of two surgical procedure records reviewed. A total of 435 procedures were performed in the most recent twelve months. Findings include: Review of the medical records of Patients #2 and #3 revealed no evidence of the provision of discharge instructions to the patient or the person accompanying them for the procedure. During interview at 5:20 PM on 11/28/16 Staff A verified there were no discharge instructions or written acknowledgment of receipt for Patient #2. During interview at 5:45 PM on 11/28/16 Staff A verified there were also no discharge instructions or written acknowledgment of receipt for Patient #3 stating, "That's not the regular recovery room nurse so I'll have to go over that with her."	C 213	C 213 - Receipt of Discharge Instructions 1. This deficiency will be corrected with the following measures: a. All staff will be retrained on proper procedures regarding documentation of patient discharge instructions. b. Charts will be reviewed at the completion of surgery days to ensure all documentation is properly recorded. (See Amendment D). 2. The following measures have been taken to ensure the deficiency does not recur: a. Chart reviews will be completed at the end of surgery days to ensure compliance. b. Clinic Director will retrain employees as needed. 3. The performance will be monitored to ensure solutions are permanent through: a. Quarterly reviews will be completed by a 3rd party inspector. b. Clinic will review at least 10% of all patient files. 4. This deficiency was corrected on 12/23/2016.	12/23/2016
C 222	O.A.C. 3701-83-18 (C) Director of Nursing Each ASF shall have a director of nursing who is an RN with experience in surgical and recovery room nursing care. The director of nursing shall be responsible for the management of nursing services. This Rule is not met as evidenced by: Based on personnel file review it was determined	C 222		

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C 222	Continued From page 16 the facility failed to provide evidence the Director of Nursing met the requirements of the position. 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 file of the appointed Director of Nursing failed to reveal evidence on the application of surgical or recovery room experience. There was no resume in the personnel file to reveal previous employment or job experience. Additionally, although permission was obtained to do reference checks, there was no evidence the checks were done or qualifications verified. This finding was verified during interview at 7:10 PM on 11/29/16 with Staff A.	C 222	C 222 - Director of Nursing 1. This deficiency will be corrected with the following measures: a. The current Director of Nursing will provide the Clinic Director proof of their experience, which includes over 3.5 years as a nurse in an ambulatory surgical setting and 4 years as a Director of Nursing. 2. The following measures have been taken to ensure that the deficiency does not recur: a. Staff files have been reviewed to ensure evidence is present of prior work experience and training.	12/15/2016
C 225	O.A.C. 3701-83-18 (F) Nurse Duty Requirements At all times when patients are receiving treatment or recovering from treatment until they are discharged, the ASF shall: (1) Have at least two nurses present and on duty in the ASF, at least one of whom shall be an RN and at least one of whom is currently certified in advanced cardiac life support who shall be present and on duty in the recovery room when patients are present; (2) In addition to the requirement of paragraph (F) (1) of this rule, have at least one RN who shall be readily available on an on-call basis; and (3) Have sufficient and qualified additional staff	C 225	3. The performance will be monitored to ensure solutions are permanent through: a. Quarterly reviews will be completed of personnel files to audit content. b. Staff will be required to provide supporting documents as needed. 4. This deficiency was corrected on 12/15/2016.	

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C 225	Continued From page 17 present to attend to the needs of the patients. This Rule is not met as evidenced by: Based on review of the facility's "Nurse Logs" it was determined the facility did not have two nurses present and on duty at all times on treatment days. This could potentially affect any of the patients served by the facility on days when only one nurse was scheduled. A total of 435 procedures were performed in the most recent twelve months. Findings include: Review of the facility's "Nurse Logs" revealed only one nurse was in the facility and worked both the surgery and recovery room for the patients treated on the following dates: 08/12/15; 08/14/15; 09/06/15; 11/04/15; 11/09/15; 01/31/16; 04/06/16; 04/24/16; 05/03/16; 05/05/16; 05/22/16; 06/08/16; 06/15/16; 06/26/16; 11/08/16 and 11/22/16. This finding was verified during interview at 7:10 PM on 11/29/16 by Staff B.	C 225	C 225 - Nurse Duty Requirements 1. This deficiency will be corrected with the following measures: a. A staff schedule will be created to ensure two nurses are scheduled at all times during surgical procedures. b. A policy has been developed requiring the retention of all staff schedules. 2. The following measures have been taken to ensure that the deficiency does not recur: a. All nursing staff and Clinic Director have undergone training regarding Nurse Duty Requirements. b. Schedules will be audited on a quarterly basis to ensure compliance was maintained. 3. The performance will be monitored to ensure solutions are permanent through: a. Monthly audits conducted by the Clinic Director. b. Quarterly audits conducted by a 3rd party inspector.	12/01/2016
C 226	O.A.C. 3701-83-18 (G) Copies of Licenses & Schedules Each ASF shall maintain the following: (1) An established system of records sufficient for the director to ascertain that all individuals	C 226	4. This deficiency was corrected on 12/01/2016.	

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C 226	Continued From page 18 employed at the ASF in a professional capacity meet the standards applicable to that profession, including, but not limited to, possessing a current Ohio license, registration, or other certification required by law, and (2) Staffing schedules, time-worked schedules, on-call schedules, and payroll records for at least two years. This Rule is not met as evidenced by: Based on personnel file review and staff interview it was determined the facility failed to verify active license status for their RN (registered nurse) staff. 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 of RN Staff #3, #4, and #5 revealed verification of licenses with an expiration date of 8/31/15. There was no evidence to reveal licenses had been checked to ensure they were current and without disciplinary action for the current period expiring 08/31/17. This finding was verified during interview with Staff B at 7:10 PM on 11/29/16.	C 226	C 226 - Copies of Licenses and Schedules 1. This deficiency will be corrected with 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 regards to retention. c. Copies of relevant licenses have been added to respective personnel files. 2. The following measures have been taken to ensure that the deficiency does not recur: a. Monthly QA audits will sample personnel files for compliance. b. Quarterly QA audits will take a complete inventory of personnel files. 3. The performance will be monitored to ensure solutions are permanent through: a. Quarterly audits conducted by a 3rd party inspector. 4. This deficiency was corrected on 12/15/2016.	12/15/2016
C 266	O.R.C. 3702.30 (B) Infection Control Program An ambulatory surgical facility shall maintain an infection control program by creating and administering a plan designed to prevent, identify,	C 266		

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C 266	Continued From page 19 and manage infections and communicable diseases; ensure that the program is directed by a qualified professional trained in infection control; ensure the program is an integral part of the ambulatory surgical facility's quality assessment and performance improvement program; and implement in an expeditious manner corrective and preventive measure that result in improvement. This Rule is not met as evidenced by: Based on review of facility documentation and staff interviews, the facility lacked evidence of an infection control program, and failed to ensure a qualified professional trained in infection control was present to ensure there was a program which was an integral part of the ambulatory surgical facility's quality assessment and performance improvement program (QAPI). 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 5:30 PM, a review was completed of facility documentation that included all of the Governing Body minutes. An interview was completed with Staff A and Staff B at that same time regarding whether the facility had an infection control program and a qualified professional trained in infection control. During this interview, Staff B stated the facility does not have a current infection control program in place and does not have an employee designated and qualified to direct an infection control program.	C 266	C 266 - Infection Control Program 1. This deficiency will be corrected with the following measures: a. A template has been created to document minutes for the Governing Board meetings to ensure that the Infection Control Program is discussed. (See Amendment A). 2. The following measures have been taken to ensure that the deficiency does not recur: a. Director of Nursing will assist in developing a comprehensive Infection Control Program. b. A 3rd party consulting firm will review the Infection Control Program for deficiencies and make recommendations. 3. The performance will be monitored to ensure solutions are permanent through: a. Governing Board will review and approve the Infection Control Program on an annual basis. b. Quarterly reviews of Governing Board meeting minutes will be conducted to ensure the Infection Control Program was discussed. c. Staff will be trained on all Infection Control Program protocols. 4. This deficiency was corrected on 12/23/2016.	12/23/2016

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C 266	Continued From page 20 Staff A was present during this interview with Staff B.	C 266		