OHIO DEPARTMENT OF HEALTH

246 North High Street
Columbus, Ohio 43215

614/466-3543
www.odh.ohio.gov

John R. Kasich/Governor

Richard Hodges/Director of Health

COPY

October 14, 2014

101514

Holly Myers, Administrator
Planned Parenthood Southwest Ohio Region
2314 Auburn Avenue
Cincinnati, OH 45219

RE: Planned Parenthood Southwest Ohio Region - License: 0286AS
Survey Completed on June 26, 2014

Dear Ms. Myers :

The Ohio Department of Health, under the authority of Chapter 3702 of the Ohio Revised Code, inspects Health Care Facilities to determine compliance with the licensure requirements set forth in Chapter 3701-83 of the Ohio Administrative Code. To attain and maintain licensure, a health care facility must be in compliance with each licensure requirement and not have any violations that jeopardize the patients' health and safety or seriously limit the facility's capacity to provide adequate care and services.

On the date noted above, we completed an inspection of your facility and cited the violation(s) annotated on the enclosed form. Therefore, in order to recommend your agency for licensure, we must receive an acceptable plan of correction **signed and dated within ten (10) calendar days** after you receive this notice. **Failure to provide an acceptable plan of correction may result in denial, revocation, or non-renewal of your license.** You have the option to fax your POC to the attention of Wanda Iacovetta at 614-564-2416.

This plan of correction must contain the following at a minimum:

What action(s) will be accomplished to correct the situation(s) or condition(s) causing or contributing to the noncompliance.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance/improvement program will be put into place.

The Plan of Correction must be written on the enclosed Statement of Deficiency form.

The projected date of correction must not exceed 30 days from the date of inspection exit date unless approval for an extended period for correction is obtained from this office.

Where documentary evidence of corrective action is appropriate, such evidence should accompany the plan of correction wherever possible. When this is not possible, these documents should be provided not later than the latest correction date submitted in your plan of correction **and accepted by this office**. Evidence of compliance may include documentation of facility monitoring, in-service training records, consultant reports, work orders, purchase orders, invoices, photographs, or other information that would confirm compliance.

Normally, an onsite revisit will be conducted to verify corrective action has been taken per the plan of correction. However, after our review of the plan of correction and any evidence of compliance, it is possible that an onsite visit will not be required. If this is the case, you may be contacted to request supporting documentation of compliance and/or receive a 2567B notifying you that your facility is now in compliance. The appropriate licensure action will also be recommended to the licensure administrator.

If you have any questions regarding this notice, please feel free to contact me at (614) 387-0801.

Sincerely,

Wanda L. Iacovetta, R.N.
Non Long Term Care Unit Supervisor
Bureau of Community Health Care Facilities and Services
Division of Quality Assurance

WLI:cc

Enclosure: STATE FORM Licensure

An Equal Opportunity Employer/Provider

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0286AS	A. BUILDING: ______ B. WING ______	R 06/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD SOUTHWEST OHIO I	2314 AUBURN AVENUE CINCINNATI, OH 45219

(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 000}	Initial Comments Post Survey Revisit The following violation is issued as a result of the post survey revisit The ASF facility has three surgical operating rooms (OR). Surgical procedures are conducted on Tuesday, Friday, Saturday, consultations Wednesday, Thursday, closed on Sunday and Monday. At the time of the post survey revisit there were a total of 2613 surgical procedures in the last year.	{C 000}		
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: This is a new citation Based on interview and policy review it was	C 234		

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C 234	Continued From page 1 determined the facility did not ensure a transfer agreement was in place for transferring of patients to a hospital if medically necessary. The total number of procedures in the last 12 months was 2,613. Interview with Staff A on 06/26/14 at 4:40PM revealed the facility does not have a transfer agreement in place and is waiting for a variance to be approved. Staff A further revealed there are three physicians at a local hospital who would take any patient whom would need to be transferred if medically necessary. This finding was confirmed with Staff A on 06/26/14 at 4:40PM.	C 234		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
0286AS	A. Building B. Wing	6/26/2014

Name of Facility	Street Address, City, State, Zip Code
PLANNED PARENTHOOD SOUTHWEST OHIO REGION	2314 AUBURN AVENUE CINCINNATI, OH 45219

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix C0104 Reg. # O.A.C. 3701-83-03 (F) LSC	Correction Completed 06/26/2014	ID Prefix C0119 Reg. # O.A.C. 3701-83-08 (A) LSC	Correction Completed 06/26/2014	ID Prefix C0150 Reg. # O.A.C. 3701-83-12 (A) LSC	Correction Completed 06/26/2014
ID Prefix C0152 Reg. # O.A.C. 3701-83-12 (C) LSC	Correction Completed 06/26/2014	ID Prefix C0201 Reg. # O.A.C. 3701-83-16 (B) LSC	Correction Completed 06/26/2014	ID Prefix C0211 Reg. # O.A.C. 3701-83-17 (F) LSC	Correction Completed 06/26/2014
ID Prefix C0255 Reg. # O.A.C. 3701-83-21 (A) - (E) LSC	Correction Completed 06/26/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: Linda Hart / BL	Date: 6/26/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 6/6/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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Planned Parenthood Southwest Ohio Region
Attn: Holly Myers
2314 Auburn Ave
Cincinnati OH 45219

10/14/2014

PS Form 3800, August 2006 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Planned Parenthood Southwest Ohio Region
Attn: Holly Myers
2314 Auburn Ave
Cincinnati OH 45219

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X ☐ Agent ☐ Addressee

B. Received by (Printed Name) BRIANA TERRD

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

OCT 23

3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number

7014 0150 0001 5877 6631 10/14/2014

PS Form 3811, July 2013 Domestic Return Receipt