The Founder's Women's Health Center

1243 East Broad Street Columbus, Ohio 43205-1438 614-251-1818 Toll Free 1-800-282-9490

September 5,2013

RE: Deficiencies/corrections of ASF #0596AS
Attn: Wanda Iacovetta, RN

Dear Ms. Iacovetta,

Per our conversation on 9-5-13 regarding dates of correction, I have left the original dates in place as you indicated to me since we did not receive our deficiences notice until 7-1-13. There is one date of correction regarding C-105 and that correction has been made. Thank you for all of your assistance regarding this matter. Please feel free to contact me if further action is needed at 614-251-1818.

Judith Nolan
Executive Director

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0596AS	A. BUILDING: _____ B. WING _____	04/30/2013

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 Licensure Compliance Inspection Executive Director: Judith Nolan County: Franklin Number of Operating Rooms: 3 Services Provided: Women's Services The following violations are issued as a result of the licensure compliance inspection completed on 04/30/13.	C 000		
C 105	O.A.C. 3701-83-03 (G) Liability Insurance Each HCF shall either maintain documentation of appropriate liability insurance coverage of the staff and consulting specialists or inform patients that the staff member or consulting specialist does not carry malpractice insurance. This Rule is not met as evidenced by: Based on a review of personnel files and interview with facility staff, it was determined that the facility failed to notify patients that Physician A did not carry malpractice liability insurance. This deficient practice had the potential to affect all patients cared for at this facility. There were 2,128 patient visits in 2012. Findings include: The personnel file for Physician A was reviewed	C 105	C 105 – Liability Insurance 1. This deficiency will be corrected with the following measures: a. Patients now receive a disclosure informing them of physician A's lack of malpractice insurance, in accordance with OAC 3701-83-03 (G) (See exhibit A) 2. The following measures have been taken to insure the deficiency does not recur: a. The disclosure has been added to patients charts b. The staff has been trained on new disclosure	07/05/2013

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C 105	Continued From page 1 on 04/29/13. There was no documentation in the physician's personnel file of malpractice liability insurance. Interview with Staff F on 04/30/13 at 2:55 P.M. verified that Physician A did not have malpractice liability insurance. Staff F stated that the surgery center used to have a form that was presented to the patients to inform them prior to surgery that Physician A did not have malpractice insurance. Staff F further stated that the surgery center stopped using that form and stopped giving the form to patients to sign as acknowledgement of being made aware of the physician's lack of malpractice insurance. Staff F stated the surgery center thought the information was contained in the surgical informed consent form; however, upon review of the informed consent form on 04/29/13, Staff F verified that the information was not contained in the informed consent form. Staff F verified that since July, 2012 till present, there was no documented evidence that patients had been made aware of Physician A not carrying malpractice liability insurance.	C 105	C 105 – Liability Insurance (Continued) 3. The performance will be monitored to ensure solutions are permanent through: a. Chart review done quarterly 4. This deficiency was corrected on July 5, 2013.	07/05/2013
C 119	O.A.C. 3701-83-08 (A) Professional Standards Each HCF shall utilize personnel that have appropriate training and qualifications for the services that they provide. Any staff member who functions in a professional capacity shall meet the standards applicable to that profession, including but not limited to possessing a current Ohio license, registration, or certification, if required by law, and working within his or her scope of practice. Copies of current Ohio licenses, registrations and certifications shall be kept in the employee's personnel files or the provider of the HCF shall have an established system to verify and	C 119	C 119 – Professional Standards 1. This deficiency will be corrected with the following measures: a. Staff N is no longer administering medications to patients. Nurses will administer medications to patients.	06/27/2013

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C 119	Continued From page 2 document the possession of current Ohio licenses, registrations, or other certifications required by law. Nurse licenses shall be copied in accordance with paragraph (E) of rule 4723-7-07 of the Administrative Code. This Rule is not met as evidenced by: Based on medical record review and staff interview, the facility failed to utilize personnel that had appropriate training and qualifications for the services they provided. This deficient practice affected 7 of 10 sampled patients. There were 2,128 patient visits in 2012. Findings include: "Staff Member" is any individual who provides direct care to patients on a full-time, part-time, temporary, contract or voluntary basis. The medical records of Patients #2, #3, #5, #7, #8, #9, and #10 were reviewed on 04/29/13 and 04/30/13. Review of these medical records revealed the pre-operative medications of Ibuprofen 600 milligrams and Cytotec 400 milligrams (used for cervical softening) were administered by Staff N. Review of the medical records revealed Cytotec 400 milligrams and Ibuprofen 600 milligrams were administered by Staff N as follows: Patient #2 had surgery on 04/12/13. Staff N documented administering Cytotec 400 milligrams (mg) at 10:55 A.M. and Ibuprofen 600 milligrams at 10:55 A.M.	C 119	C 119 – Professional Standards (Continued) 2. The following measures have been taken to ensure the deficiency does not recur: a. Personnel files have been reviewed to ensure facility personnel that have appropriate training and qualifications 3. The performance will be monitored to ensure solutions are permanent through: a. Facility nurses will review charts at the end of every surgery day to ensure that there are no deficiencies. b. Any deficiencies noted will immediately be reported to the Director of Nursing. 4. This deficiency was corrected on June 27, 2013.	06/27/2013

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C 119	Continued From page 3 Patient #3 had surgery on 03/29/13. Staff N documented administering Cytotec 400 mg at 12:42 P.M. and Ibuprofen 600 milligrams at 12:48 P.M. Patient #5 had surgery on 03/21/13. Staff N documented administering Cytotec 400 mg and Ibuprofen 600 mg at 4:06 P.M. Patient #7 had surgery on 04/02/13. Staff N documented administering Cytotec 400 mg and Ibuprofen 600 mg at 10:31 P.M. Patient #8 had surgery on 03/23/13. Staff N documented administering Cytotec 400 mg at 9:59 A.M. and 10:51 A.M. and Ibuprofen 600 mg at 9:59 A.M. Patient #9 had surgery on 04/10/13. Staff N documented administering Cytotec 400 mg at 10:14 A.M. and 11:05 A.M. Patient #10 had surgery on 03/18/13. Staff N documented administering Cytotec 400 mg at 10:18 A.M. During interview with Staff N on 04/30/13 at 11:20 A.M. the staff member stated they were a former Licensed Practical Nurse but they had let their license lapse sometime in the 1980's. Staff N further verified that they only worked in the facility as a volunteer, as they were a relative of one of the nurses. Staff N further verified that they were not on the facility's payroll. Staff N stated they were a Medical Assistant, but could not produce evidence of this certification at the time of the inspection. Interview with Staff M on 05/01/13 per telephone at 10:15 A.M. verified that there was no	C 119		

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C 119	Continued From page 4 documentation that Staff N was a Medical Assistant. Staff M verified that Staff N worked only as a volunteer and stated Staff N had previously worked at the facility and may have documentation in an old personnel file that was in a locked cabinet with a lost key. Staff M stated they would try to get access to this cabinet and see if there was any evidence of Staff N's certification as a Medical Assistant. Staff M verified at the conclusion of this inspection that the facility could not produce evidence that Staff N was a Medical Assistant and able to administer medications.	C 119		
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 a review of personnel files and interview with the facility staff, it was determined that the facility failed to ensure eight of nine facility staff (Staff D, E, F, G, H, I, J, and K) had documentation of orientation appropriate to the	C 123	C 123 – Staff Orientation & Training 1. This deficiency will be corrected \with the following measures: a. Facility will conduct training with all staff members regarding their job duties and responsibilities. b. Facility will provide written job description for all staff members. 2. The following measure have been taken to ensure the deficiency does not recur: a. HR manager will conduct annual review of personnel files for completeness. b. Facility will create new hire orientation program to ensure all incoming staff fully understand their responsibilities and facility expectations.	07/16/2013

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C 123	Continued From page 5 tasks that each staff member would be expected to perform. This deficient practice had the potential to affect all patients cared for at this facility. There were 2,128 patient visits in 2012. Findings include: The facility's personnel files were reviewed on 04/29/13 and 04/30/13. Review of the personnel files for Staff D, E, F, G, H, I, J, and K revealed no documentation that the facility staff received orientation appropriate to the tasks that each staff member would be expected to perform. Review of the personnel files further revealed the following dates of hire for each staff member listed above: Staff D (Registered Nurse) Hire Date: 09/01/10 Staff E (Registered Nurse) Hire Date: 0614/12 Staff F (Registered Nurse) Hire Date: 06/14/13 Staff G (Licensed Practical Nurse) Hire Date: 02/11/12 Staff H (Medical Assistant) Hire Date: 06/04/12 Staff I (Patient Care Assistant) Hire Date: 06/14/12 Staff J (Patient Care Assistant) Hire Date: 10/23/11 Staff K (Patient Care Assistant) Hire Date: 06/14/12 Interview with Staff L on 04/30/13 at approximately 2:00 P.M. verified the lack of documentation in the staff's personnel files.	C 123	C 123 – Staff Orientation & Training (Continued) 3. The performance will be monitored to ensure solutions are permanent through: a. HR manager will be present for staff training. b. HR manager will conduct annual review of personnel files to ensure training has been properly documented. 4. Staff training is scheduled to be conducted on July 16, 2013 and written job descriptions will be passed out at that time.	07/16/2013
C 129	O.A.C. 3701-83-09 (A) Standards of Practice The HCF shall assure all staff members provide services in accordance with: (1) Applicable current and accepted standards of	C 129	C 129 - Standards of Practice 1. This deficiency will be corrected with the following measures:	07/16/2013

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C 129	Continued From page 6 practice and the clinical capabilities of the HCF; and (2) Applicable state and federal laws and regulations. This Rule is not met as evidenced by: Based on a review of medical records and interview with the facility staff, the facility failed to ensure there were physician orders for the administration of second doses of an oral medication (Cytotec/cervical softener) for two patients (Patients #8 and #9) and failed to provide documentation of staff administering intravenous sedation for Patient #9. The sample size was 10. There were 2,128 patient visits in 2012. Findings include: The medical record of Patient #8 was reviewed on 04/30/13. The patient had surgery on 03/23/13. The medical record revealed that Staff N administered Cytotec 400 mg at 9:59 A.M. and 10:51 A.M. There was no physician's order for the second dose of the Cytotec. During interview with Staff N on 04/30/13 at 11:20 A.M., the staff (volunteer) stated Physician A wanted to have a second dose of Cytotec 400 mg given to all surgical patients over 13 weeks gestation. Staff N further stated that Physician A wanted the second dose of Cytotec 400 mg given one hour after the initial dose and then proceed with surgery one hour after the administration of the second dose of Cytotec 400 mg. Staff N stated this was an understood request of Physician A, but verified there was no approved protocol/doctor's order for the administration of the second dose of Cytotec	C 129	C 129 - Standards of Practice (Continued) a. The "Medical Notes" form was updated to reflect doctor's orders for medications. (See exhibit B) b. Nursing staff will be trained on proper documentation procedures. 2. The following measures have been taken to ensure the deficiency does not recur: a. Training will be conducted with all staff on a periodic basis to review the importance of proper documentation. 3. The performance will be monitored to ensure solutions are permanent through: a. Facility nurses will review charts at the end of every surgery day to ensure that there are no deficiencies. b. Any deficiencies noted will immediately be reported to the Director of Nursing. 4, "Medical Form" was updated on April 30, 2013. Nursing staff is scheduled to be trained on July 16, 2013. All deficiencies will be remedied as of July 16, 2013.	07/16/2013

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C 129	Continued From page 7 to be given. The medical record of Patient #9 was reviewed on 04/30/13. The patient had surgery on 04/10/13. The medical record revealed that Staff N administered Cytotec 400 mg at 10:14 A.M. and 11:05 A.M. There was no physician's order for the second dose of Cytotec. Patient #9's medical record revealed the patient was given intravenous sedation of Fentanyl 125 micrograms at 12:10 P.M. and 12:15 P.M. and Versed 25 milligrams at 12:05 P.M. during the operative procedure. There were no signatures/initials of the staff person administering these medications. This was confirmed during an interview with Staff F on 04/30/13 at 1:20 P.M. On 04/30/13 at 1:25 P.M. Staff F presented a written protocol for the administration of the second dose of Cytotec. The protocol was signed by Physician A (initials), but lacked a date of the signature. The protocol also lacked a date. An interview was conducted with Staff F on 04/30/13 at 1:25 P.M. and Staff F stated this protocol had just been developed and initialed by Physician A on 04/30/13.	C 129		
C 140	O.A.C. 3701-83-10 (C) Disaster Planning The HCF shall develop a disaster preparedness plan including evacuation in the event of a fire. The HCF shall review evacuation procedures at least annually, and conduct practice drills with staff at least once every six months. This Rule is not met as evidenced by: Based on a review of the facility's fire drill and disaster drill records and interview with the facility	C 140	C 140 – Disaster Planning 1. This deficiency will be corrected with the following measures: a. Facility will conduct a fire drill. b. Facility will conduct a disaster drill.	07/05/2013

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C 140	Continued From page 8 staff, it was determined that the facility failed to conduct fire and disaster drills at least once every six months with facility staff. This deficient practice had the potential to affect all patients cared for at this facility. There were 2,128 patient visits in 2012. Findings include: The facility's fire and disaster drill records were reviewed on 04/29/13. Review of fire drill records revealed that a fire drill was conducted on 04/11/12 and 01/10/13. There was no documentation of any other fire drills conducted in 2012. In addition, there was only one documented disaster drill which was conducted on 04/08/12. Further review revealed no documentation of the names/titles of the staff members or patients who participated in these drills. Interview with Staff M on 04/29/12 at 4:00 P.M. verified that these were the only drills conducted and confirmed there was no documentation of which staff members and patients participated in the drills.	C 140	C 140 – Disaster Planning (Continued) 2. The following measures have been taken to ensure the deficiency does not recur: a. The facility has created documents to record the all drills (See exhibit C). b. The Executive Director is responsible for conducting all drills and completing all relevant documentation. 3. The performance will be monitored to ensure solutions are permanent through: a. Verification of documents as part of the monthly safety audit. (See exhibit D) 4. Fire drill was conducted on July 3, 2013 (See exhibit C-B) and disaster drill was conducted on performed on July 05, 2013 (See exhibit C-A). All deficiencies are corrected as of July 05, 2013.	07/05/2013
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	C 152	C 152 – QA & Improvement Requirements 1. This deficiency will be corrected with the following measures: a. The facility has created a new comprehensive quality control program. (See exhibit E)	07/16/2013

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C 152	Continued From page 9 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; (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 record review and staff interview, it was determined that the facility failed to ensure the quality assessment and improvement program monitored and evaluated the quality of patient	C 152	C 152 – QA & Improvement Requirements (Continued) 2. The following measures have been taken to ensure the deficiency does not recur: a. All staff will be trained on new Quality Control protocols. b. Facilities CEO will conduct the training. 3. The performance will be monitored to ensure solutions are permanent through: a. The governing board shall review the quality assurance program on an annual basis in making the determination to make alterations to the existing plan. 4. Quality Control Program was finalized on July 01, 2013. Governing Board is scheduled to review the Quality Assurance Program on July 10, 2013. Training is scheduled for July 16, 2013. All deficiencies will be corrected as of July 16, 2013.	07/16/2013

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C 152	Continued From page 10	C 152		

care and developed plans to improve the facility's governance and management. This deficient practice had the potential to affect all patients cared for at this facility. There were 2,128 patient visits in 2012.

Findings include:

During the entrance conference on 04/29/13 at 9:30 A.M., Staff M was asked to provide the meeting minutes of the Quality Assessment and Improvement Committee for the last 12 months. Review of the meeting minutes revealed only one meeting had been held in the past 12 months in November, 2012 and had identified no issues requiring an improvement plan. There were no current improvement plans in place.

Review of the facility's Quality Control protocol and the meeting minutes on 04/29/13 revealed no evidence that the Quality Assessment and Improvement Committee was :

Monitoring and evaluating all aspects of care including effectiveness, appropriateness, accessibility, continuity, efficiency, patient outcome, and patient satisfaction;

Establishing expectations, developing plans, and implementing procedures to assess and improve the quality of care and resolve identified problems;

Establishing expectations, developing plans, and implementing procedures to assess and improve the health care facility's governance, management, clinical and support processes;

Establishing information systems and appropriate data management processes to facilitate the

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C 152	Continued From page 11 collection, management, and analysis of data needed for quality assessment and performance improvement; Documenting and reporting the status of quality assessment and improvement program to the governing body every twelve months; Documenting and reviewing all unexpected complications and adverse events, whether serious injury or death, that arise during an operation or procedure; and Holding 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. There was also no evidence that any patterns that might have indicated a problem were investigated and remedied. Interview with Staff L on 04/30/13 at 4:00 P.M. revealed that no quality improvement projects had been implemented in the past 12 months, but they are in the process of making "major changes" to the quality assessment and improvement program. Staff L further stated that those changes have not been finalized and have not been presented to the governing body as of yet.	C 152		
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	C 214	C 214 – Patient Accompanied at Discharge 1. This deficiency will be corrected with the following measures:	07/16/2013

PRINTED: 05/16/2013
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
	0596AS	A. BUILDING: _____ B. WING _____	04/30/2013

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

(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)	(X5) COMPLETE DATE
C 214	Continued From page 12 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 a review of medical records and interview with the facility staff, it was determined that the facility failed to ensure the attending or discharging physician documented the circumstances of discharge in the patient's medical records for two of ten sampled patients (Patients #5 and #8) who were discharged unaccompanied by a responsible adult. There were 2,128 patient visits in 2012. Findings include: The medical record of Patient #5 was reviewed on 04/29/13. The patient had a surgical procedure on 03/21/13. The patient was discharged from the recovery room to home on 03/21/13 at 10:51 A.M. The medical record documented the patient was discharged to self and was not accompanied by a responsible adult. The medical record lacked documentation by the physician (Physician A) of the circumstances for discharge to self and being unaccompanied by a responsible adult. This finding was verified with Staff M on 04/29/13 at 4:00 P.M. The medical record of Patient #8 was reviewed on 04/29/13. The patient had a surgical procedure on 03/23/13. The patient was discharged from the recovery room to home on 03/23/13 at 1:27 P.M. The medical record documented the patient was discharged to self and was not accompanied by a responsible adult. The medical record lacked documentation by the	C 214	C 214 – Patient Accompanied at Discharge (Continued) a. The "Medical Form" Was updated to reflect patient discharge status. (See exhibit B) b. Nursing staff and physicians will be trained on proper document procedures regarding discharge status. 2. The following measures have been taken to ensure the deficiency does not recur: a. Training will be conducted with all staff on a periodic basis to review the importance of proper documentation. 3. The performance will be monitored to ensure solutions are permanent through: a. Facility nurses will review charts at the end of every surgery day to ensure that there are no deficiencies. b. Any deficiencies noted will immediately be reported to the Director of Nursing. 4. "Medical Form" was updated on April 30, 2013. Training is scheduled for July 16, 2013. All deficiencies will be corrected as of July 16, 2013.	07/16/2013

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FORM APPROVED

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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 214	Continued From page 13 physician (Physician A) of the circumstances for discharge to self and being unaccompanied by a responsible adult. This finding was verified with Staff M on 04/29/13 at 4:00 P.M. During an interview on 04/29/13 at 4:00 P.M. Staff M stated they were not aware the physician was to document the circumstances of the discharge when a patient was discharged to self and unaccompanied by a responsible adult.	C 214		

C-1401

THE FOUNDER'S WOMEN'S HEALTH CENTER

FIRE DRILL CHECKLIST

DATE: 7-3-13 TIME: 9:31 a.m. 9:33 a.m.

CHECKLIST:

- ☑ Patients and staff were removed from immediate vicinity of fire or evacuated from building.
- ☑ All persons in facility were accounted for.
- ☑ Exact location of "fire" was announced over the Intercom System 3 times.
- ☑ Designated person (administrator/ supervisor) simulated phone call to Fire Department.
- ☑ All doors were closed.
- ☑ Closed doors remained closed.
- ☑ Staff knew location of and retrieved fire extinguishers.
- ☑ Staff remained calm and moved quietly and swiftly.

COMMENTS: weather conditions: cloudy

Pt's # HAP 1114
ISB 0815

Mary P. Hubb

Signature

Eileen Ray

QUARTERLY FIRE DRILL

	Date	Time	Weather	# of Evacuees	Type of Drill	Conditions Simulated	Alarm Sounded	Evacuation Time	Problems Encountered and Resolution Taken	Drill Administrator
1st Quarter										
2nd Quarter										
3rd Quarter	7-3-13	9:31 a.m.	cloudy	9	fire	fire in conference room	via intercom	2 min.	none 7-staff 2-pt. 0-visitors	J. Hall
4th Quarter										

QUARTERLY DISASTER DRILL

	Date	Time	Weather	# of Participants	Type of Drill	Conditions Simulated	Response Time	Problems Encountered and Resolution Taken	Drill Administrator
1st Quarter									
2nd Quarter									
3rd Quarter	7-5-13	9:10	cloudy/ off+on rain	15	Disaster- Tornado		9:10 a.m. 9:13 a.m. 3 min	Staff - 4 patients - 5 Visitors - 6 None	J. Hoba
4th Quarter									

2-1403

:-1404

9-5-13

Mary E. Rudd

S. ISSOO815
DILO519
SHP 0926
MIS 0723
TEI 0905

C-129

July 16 2013
Meeting notes concerning change on patients chart

An inservice with medical staff is conducted today to explain the changes on patient records. The change includes a physician order for medications to be administered for each individual order. Physician medication orders are to be administered by an RN or an LPN within their scope of practice.

Each staff member is informed that if an error is made, to go to the director of nursing with the error in question without fear of reprimand. Additional training will be provided as necessary.

Attending were nurses and medical assistants

LAURA STEphenson

Terri Hubbard TERRIE HUBBARD

Nancy Waituka NANCY WAITUKA

Eileen Racz EILEEN RACZ

Mary Ellen MARY GREEN