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	0596AS	A. BUILDING _____ B. WING _____	03/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNDER'S WOMEN'S HEALTH CENTER THE	1243 EAST BROAD STREET COLUMBUS, OH 43205

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C 000	Initial Comments LR, LB REVISED Licensure Compliance Inspection Administrator: Judith Nolan, Administrator County: Franklin Number of ORs: 4 Services provided: Surgical and Medical Abortions License Current: Yes License Expiration Date: March 2012 The following violation is issued as a result of the licensure compliance inspection completed on 03/14/12.	C 000		
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 prteparedness plan.	C 104		

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C 104	Continued From page 1 This Rule is not met as evidenced by: Based on staff interviews, and review of governing body meeting minutes, the facility failed to provide evidence the governing body approved policies and procedures, and evaluated the facility's quality assessment and performance improvement program on an annual basis. The facility performed a total of 1,319 procedures in the past 12 months. Findings include: On 03/13/12, a review of the facility's governing body minutes was conducted. These minutes were silent to an annual evaluation of the facility's quality assessment and performance improvement program. There was no evidence policies and procedures had been approved by the governing body. This was verified with Staff G during an interview on 03/12/12 at 9:30 AM.	C 104		
C 122	O.A.C. 3701-83-08 (D) Job Descriptions The HCF shall provide each staff member with a written job description delineating his or her responsibilities. This Rule is not met as evidenced by:	C 122		

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C 122	Continued From page 2 Based on staff interview, and review of personnel files, the facility failed to provide each staff member with a written job description delineating his or her responsibilities. This involved 3 of 5 personnel records reviewed (Staff C, D,and E). The facility performed a total of 1,319 procedures in the past 12 months. Findings include: Review of personnel files was conducted on 03/13/12 for Staff C, D, and E. These staff members worked directly with patients. There was no evidence of job descriptions in the aforementioned employees personnel files. This was verified with Staff G on 03/13/12 at 1:50 PM.	C 122		
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 staff interview, and review of personnel files, the facility failed to provide each staff	C 123		

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C 123	Continued From page 3 member with orientation to their job duties. This involved 3 of 5 personnel records reviewed (Staff C, D,and E). The facility performed a total of 1,319 procedures in the past 12 months. Findings include: Review of personnel files was conducted on 03/13/12 for Staff C, D, and E. These staff members worked directly with patients. There was no evidence of orientation to their jobs in the aforementioned employees personnel files. This was verified with Staff G on 03/13/12 at 1:50 PM.	C 123		
C 126	O.A.C. 3701-83-08 (H) Staff Schedules Each HCF shall retain 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 review of staffing schedules and staff interview, the facility failed to retain staffing and on-call schedules for the past two years. The facility performed a total of 1,319 procedures in the past 12 months. Findings include: A review of staffing schedules was conducted on 03/14/12 at 9:30 PM. The only schedules provided by the facility was for February and March 2012. Staff G was interviewed at that time and revealed the facility does not retain staffing schedules, with the exception of February and March 2012.	C 126		

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C 139	Continued From page 4	C 139		
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 preventative maintenance records, observations, and staff interviews, the facility failed to ensure 4 of 4 operating room tables were maintained in a safe manner. The facility performed a total of 1,319 procedures in the past 12 months. Findings include: A tour of the facility on 03/14/12 with Staff G revealed 4 operating rooms (ORs) which each contained a table with an electrical cord. The tables in ORs 2, 3, and 4 were observed with a bright pink sticker that stated "danger, table unsafe for use". These stickers were observed on the sides of the tables in OR 2, 3, and 4, were small in size, and not easily viewed. The male terminal ends of the electrical cords on OR tables 2, 3 and 4 were observed with plastic zipties that passed through the openings. Staff G stated the medical equipment company told the facility to put the zipties on the cords so they could not be plugged into the electrical outlets. The electrical cords to these tables lacked a warning label to not plug the cords into the wall. During tour, when asked what the danger was, Staff G stated when the tables are plugged into the electrical outlet, the person on the table could feel a "tingle". This employee stated all staff were informed of the danger to the tables. However, an interview with a recovery room nurse (Staff E) on 03/14/12 at 9:43 AM, revealed the employee	C 139		

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C 139	Continued From page 5 was not aware of the danger to the tables, stating he/she does not work in the operating rooms. Staff G verified these tables are currently used to place patients on during the surgical procedures. On, 03/14/12, a review of preventative maintenance logs by the outside service company employee, in February 2012, stated OR tables 1,2,3, and 4 failed, unsafe for use. The same company report, dated February 2011, stated these OR tables failed several previous inspections.	C 139		
C 152	O.A.C. 3701-83-12 (C) Q A & Improvement Requirements The quality assessment and performance improvement program shall do all of the following: (1) Monitor and evaluate all aspects of care including effectiveness, appropriateness, accessibility, continuity, efficiency, patient outcome, and patient satisfaction; (2) Establish expectations, develop plans, and implement procedures to assess and improve the quality of care and resolve identified problems; (3) Establish expectations, develop plans, and implement procedures to assess and improve the health care facility's governance, management, clinical and support processes; (4) Establish information systems and appropriate data management processes to facilitate the collection, management, and analysis of data needed for quality assessment and performance improvement, and to comply with the applicable data collection requirements of Chapter 3701-83 of the Administrative Code;	C 152		

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C 152	Continued From page 6 (5) Document and report the status of quality assessment and improvement program to the governing body every twelve months; (6) Document and review all unexpected complications and adverse events, whether serious injury or death, that arise during an operation or procedure; and (7) Hold regular meetings, chaired by the medical director of the HCF or designee, as necessary, but at least within sixty days after a serious injury or death, to review all deaths and serious injuries and report findings. Any pattern that might indicate a problem shall be investigated and remedied, if necessary. This Rule is not met as evidenced by: Based on staff interviews, and review of the quality assessment plan, the facility failed to monitor and evaluate all aspects of patient care, failed to establish expectations, develop plans, and implement procedures to assess and improve the quality of care and resolve identified problems, and failed to document and report the status of quality assessment and improvement program to the governing body every twelve months. The facility performed a total of 1,319 procedures in the past 12 months. Findings include: On 03/14/12, a review was conducted of the facility's quality assessment plan (QA). The facility lacked documentation of regular QA meetings. The only item being monitored for	C 152		

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C 152	Continued From page 7 quality assurance was chart audits. The facility lacked documented evidence of monitoring patient care, and lacked plans and procedures to assess and improve quality of care. There was no evidence the governing body was made aware of the status of the quality assessment program on an annual basis. This was verified by Staff G, on 03/14/12 at 9:40 AM.	C 152		
C 157	O.A.C. 3701-83-13 (A) Complaints Policy & Procedures Each HCF shall develop and follow policies and procedures to receive, investigate, and report findings on complaints regarding the quality or appropriateness of services. The documentation of complaints shall, at a minimum, include the following: (1) The date complaint was received; (2) The identity, if provided, of the complainant; (3) A description of complaint; (4) The identity of persons or facility involved; (5) The findings of the investigation; and (6) The resolution of the complaint. This Rule is not met as evidenced by: Based on review of facility policies and procedures, and staff interview, the facility failed to develop policies and procedures to receive, investigate, and report findings in regards to complaints. The facility performed a total of	C 157		

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C 157	Continued From page 8 1,319 procedures in the past 12 months. Findings include: A review of facility policies on 03/14/12 revealed the facility lacked a written policy for complaint investigation. An interview with Staff G, on 03/14/12 at 9:45 AM, verified there was no written procedure in place in which to investigate and report findings of complaint investigations.	C 157		
C 201	O.A.C. 3701-83-16 (B) Governing Body Duties The governing body shall: (1) At least every twenty-four months review, update, and approve the surgical procedures that may be performed at the facility and maintain an up-to-date listing of these procedures; (2) Grant or deny clinical (medical-surgical and anesthesia) privileges, in writing and reviewed or re-approved at least every twenty-four months, to physicians and other appropriately licensed or certified health care professionals based on documented professional peer advice and on recommendations from appropriate professional staff. These actions shall be consistent with applicable law and based on documented evidence of the following: (a) Current licensure and certification, if applicable; (b) Relevant education, training, and experience; and (c) Competence in performance of the procedures for which privileges are requested, as indicated in part by relevant findings of quality assessment and improvement activities and other reasonable indicators of current competency.	C 201		

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C 201	Continued From page 9 (3) In the case of an ASF owned and operated by a single individual, provide for an external peer review by an unrelated person not otherwise affiliated or associated with the individual. The external peer review shall consist of a quarterly audit of a random sample of surgical cases. This Rule is not met as evidenced by: Based on staff interview, and review of surgeons' personnel files, the governing body failed to approve surgical procedures that may be performed at the facility, failed to grant clinical privileges in writing every twenty-four months to 2 of 2 licensed physicians (Staff A and B), and failed to verify current license for 1 of 2 surgeons. The facility performed a total of 1,319 procedures in the past 12 months. Findings include: Review of personnel files was conducted on 03/13/12 for Staff A and B (surgeons). Based on review of five medical records, and interview with Staff G, on 03/14/12 at 9:30 AM, these surgeons were currently performing surgical procedures on patients. A review of both surgeons' personnel files revealed there was no evidence these surgeons were granted surgical privileges in the past twenty-four months by the governing body. Staff A's surgical privileges in the facility expired October 2008, and Staff B's in January 2012.	C 201		

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C 201	Continued From page 10 Review of Staff B's personnel file lacked documented evidence his/her medical license had been verified as current in the State of Ohio. This was confirmed during interview with Staff G, on 03/14/12, at 9:50 AM.	C 201		
C 214	O.A.C. 3701-83-17 (I) Patient Accompanied at Discharge The ASF shall discharge a patient only if accompanied by a responsible person, unless the attending or discharging physician, podiatrist, or anesthesia qualified dentist determines that the patient doesnot need to be accompanied and documents the circumstances of discharge in the patient's medical record. This Rule is not met as evidenced by: Based on medical record reviews, and staff interview, the facility failed to document discharge status of five of five patients in regards to whether they were discharged with/without a responsible person. This involved Patients #1 through #5). Findings include: A review of Patients #1, #2, #3, #4, and #5's medical records were conducted on 03/14/12. These patients received a surgical abortion between July 2011 and March 2012. These medical records were silent to discharge status of these patients, and to whether the patients were discharged with a responsible party or unaccompanied. These medical records were silent to physician's determination as to whether the patients needed to be accompanied at the time of discharge. This was verified with Staff G, on 03/14/12 , at 9:20 AM.	C 214		

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C 234	O.A.C. 3701-83-19 (E) Transfer Agreement The ASF shall have a written transfer agreement with a hospital for transfer of patients in the event of medical complications, emergency situations, and for other needs as they arise. A formal agreement is not required in those instances where the licensed ASF is a provider-based entity of a hospital and the ASF policies and procedures to accommodate medical complications, emergency situations, and for other needs as they arise are in place and approved by the governing body of the parent hospital. This Rule is not met as evidenced by: Based on review of facility documentation and staff interview, the facility failed to have evidence of a written transfer agreement with a hospital for transfer of patients in the event of medical complications, emergency situations, and for other needs. The facility was not a provider-based entity of a hospital. The facility performed a total of 1,319 procedures in the past twelve months. Findings include: On 03/13/12 and 03/14/12, a review was conducted of the facility's documents. During this review, there was no evidence of a written transfer agreement with a hospital. On 03/13/12, at 2:10 PM, Staff G verified the facility does not have a written transfer agreement with a hospital.	C 234		

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C 234	Continued From page 12 This employee stated both physicians, employed in the facility, have been granted privileges at local hospitals, stating Staff A has privileges at one hospital, and Staff B at 3 hospitals. This employee verified the facility did not have any documentation of these privileges, and stated the facility is not a provider-based entity of a hospital.	C 234		