If continuation sheet 1 of 9

Ohio Dept Health

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	0530AS		1		00/4	4/0040	
NAME OF F	ROVIDER OR SUPPLIER	000070	STREET ADD	RESS CITY	STATE, ZIP CODE	02/1	<u>4/2013</u>
	D PARENTHOOD EAS	ST HEALTH CENT	3255 EAS	T MAIN STI JS, OH 432	REET		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
C 000	Initial Comments			C 000		*	
	County: Franklin Number of Operatin Services Provided: License Current: Ye License expiration of The following violati	er: Sarah Courtney g Rooms: Two (2) Surgical Abortions es					
C 129	O.A.C. 3701-83-09	(A) Standards of Pra	ctice	C 129			
	The HCF shall assu services in accordan	re all staff members nce with:	provide				
ì		nt and accepted star ical capabilities of th					
	(2) Applicable state regulations.	and federal laws and	1	į			
	interview, the facility the administration of staff was documented six patient's (Patient The facility also faile administration of an medication and the contra-muscular inject medical record for P was 16. The facility	ecord review and star failed to ensure the foral medications by ed in the medical rec at #3, 4, 12, 13, 14, and to ensure the time intravenous push (IV) dose and time of and ion was documented atient #16. The same	time of licensed ords for id 16). of the /P)				
Ohio Departm	ent of Health				TITLE		(X6) DATE

92S911

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	FIPLE CONSTRUCTION	(X3) DATE (
ı	0530AS		B. WING		_	4 4 10 0 4 0	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	I DRESS, CITY,	STATE, ZIP CODE	021	14/2013
PLANNE	ED PARENTHOOD EAS	ST HEALTH CENT	3255 EAS	T MAIN ST US, OH 432	REET		
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 129	Continued From pa	ige 1		C 129			
	in 2012.						
	Findings include:						
	on 02/13/13. Docur record dated 06/27/administered Misop induce uterine contrabortion) 200 milligr #3. The time the mass not documente during interview with PM. Staff A stated i document the time of Staff A visualized that the medication admidocumented.	If for Patient #3 was rementation in the med /12 revealed that Phyprostol (a medication gractions during a medication was administed. This finding was on Staff A on 02/13/13 it was facility policy to of medication administed chart and whinistration time was remedical chart and white was remedical ch	dical ysician A used to dical to Patient istered confirmed at 4:08 o stration verified not				
	on 02/13/13. Docur record dated 07/09/ practical nurse reco sheet that she admi medication) 400 mill licensed practical nutime the medication finding was verified 4:30 PM. Staff A vis	for Patient #4 was rementation in the medi/12 revealed that a licorded on the pre-oper inistered Ibuprofen (alligrams to Patient #4 urse did not document was administered. The with Staff A on 02/13, sualized the medical of for the time of the medical for the time of the medical for the time of the medical of the time of the medical for the medical for the time of the medical for the time of the medical for the time of the medical for the	lical censed rative a pain the nt the This 3/13 at chart and				
	on 02/14/13. Docum record dated 12/28/ practical nurse admi nausea medication) push according to the licensed practical nurse	for Patient #16 was rementation in the medical formula for the medical formula for the medication log. The medication log. The medical formula for the medical for the medical for the medical formula for the medical for the medical formula for the medical	ical censed anti ravenous he nt the				

92S911

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		0530AS		B. WING_		02/	14/2013
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		14/2013
PLANNE	D PARENTHOOD EA	ST HEALTH CENT		ST MAIN STI US, OH 432			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
C 129	addition, review of the revealed a licensed the administration of used to control posintra-muscularly. The medication administration administration administration administration administration and time the Zofran was and time that the M were not document. The medical record on 02/13/13. Documerord revealed a dipregnancy of approfor which a medical review of the record administered for the hours apart and the (Misoprostol) was god/27/12, but no time interview with Staff A confirmed the for the administration further stated that the did not have a space although the expect document the time administered. The medical record on 02/13/13. Document of the medical record on 02/13/13.	the moderate sedation of practical nurse documents of Methergine (a medit partum hemorrhage he dose and time of tration was not documented with Staff D. M. Staff D. Visualized his time and verified to administered and the ethergine was administered and the ethergine was administered. If or Patient #12 was mentation in the medit in the pile abortion was sought if revealed that the pile abortion were space third day dose of iven by the physician was recorded. In a A on 02/13/13 at 4:08 at no time had been on of the medication, the form for the document for the time to be proposed in the medications are for Patient #13 was mentation in the medital for Patient #13 was mentation in the medit	umented lication) the mented.) on the that the ne dose nistered reviewed lical electron to Further Ils ed 48 n on an 3 PM, recorded Staff A mentation placed,	C 129			
	pregnancy of appro- days gestation for w sought. Further revi- the third day pill in the	iagnosis of a positive ximately six weeks a rhich a medical abort ew of the record reven ne series of the medi by the physician on 0	nd three ion was ealed that cal				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		B. WING	B. WING				
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		14/2013
PLANNE	D PARENTHOOD EAS	ST HEALTH CENT		ST MAIN ST US, OH 432			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL				PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 129	but no time was reco2/13/13 at 4:08 PN expectation was for the administration of the administration of the medical record on 02/14/13. Documer of the revealed a different proposed of the sought. Further revealed the sought of the swas given on 09/07, administration was on 02/13/13 at 4:08	corded. In an interview, Staff A stated that a time to be document all medications. for Patient #14 was mentation in the mediagnosis of a positive ximately six weeks anich a medical abortiview of the record she series of the medical /12, but no time of documented. In an in PM, Staff A stated the atime to be documented.	reviewed dical e and one on was owed the abortion enterview nat the	C 129			
C 139	The HCF shall be maintained in a safe and sanitary manner. This Rule is not met as evidenced by:			C 139			
į	staff, the facility faile were stored in a sar	ons and interview with the distribution of the	use items were				
Phia Donnte	A tour of the facility of During a tour of the approximately 9:48 and Staff D, multiple care supplies were rethe concrete floor. T	facility's basement a AM, accompanied by cardboard boxes whoted to be stored di	t / Staff A ith patient rectly on				

Ohio De	ept Health						APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/ IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TPLE CONSTRUCTION	(X3) DATE S COMPL	
		0530AS		B. WING		021'	14/2013
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	STREET AD	DRESS, CITY,	STATE, ZIP CODE	, VEI	1-112010
PLANNE	D PARENTHOOD EAS	ST HEALTH CENT		ST MAIN ST US, OH 432			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
C 139	Continued From pa	ge 4		C 139			-
C 214	hygiene products (a drape sheets, exam cases, bathroom tis folders. Staff A and of the multiple cardle directly on the concare supplies. In an stated that the facility	glass jars, gloves, feabsorbent pads), dispose table paper rolls, piesue, bulk condoms, distaff Diverified the board boxes being strete floor containing interview at 9:54 AM ty was in need of motoget the boxes off the boxes off the patient Accompanion of the page of the	cosable illow and chart presence cored patient II, Staff A ore the floor.	C 214			
	The ASF shall disch accompanied by a rattending or dischar anesthesia qualified patient doesnot nee	narge a patient only in responsible person, urging physician, podial dentist determines to dentist determines to dentist of dischar	f unless the atrist, or that the	<i>5</i> - <i>1 1</i>			
	interview, the facility sampled patients (P discharged only if ac person, unless the a physician determine	ecord review and star failed to ensure four atients #1, 2, 7, and eccompanied by a res attending or discharged that the patients disanced and documents at discharge in the pate facility performed 1	r of 16 12) were ponsible ing d not ed the itient's				

Findings include:

The medical record for Patient #1 was reviewed on 02/13/13. Review of the medical record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		SURVEY LETED
	0530AS		B. WING	02/14/2013			
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	021	14/2013
PLANNE	D PARENTHOOD EAS	ST HEALTH CEN1	3255 EAS	ST MAIN ST US, OH 432	REET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
C 214	Continued From pa	ge 5	·	C 214			
	revealed that the paragraph (surgical abortion) anesthesia on 04/13 discharged home physician that the paccompanied by a recompanied by a responsible pedocumentation by the discharge. This find interview with Staff A stated they were surgical procedure of 04/17/12 due to an 03/24/12. The patien 04/17/12 at 12:15 Phy a responsible pedocumentation by the did not need to be a person, nor of the codischarge. This find interview with Staff A stated they we physician needed to record if the patient person. The medical record on 02/13/13. Review	atient's surgical processas performed under 2/12. The patient was per self on 04/13/12 a documentation by the atient did not need to responsible person, redischarge. This fir on 02/13/13 at 4:30 into the medical recompanied persons for Patient #2 was reduced that the patient (dilation and curettage) incomplete abortion of the medical recompanied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a resircumstances of the ding was verified during a companied by a res	r local is t 1:05 e t 0 be nor of the nding was PM. Staff nysician ird if the eviewed the had a ie) on ome on mpanied patient sponsible ng O PM. he dical sible				
	revealed that the pa facility under local a patient was discharg was no documentati patient did not need responsible person,	tient received service nesthesia on 02/10/1 ged home per self. Ton by the physician to be accompanied I nor of the circumstant interview on 02/13/2	es at the 2. The here that the by a nces of				j

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
0530AS		B. WING		02/	14/2013		
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		14/2013
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C 214	Continued From pa	ge 6		C 214			
	12:04 PM, Staff A verified there was no documentation by the physician of the circumstances of the patient's discharge on the surgery treatment plan. The medical record for Patient #12 was reviewed						
	on 02/13/13. Review of the medical record revealed that the patient received services at the facility under local anesthesia on 05/18/12. The patient was discharged home per self. There was no documentation by the physician that the patient did not need to be accompanied by a responsible person, nor of the circumstances of the discharge. In an interview on 02/13/13 at 12:04 PM, Staff A verified there was no documentation by the physician of the circumstances of the patient's discharge on the surgery treatment plan.						
C 231	O.A.C. 3701-83-19 Accountability	(B) Drug Control &		C 231			
	The ASF shall:			İ			
	for storage and the	e space, equipment, administration of drug te and federal laws a	gs in				
	(2) Establish and implement a program for the control and accountability of drug products throughout the facility and maintain a list of medications that are always available.		ts				
	This Rule is not met as evidenced by: Based on medical record review, review of the narcotic control/accountability signature logs, staff interview, and review of the facility policy entitled						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	0530AS			B. WING		02/1	14/2013
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		14/2013
PLANNE	D PARENTHOOD EAS	ST HEALTH CENT	3255 EAS	T MAIN ST US, OH 432	REET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	(X5) COMPLETE DATE	
C 231	Continued From pa	ge 7	i	C 231			
	to ensure two licens being wasted. The procedures in 2012	nent Protocol", the fac sed staff witnessed n facility performed 16	arcotics				
	Findings include:						
!	Protocol" was revieg stated under number	ntitled "Narcotic Man wed on 02/13/13. Ther 1, "Wasting of any by two licensed staff.	ne policy narcotic				
	The narcotic storage and the narcotic accountability/control logs were reviewed with Staff B on 02/13/13 between 1:30 PM and 2:00 PM. Review of the narcotic control /accountability log revealed Versed (narcotic) was wasted on the following dates, in these quantities without a second licensed staff signature/witness: 01/11/13 - Versed 5 mg (milligrams) 01/16/13 - Versed 3 mg 01/18/13 - Versed 1.5 mg 01/25/13 - Versed 10.5 mg						
	02/13/13 at 1:45 PM licensed staff should	e confirmed with Staf I. Staff B stated that I have signed as witr arcotic on the narcoti	two nessing				
	Fentanyl (narcotic) v	e narcotic count log r was not witnessed by wasted on the follow	∕ two				
	12/28/12 - Fentanyl 01/02/13 - Fentanyl 01/04/13 - Fentanyl		6)				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE	:R/CLIA MBER:	(X2) MULT A. BUILDIN B. WING		(X3) DATE SI COMPLE	
		0530AS				02/1	4/2013
NAME OF P	PROVIDER OR SUPPLIER	1			STATE, ZIP CODE		
PLANNE	D PARENTHOOD EAS	ST HEALTH CENT		ST MAIN STI US, OH 432			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETE DATE	
C 231	Continued From pa	age 8		C 231			
1	01/11/13 - Fentanyl 01/16/13 - Fentanyl	I 50 mcg I 100 mcg re verified with Staff B	3 on				
	02/10/10 002.00	VI.	!				
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