

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/01/2010
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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	<p>Initial Comments</p> <p>CM</p> <p>Initial Licensure Inspection</p> <p>Administrator: Carol Westfall</p> <p>County: Summit</p> <p>Capacity: 1 (one) Operating Room</p> <p>Akron Women's Medical Group is in compliance with the rules for Ambulatory Surgery Center at rule #3701-83-03 (A) through 3701-83-22 at the time of the Initial Inspection completed on 04-01-10.</p> <p>Licensure is recommended.</p>	C 000		

Ohio Department of Health
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TITLE



(X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/08/2011
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 CMu/KHo Inspection Inspection Administrator: Lisa Perks County: Franklin Capacity: 2 Operating Rooms The following violation was issued as a result of the inspection of an Ambulatory Surgery Center completed on 3/8/11.	C 000		
C231	3701-83-19 (B) Drug Control & Accountability The ASF shall: (1) Provide adequate space, equipment, and staff for storage and the administration of drugs in compliance with state and federal laws and regulations. (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. This Rule is not met as evidenced by: Based on a tour of the facility and staff interview it was determined that the facility failed to ensure that expired medications were not available for patient use. The patient census for 2010 was 1,412. Findings include: The facility tour was conducted on 03/08/11 at	C231		3/24/11

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03/24/11

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C231	Continued From page 1 10:20 AM with Staff A. The medication supply closet contained 23 bottles of an antibiotic that had expired on 10/1/10. This was confirmed with Staff A at 10:35 AM.	C231		

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
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C 000	<p>Initial Comments</p> <p>JS/KH</p> <p>Type of Inspection: Initial Licensure Compliance Inspection</p> <p>Administrator: Regan Clawson</p> <p>County: Cuyahoga</p> <p>Number of Operating Rooms: Three</p> <p>Number of Procedure Rooms: Three</p> <p>Services Provided: Women's Services</p> <p>The following violations are issued as a result of the initial licensure compliance inspection completed on 12/14/11. Licensure is recommended with an acceptable plan of correction and verification upon a revisit inspection.</p>	C 000		
C 140	<p>O.A.C. 3701-83-10 (C) Disaster Planning</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on facility observation, review of facility documentation, personnel files and staff interview and verification, the facility failed to ensure that a disaster preparedness plan including evacuation in the event of a fire was completed and that</p>	C 140		

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C 140	Continued From page 1 review of evacuation procedures and practice drills with staff were completed. The facility was not providing any services for patients. Findings include: On 12/14/11 at 1:05 P.M. tour of the facility was initiated with Staff A. Observation of the surgical facility revealed it to be located in a three story building. The building was noted to be provided with an automatic sprinkler system. The surgical facility was located on the first and second floor of the building. The operating, procedure and recovery areas for patients were located on the second floor. Review of personnel files revealed there were at least 10 staff hired and prepared to work in the new facility. There was no documented evidence that staff had been informed of or practiced any disaster or fire plan for the facility. Staff A was interviewed regarding practice fire or disaster drills for staff. Staff A verified that none had been completed with the staff.	C 140		
C 146	O.A.C. 3701-83-11 (D) Medical Records Confidentiality The HCF shall maintain an adequate medical record keeping system and take appropriate measures to protect medical records against theft, loss, destruction, and unauthorized use. The HCF shall have policies and procedures to ensure the confidentiality of patient medical records.	C 146		

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C 146	<p>Continued From page 2</p> <p>This Rule is not met as evidenced by: Based on facility tour and staff interview and verification the facility failed to ensure there was an adequate medical record keeping system with regards to appropriate measures to protect medical records against theft, loss and destruction. The facility was not providing any services for patients.</p> <p>Findings include:</p> <p>On 12/14/11 at 1:05 P.M. tour of the facility was initiated with Staff A. Observation of the facility revealed it to be located in a three story building. The building was noted to be provided with an automatic sprinkler system. The surgical facility was located on the first and second floor of the building.</p> <p>Observation of the patient flow revealed that patients would come into a reception area located on the first floor. In the center of the reception area was an office area with a large open window. Staff A noted the area was the location for patient medical record storage. There were no cabinets or other mechanism to store patient medical records to protect from them theft, loss or any damage. Staff A stated that cabinets were to be put in the area but were not in the facility yet.</p>	C 146		
C 241	<p>O.A.C. 3701-83-20 (B) OR & Recovery Room Equipment</p> <p>Each ASF shall have the following equipment accessible to the operating suite and recovery area:</p> <p>(1) Adequate resuscitation equipment: (a) ASFs</p>	C 241		

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C 241	<p>Continued From page 3</p> <p>providing surgical procedures under topical and local infiltration blocks with or without oral or intramuscular preoperative sedation shall have: airways, bag mask respirator, oxygen source, suction equipment, and age-appropriate resuscitative drugs; (b) ASFs providing surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs or providing surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have: airways, endotracheal tubes, laryngoscope, oxygen delivery capability under positive pressure, suction equipment, and suitable resuscitative drugs.</p> <p>(2) Appropriate monitoring equipment: (a) Each ASF shall have size-specific blood pressure apparatus and stethoscopes, electrocardiogram, oscilloscopes and when pediatric patients are treated, size-specific emergency equipment and medications; (b) ASFs performing surgical procedures in conjunction with oral, parenteral, or intravenous sedation or under an analgesic[sic] or dissociative drugs, or performing surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have a defibrillator, pulse oximeter with alarm, and temperature monitor. (c) ASFs using inhalation anesthesia shall have an anesthesia machine.</p> <p>(3) Each ASF shall have suitable surgical instruments customarily available for the planned surgical procedure in the operating suite.</p> <p>(4) Each ASF shall have in the recovery room, an emergency call system that is connected</p>	C 241		

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C 241	<p>Continued From page 4</p> <p>electronically, electrically by radio transmission or in a like manner and that effectively alerts staff.</p> <p>This Rule is not met as evidenced by: Based on facility tour and staff interview and verification the facility failed to have in the recovery room, an emergency call system that was connected electronically, electrically by radio transmission or in a like manner and that effectively could alert staff. The facility was not providing any services for patients.</p> <p>Findings include:</p> <p>On 12/14/11 at 1:05 P.M. tour of the facility was initiated with Staff A. Tour of the recovery area revealed five cubical areas designed for patients to recover post surgically. The cubicles were complete with privacy curtains that could be closed. Observation of the five recovery area cubicles revealed there was no emergency call system in place for patients to use if needed. If cubicle curtains were closed the patients would have to call out for assistance.</p> <p>Staff A was present on tour and verified there was no call system available in the recovery cubicles but that staff would always be present in the recovery room area.</p>	C 241		

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NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
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C 000	<p>Initial Comments</p> <p>JS/DK</p> <p>County: Cuyahoga Administrator: Heather Harrington Type of Survey: Licensure Number of Procedure Rooms: Five</p> <p>At the time of the licensure survey completed on 03/16/11, Preterm was in compliance with the Ohio Rules and Regulations for Ambulatory Surgical Centers.</p>	C 000		

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NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
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C 000	Initial Comments JS/DK County: Cuyahoga Administrator: Vickie Griffin, NREMT-P Type of Survey: Licensure Number of Procedure Rooms: Two The following violations were based on the licensure survey completed on 03/17/11.	C 000		
C 105	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 review of staff credentialing files and staff interview and verification, the facility failed to ensure that appropriate liability insurance coverage of the staff was maintained or inform patients that the staff member did not carry malpractice insurance. One of four staff credentialing files (Staff K) was affected. The facility provided services for 1638 patients in 2010. Findings included: On 03/17/11 the credentialing files for the facility's medical and certificated registered nurse anesthetists(CRNA) were reviewed. The facility utilized two physicians and two CRNA's for the provision of surgical services.	C 105		3/31/11

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C 105	Continued From page 1 Review of the credentialing file for Staff K, revealed there was no documented evidence the CRNA had current liability insurance. The was no documented evidence that patients were informed the CRNA did not have liability insurance. Interview of Staff A on 03/17/11, revealed that Staff K typically provided anesthesia services for the facility on surgery days. Staff A verified there was no documented evidence that Staff K had maintained current liability insurance. Staff A also verified there was no documented evidence or information that informed patients the CRNA did not have liability insurance.	C 105		
C 122	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: Based on review of staff personnel files and staff interview and verification, the facility failed to provide each staff member with a written job description delineating his or her responsibilities. Four of six staff personnel files (Staff A, G, H, and J) were affected. The facility provided services for 1638 patients in 2010. Findings included: On 03/17/11 personnel files were reviewed for staff employed by the facility. The following personnel files did not contain documented	C 122		3/31/11

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C 122	<p>Continued From page 2</p> <p>evidence of job descriptions for the duties the staff were assigned at the facility.</p> <p>1. Staff A, hired on 03/07/11, was assigned the duties of administrator of the facility. The personnel file for Staff A was incomplete. Portions of the file were faxed to the facility for review from the corporate office. Information faxed did not include the job description of administrator.</p> <p>2. Staff G, hired on 06/07/10, was noted to have completed an application for recovery room nurse. The personnel file did not contain documented evidence that Staff G had received information of the job duties for a recovery room nurse. Observation of Staff G revealed he/she was working in the recovery room on 03/17/11.</p> <p>3. Staff H, hired on 07/31/10, was noted to have been educated as a medical assistant. The personnel file did not contain documented evidence that Staff H had received information of the job duties for a medical assistant. Observation of Staff H revealed he/she was working in the patient reception area on 03/17/11.</p> <p>4. Staff J, hired on 03/17/92, was identified by Staff A as the current director of nursing (DON) for the facility. The personnel file for Staff J contained various job descriptions for positions held since hired in 1992. The personnel file did not contain information as to when Staff J became the DON and there was no documented evidence that Staff J had received information of the job duties for the director of nursing. Staff J was not present in the facility on 03/17/11.</p> <p>On 03/17/11 Staff A provided a large binder labeled job descriptions. Review of the binder revealed there was no job description identified</p>	C 122		

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C 122	Continued From page 3 as administrator. The binder did not contain documented evidence that staff in the facility were aware of the positions and job duties described in the binder. Staff A could not verify that staff were aware of specific job duties for the respective positions.	C 122		
C 123	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 staff personnel files and staff interview and verification, the facility failed to provide each staff member with an ongoing training program which included orientation and continuing training to all staff members. The orientation was to be appropriate to the tasks that each staff member was expected to perform. Continuing training was to be designed to assure appropriate skill levels were maintained and that staff were informed of changes in techniques, philosophies, goals, and similar matters. Two of six staff personnel files (Staff G and H) were affected. The facility provided services for 1638 patients in 2010.	C 123		3/31/11

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C 123	<p>Continued From page 4</p> <p>Findings included:</p> <p>1. On 03/17/11 personnel files were reviewed for staff employed by the facility. Staff G, a registered nurse was noted to be hired on 06/07/10 and Staff H, a medical assistant was hired on 07/31/10. Both personnel files did not contain documented evidence that orientation had been provided and completed prior to assuming respective job duties.</p> <p>2. Review of the personnel file for Staff H revealed a hire date of 07/31/10. The personnel file contained an employee written warning dated 12/09/10. The written warning described incorrect performance during a procedure to obtain a sample of blood from a former patient. Further review of the document revealed that proficiency testing was to have been completed prior to Staff H's work in the lab area. Staff H documented that proficiency testing had not been initially completed prior to working in the lab area but was completed on 12/08/10.</p> <p>Review of the action to be taken on the warning notice indicated Staff H was placed on probation. There was no documented evidence that review of facility policy and proper procedure had been completed or continuing education was to be provided. Interview of Staff A on 03/17/11 verified there was no documented evidence that further education or review of proper procedure had been provided for Staff H.</p> <p>3. On 03/17/11 at 9:10 A.M., Staff A was asked to provide any in-service education provided for the staff in 2010 as well as in-services planned for 2011. Staff A indicated that all appropriate staff had been provided advanced cardiac life support</p>	C 123		

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C 123	Continued From page 5 (ACLS) and cardio-pulmonary resuscitation(CPR) training in 2011. There was no documented evidence of in-services provided in 2010 and no further training planned for staff in 2011.	C 123		
C 125	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 review of staff personnel files and staff interview and verification, the facility failed to evaluate the performance of each staff member at least every twelve months. Three of six staff personnel files (Staff E, I and J) were affected. The facility provided services for 1638 patients in 2010. Findings included: On 03/17/11 personnel files were reviewed for staff employed by the facility. The following personnel files did not contain documented evidence of evaluation of staff members at least every 12 months. 1. Staff E, hired on 12/10/04, was noted to have a job performance evaluation completed on 03/06/08. There was no further documented evaluation of the employee's performance. 2. Staff I, hired on 02/05/03, did not have documented evidence of evaluation of employee performance in the personnel file completed in 2010 or to date in 2011. 3. Staff J, hired on 03/17/92, was noted to have a	C 125		3/31/11

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(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 125	Continued From page 6 job performance evaluation completed in April 2008. There was no further documented evaluation of the employee's performance. Interview of Staff A on 03/17/11, verified the personnel files did not contain evidence that employee performance evaluations had been completed at least every 12 months for employees working in the facility longer than one year.	C 125		
C 139	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 tour and observation, the facility failed to ensure that is was maintained in a safe and sanitary manner. The facility provided services for 1638 patients in 2010. Findings included: On 03/17/11 between the hours of 9:30 A.M. and 10:45 A.M. tour of the facility was completed with Staff A. The following observations were noted and verified by Staff A. 1. Located in the recovery room, were nine large boxes, taped closed, labeled infectious waste. Staff A present on tour verified the boxes were filled with infectious waste that was waiting to be picked up by the contracted company. Staff A stated there was no other areas in the facility where the boxes could be stored. One patient was observed to be in the recovery room.	C 139		3/31/11

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C 139	Continued From page 7 2. A gurney was observed in the recovery room, stored next to the boxes of infectious waste. The gurney cushion was covered with a heavy black plastic cover. The black cover was taped at the comers and was noted to have an opening present on the surface approximately the size of a dime. The cushion cover was frayed at the edges which allowed small pieces of foam cushion to be visibile on the cart. Staff A verified the gurney was used on surgery days when patients were brought from the procedure room to the recovery area. 3. An anesthesia machine was observed to be stored in the procedure room. Staff A verified the anesthesia machine was not used in that the facility did not provide general anesthesia. Observation of a biomedical sticker on the side of the machine revealed that it was due to be serviced in December 2010. 4. A portable suction machine on the counter in the procedure room was observed to covered with dust.	C 139		
C 143	3701-83-11 (A) Medical Records The HCF shall maintain a medical record for each patient that documents, in a timely manner and in accordance with acceptable standards of practice, the patient's needs and assessments, and services rendered. Each medical record shall be legible and readily accessible to staff for use in the ordinary course of treatment. This Rule is not met as evidenced by: Based on patient medical record review and staff	C 143		3/31/11

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C 143	<p>Continued From page 8</p> <p>interview and verification the facility failed to ensure that each patient's medical record was maintained in accordance with acceptable standards of practice with regard to legibility. One of the sample of patient medical records (Patient #3) was affected. The facility provided services for 1638 patients in 2010.</p> <p>Findings included:</p> <p>On 03/17/11 review of Patient #3 medical record was completed. Upon entrance, Staff A was asked to provide the medical records of any patients who were transferred to a hospital directly from the facility. The medical record for Patient #3 was provided.</p> <p>Review of the medical record for Patient #3 revealed the patient was admitted to the facility for a surgical procedure on 02/04/11. Review of the anesthesia record revealed the surgery began at 2:29 P.M. and was stopped at 2:50 P.M. The patient was noted to have been sent by ambulance to a local hospital.</p> <p>Review of the written operative report completed by the physician, revealed the writing was mostly illegible. Few words could be determined in the hand written note that could indicate what had occurred with the patient during the operative procedure. It was determined that patient was transferred to the hospital due to an unusually large amount of bleeding.</p> <p>Staff A reviewed and verified the physician's documentation was mostly illegible and a complete account of the operative procedure could not be determined.</p>	C 143		

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C 152	Continued From page 9	C 152		
C 152	<p>3701-83-12 (C) Q A & Improvement Requirements</p> <p>The quality assessment and performance improvement program shall do all of the following:</p> <p>(1) Monitor and evaluate all aspects of care including effectiveness, appropriateness, accessibility, continuity, efficiency, patient outcome, and patient satisfaction;</p> <p>(2) Establish expectations, develop plans, and implement procedures to assess and improve the quality of care and resolve identified problems;</p> <p>(3) Establish expectations, develop plans, and implement procedures to assess and improve the health care facility's governance, management, clinical and support processes;</p> <p>(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;</p> <p>(5) Document and report the status of quality assessment and improvement program to the governing body every twelve months;</p> <p>(6) Document and review all unexpected complications and adverse events, whether serious injury or death, that arise during an operation or procedure; and</p> <p>(7) Hold regular meetings, chaired by the medical director of the HCF or designee, as necessary,</p>	C 152		3/31/11

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C 152	<p>Continued From page 10</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on review of the facility quality improvement program and review of governing body meeting minutes the facility failed to ensure that a report of the status of the quality assessment and improvement program was provided to the governing body every twelve months. The facility provided services for 1638 patients in 2010.</p> <p>Findings included:</p> <p>On 03/17/11 review of the facility's quality assurance program and governing body meeting minutes was completed. Documentation of the of the quality improvement (QI) program revealed the facility had a program but no documented evidence of ongoing QI projects. There was no documented evidence of QI meetings held in 2010 and to date in 2011.</p> <p>Review of governing body meeting minutes revealed the last documented governing body meeting was held on January 31, 2010.</p> <p>Interview of Staff A revealed there was no documentation of QI projects available for review. Staff A further verified the last documented governing body meeting was completed in 2010 with no documented evidence that QI information was presented at the meeting.</p>	C 152		

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C201	Continued From page 11	C201		
C201	<p>3701-83-16 (B) Governing Body Duties</p> <p>The governing body shall:</p> <p>(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;</p> <p>(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:</p> <p>(a) Current licensure and certification, if applicable;</p> <p>(b) Relevant education, training, and experience; and</p> <p>(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.</p> <p>(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.</p>	C201		3/31/11

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C201	Continued From page 12 This Rule is not met as evidenced by: Based on review of physician credentialing information and staff interview and verification, the facility failed to ensure that a review, update and approval of the surgical procedures that may be performed at the center were maintained in an up-to-date listing of the procedures for the physician's who requested clinical privileges. Two of two physician files were affected. The facility provided services for 1638 patients in 2010. Findings included: On 03/17/11 review of the physician credentialing files was completed. The facility utilized two physicians for the provision of surgical services. Review of both physician credentialing files revealed there was no delineation of requested procedures. The files did not contain an updated list of the procedures requested by the physicians to be performed in the facility, no review and no approval date for procedures currently performed by the physicians. Staff A verified the credentialing files for the physicians did not contain an updated list of requested and approved procedures performed in the facility.	C201		
C243	3701-83-20 (D) Ventilation & Humidity Levels Each ASF shall have appropriate ventilation and humidity levels in order to minimize the risk of infection and to provide for the safety of the patient. This Rule is not met as evidenced by:	C243		3/31/11

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C243	Continued From page 13 Based on tour of the facility, review of facility information and staff interview and verification, the facility failed to ensure appropriate ventilation and humidity levels were maintenance in order to minimize the risk of infection and to provide for the safety of the patients. The facility provided services for 1638 patients in 2010. Findings included: On 03/17/11 tour of the facility was completed between 9:30 A.M. and 10:45 A.M. with Staff A. The facility was noted to be on two floors. The main floor was the reception area, counseling areas and a large waiting area for patients and others. The lower level of the facility contained the procedure rooms, recovery area, instrument processing areas, small lab area and a small waiting area. Review of the facility's temperature and humidity logs revealed the temperature and humidity levels were monitored only for the main level of the facility. There was no documented monitoring of humidity levels for the lower level of the facility since May 2010. Interview of Staff A verified that instruments to monitor the humidity were kept on the main level of the facility. Staff A verified the humidity level for the procedure and recovery areas had not been monitored for some time.	C243		
C244	3701-83-20 (E) Emergency Power Each ASF shall have emergency power available in operative, procedure, and recovery areas.	C244		3/31/11

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C244	<p>Continued From page 14</p> <p>This Rule is not met as evidenced by: Based on facility tour and staff interview and verification, the facility failed to ensure that emergency power was available in operative and recovery areas. The facility provided services for 1638 patients in 2010.</p> <p>Findings included:</p> <p>On 03/17/11 tour of the facility was completed between 9:30 A.M. and 10:45 A.M. with Staff A. The facility was noted to be on two floors. The lower level of the facility contained the procedure rooms, recovery area, instrument processing areas, small lab area and a small waiting area. Interview of Staff A revealed there was no emergency power provided for the procedure or recovery areas.</p> <p>At 4:30 P.M. Staff A indicated the facility did have emergency power available to the ares in the form of a battery pack. Staff A could not provide documentation of preventative maintenance and testing information to verify the emergency power pack was operable.</p>	C244		

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NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	<p>Initial Comments</p> <p>CMu/KHo</p> <p>Licensure Inspection</p> <p>Administrator: Judy Nolan</p> <p>County: Franklin</p> <p>Capacity: 4 Operating Rooms</p> <p>The Founder's Women's Health Center was in compliance with the rules for Ambulatory Surgery Facilities at rule #3701-83-03(A) through 3701-83-22 at the time of the licensure inspection completed on 03/09/11.</p>	C 000		

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

TITLE



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NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
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{C 000}	Initial Comments JS County: Summit Administrator: Carol Westfall Post Inspection Revisit To Licensure Inspection Completed 03/17/11 Complaint Investigation Complaint Number OH00060587 Number of Operating Rooms: Two	{C 000}		
C 114	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; (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.	C 114		

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

TITLE



(X6) DATE

06/17/11

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C 114	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on review of employee personnel files, review of employee job descriptions and staff interview and verification, the facility failed to ensure that each patient was treated with consideration, respect, and full recognition of dignity and individuality. The facility provided care and services for 461 patients between 03/17/11 and 05/17/11.</p> <p>Findings included:</p> <p>On 05/17/11 review of the facility personnel files was completed. Review of the personnel file for Staff G7 revealed employment with the facility began 12/10/04. According to documentation Staff G7's recent performance evaluation was dated 03/30/11. Staff G7 was noted to hold a position which required receptionist, telephone and cashier duties. Review of the most recent performance evaluation revealed Staff G7 had occasional problems with patient interaction and lacked professionalism while interacting with patients.</p> <p>On 05/17/11 Staff C was interviewed regarding the comments noted on the employee evaluation. Staff C verified that Staff G7 occasionally speaks in a curt and short manner to patients during the admission process. Staff C stated the curt and short interaction with patients had been addressed with Staff G7.</p> <p>Review of the job description for Staff G7 indicated that phone counseling was to be done in a calm, supportive and understanding manner. The job description noted the employee was the</p>	C 114		

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C 114	Continued From page 2 first contact and the first impression so must be friendly, helpful and be pleasant. Qualifications for the position noted the staff was to possess warmth and sensitivity. Interview on 05/17/11 with Staff A and B regarding staff assignments in the facility revealed Staff G7 was only assigned to the receptionist, phone and cashier duties. Staff A and B further verified that Staff G7 had been over heard to be short and curt during interaction with patients. This violation substantiated Allegation #1 in Complaint Number OH00060587.	C 114			
{C 139}	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: RECITE Based on tour of the facility, review of facility maintenance receipts, employee job descriptions, facility policy and procedures and staff interview and verification it was determined the staff failed to ensure the facility was maintained in a safe and sanitary manner. Although the previous safety and sanitary issues identified during the licensure inspection completed 03/17/11, were corrected, observation during the revisit revealed the facility was continues to be not maintained in a safe and sanitary manner. The facility provided care and services for 461 patients between 03/17/11 and 05/17/11.	{C 139}			3/31/11

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{C 139}	<p>Continued From page 3</p> <p>Findings included:</p> <p>On 05/17/11 between 9:50 A.M. and 10:20 A.M., tour of the facility was completed with Staff A and revealed the following:</p> <p>1. The main waiting area on the upper floor of the facility was observed to have a used can of an energy drink sitting on the floor under a chair. Also observed was a large crumb of a snack food on the floor as well as a discarded clear wrapper. The carpet in the waiting area was noted to have large stained and dirty looking areas.</p> <p>Staff A and B were interviewed regarding the cleaning practices of the facility. A receipt was provided that indicated the upper floor waiting area had the carpet cleaned in April 2011. Review of the job description for the receptionist/ telephone/cashier employees revealed that duties included responsibility for the appearance of the waiting rooms.</p> <p>2. Observation of the lower level of the facility, specifically the main operating room, revealed unlocked cabinets where antibiotics and physician prescription pads were kept.</p> <p>A red instrument cart and ultrasound machine were covered with a layer of dust and powdery white residue.</p> <p>Twenty-six multi-dose bottles of a blood thinning medication and one ampule of a heart medication were sitting on a counter top in the operating room.</p> <p>Five cardboard boxes of extension sets commonly used by the certified registered nurse anesthetist (CRNA) for intravenous sedation</p>	{C 139}		

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NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP			STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
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{C 139}	<p>Continued From page 4</p> <p>during procedures were observed sitting on the operating room floor. Staff A verified the boxes had been delivered to the facility four days earlier.</p> <p>One multi-dose bottle of lidocaine (an analgesic) approximately half full, was observed sitting on a window sill with a needle inserted and still in place in the stopper of the bottle. The bottle was not dated as to when it was initially opened. Staff A verified the lidocaine was last used during procedures performed in the operation room four days ago.</p> <p>Six, 22 gauge caths, used by the CRNA during intravenous sedation, were observed in their wrappers, openly lying on a surface close to the operating table.</p> <p>Observed next to the operating table was a 10 gallon red sharps container with no lid in place. The red sharps container was slightly over half full of used syringes with needles attached. Two syringes lying at the top of the pile of syringes was noted to have visible blood in the syringes.</p> <p>Staff A verified the operating room had not been properly cleaned and secured after the completion of procedures, four days earlier.</p> <p>3. Observation of a patient holding area on the lower level of the facility revealed the carpet in the room had small pieces for white debris on the flooring. Staff A verified the carpet had not been vacuumed for at least four days.</p> <p>Review of facility policy and procedures revealed facility staff failed to follow facility policy and procedures with regards to storage of clean and sterile supplies, universal precautions including CDC recommendations, multi-dose vials, control</p>	{C 139}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/17/2011
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 139}	Continued From page 5 of restricted items, inspection of drug storage area, general security measures, physician ordering of medication, prescription blanks, medication administration, and environmental cleaning. This violation substantiated Allegation #2 of Complaint Number OH00060587.	{C 139}		
{C 152}	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; (5) Document and report the status of quality assessment and improvement program to the	{C 152}		3/31/11

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{C 152}	<p>Continued From page 6</p> <p>governing body every twelve months;</p> <p>(6) Document and review all unexpected complications and adverse events, whether serious injury or death, that arise during an operation or procedure; and</p> <p>(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.</p> <p>This Rule is not met as evidenced by: RECITE</p> <p>Based on review of the facility quality improvement program and review of governing body meeting minutes the facility failed to ensure that a report of the status of the quality assessment and improvement program was provided to the governing body at least every 12 months. The facility provided care and services for 461 patients between 03/17/11 and 05/17/11.</p> <p>Findings included:</p> <p>On 05/17/11 review of the facility's quality assurance program and governing body meeting minutes was completed. Documentation of the quality improvement (QI) program revealed the facility had a program but no documented evidence of ongoing QI projects. There was no documented evidence of QI meetings held in 2010 and to date in 2011.</p>	{C 152}		

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{C 152}	Continued From page 7 Review of governing body meeting minutes revealed the most recent documented governing body meeting was held on 03/31/11. The minutes noted that twenty patient medical records were reviewed for quality assurance and were found to have no errors. Interview of Staff C on 05/17/11 at 1:30 P.M. revealed there was no documentation of QI projects available for review. Staff C revealed changes in the QI program were still in the works and were not yet completed.	{C 152}		
{C201}	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	{C201}		3/31/11

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{C201}	<p>Continued From page 8</p> <p>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.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: RECITE</p> <p>Based on review of physician credentialing information and staff interview and verification, the facility failed to ensure that a review, update, and approval of the surgical procedures that may be performed at the center were maintained in an up-to-date listing of the procedures for the physician's who requested clinical privileges. One of two physician files (Physician #2) was affected. The facility provided care and services for 461 patients between 03/17/11 and 05/17/11.</p> <p>Findings included:</p> <p>On 05/17/11 review of the physician credentialing files was completed. The facility utilized two physicians for the provision of surgical services. Review of both physician credentialing files revealed there was no delineation of requested procedures for one physician. The file for Physician #2 did not contain an updated list of the procedures requested by the physician to be performed in the facility, no review and no</p>	{C201}			

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{C201}	Continued From page 9 approval date for procedures currently performed by the physician. Staff A and B verified the credentialing file for Physician #2 did not contain an updated list of requested and approved procedures performed in the facility.	{C201}			

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C 000	Initial Comments JS County: Summit Administrator: Carol Westfall Post Inspection Revisit to Licensure Inspection on 03/17/11 Complaint Investigation Complaint Number: OH00060587 Number of Operating Rooms: Two	C 000		
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; (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.	C 114		

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TITLE



(X6) DATE

06/17/11

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C 114	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on review of employee personnel files, review of employee job descriptions and staff interview and verification, the facility failed to ensure that each patient was treated with consideration, respect, and full recognition of dignity and individuality. The facility provided care and services for 461 patients between 03/17/11 and 05/17/11.</p> <p>Findings included:</p> <p>On 05/17/11 review of the facility personnel files was completed. Review of the personnel file for Staff G7 revealed employment with the facility began 12/10/04. Staff G7's most recent performance evaluation was dated 03/30/11. According to documentation, Staff G7 was noted to hold a position which required receptionist, telephone and cashier duties. Review of the most recent performance evaluation revealed Staff G7 had occasional problems with patient interaction and lacked professionalism while interacting with patients.</p> <p>On 05/17/11 Staff C was interviewed regarding the comments noted on the employee evaluation. Staff C verified that Staff G7 occasionally speaks in a curt and short manner to patients during the admission process. Staff C stated the curt and short interaction with patients had been addressed with Staff G7.</p> <p>Review of the job description for Staff G7 indicated that phone counseling was to be done in a calm, supportive and understanding manner.</p>	C 114		

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C 114	Continued From page 2 The job description noted the employee was the first contact and the first impression so must be friendly, helpful and be pleasant. Qualifications for the position noted the staff was to possess warmth and sensitivity. Interview on 05/17/11 with Staff A and B regarding staff assignments in the facility revealed Staff G7 was only assigned to the receptionist, phone and cashier duties. Staff A and B further verified that Staff G7 had been over heard to be short and curt during interaction with patients. This violation substantiated Allegation #1 in Complaint Number OH00060587.	C 114		
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: Recite Based on tour of the facility, review of facility maintenance receipts, employee job descriptions, facility policy and procedures and staff interview and verification it was determined the staff failed to ensure the facility was maintained in a safe and sanitary manner. Although the previous safety and sanitary issues identified during the licensure inspection completed 03/17/11 were corrected, observation during the revisit revealed the facility continues to be not maintained in a safe and sanitary manner. The facility provided care and services for 461 patients between 03/17/11 and 05/17/11.	C 139		

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C 139	<p>Continued From page 3</p> <p>Findings included:</p> <p>On 05/17/11 between 9:50 A.M. and 10:20 A.M., tour of the facility was completed with Staff A and revealed the following:</p> <p>1. The main waiting area on the upper floor of the facility was observed to have a used can of an energy drink sitting on the floor under a chair. Also observed was a large crumb of a snack food on the floor as well as a discarded clear wrapper. The carpet in the waiting area was noted to have large stained and dirty looking areas.</p> <p>Staff A and B were interviewed regarding the cleaning practices of the facility. A receipt was provided that indicated the upper floor waiting area had the carpet cleaned in April 2011. Review of the job description for the receptionist/ telephone/cashier employees revealed that duties included responsibility for the appearance of the waiting rooms.</p> <p>2. Observation of the lower level of the facility, specifically the main operating room, revealed unlocked cabinets where antibiotics and physician prescription pads were kept.</p> <p>A red instrument cart and ultrasound machine were covered with a layer of dust and powdery white residue.</p> <p>Twenty-six multi-dose bottles of a blood thinning medication and one ampule of a heart medication were sitting on a counter top in the operating room.</p> <p>Five cardboard boxes of extension sets commonly used by the certified registered nurse</p>	C 139		

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C 139	<p>Continued From page 4</p> <p>anesthetist (CRNA) for intravenous sedation during procedures were observed sitting on the operating room floor. Staff A verified the boxes had been delivered to the facility four days earlier.</p> <p>One multi-dose bottle of lidocaine (an analgesic) approximately half full, was observed sitting on a window sill with a needle inserted and still in place in the stopper of the bottle. The bottle was not dated as to when it was initially opened. Staff A verified the lidocaine was last used during procedures performed in the operation room four days ago.</p> <p>Six, 22 gauge caths, used by the CRNA during intravenous sedation, were observed in their wrappers, openly lying on a surface close to the operating table.</p> <p>Observed next to the operating table was a 10 gallon red sharps container with no lid in place. The red sharps container was slightly over half full of used syringes with needles attached. Two syringes lying at the top of the pile of syringes was noted to have visible blood in the syringes.</p> <p>Staff A verified the operating room had not been properly cleaned and secured after the completion of procedures, four days earlier.</p> <p>3. Observation of a patient holding area on the lower level of the facility revealed the carpet in the room had small pieces for white debris on the flooring. Staff A verified the carpet had not been vacuumed for at least four days.</p> <p>Review of facility policy and procedures revealed facility staff failed to follow facility policy and procedures with regards to storage of clean and sterile supplies, universal precautions including</p>	C 139			

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C 139	Continued From page 5 CDC recommendations, multi-dose vials, control of restricted items, inspection of drug storage area, general security measures, physician ordering of medication, prescription blanks, medication administration, and environmental cleaning. This violation substantiated Allegation #2 of Complaint Number OH00060587.	C 139		

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NAME OF PROVIDER OR SUPPLIER WOMEN'S MED CENTER OF DAYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 E. STROOP ROAD DAYTON, OH 45429		
(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 CM/LR Re-Licensure Inspection Administrator: Martin Haskell County: Montgomery Capacity: 2 Operating rooms The following violations were issued as a result of the Re-Licensure inspection of an Ambulatory Surgical Center inspection completed on 2/23/11	C 000		
C210	3701-83-17 (E) Discharge Within 24 Hours The attending or other designated physician, podiatrist, or anesthesia qualified dentist shall discharge a patient meeting discharge criteria from the ASF within twenty-four hours of the start of the operation or procedure, or induction of anesthesia, whichever is first, or transfer the patient to a setting appropriate for the patient's needs. This Rule is not met as evidenced by: Based on clinical record reviews, and staff interview, the physician failed to discharge two of five sampled patients from the facility. This involved Patients #1 and #5. Findings include: Clinical record reviews were conducted for Patients #1 and #5 on 02/23/11. Both clinical records revealed these patients had surgery in the facility; however, were discharged on the same date without signed physician's discharge	C210		

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TITLE



(X6) DATE

03/11/11

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C210	Continued From page 1 orders. Although there was a space on the clinical record for the physician's signature, and time of the signature, both medical records lacked a physician's signature ordering the discharge of the patients. Patient #1's surgery was completed on 01/14/11 between 12:49 PM and 12:54 PM, and was discharged at 1:20 PM. Patient #5's surgery was completed on 01/07/11 at 3:04 PM, and was discharged at 3:32 PM. During an interview on 02/23/11, at 2:35 PM, Staff A verified the lack of physician's discharge orders for these two patients.	C210		
C231	3701-83-19 (B) Drug Control & Accountability The ASF shall: (1) Provide adequate space, equipment, and staff for storage and the administration of drugs in compliance with state and federal laws and regulations. (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. This Rule is not met as evidenced by: C 231 Drug Control & Accountability 3701-83-19 (B) Based on observation and staff interview the facility failed to ensure open multiple dose vials of medications were dated when opened and initialed by the staff member who opened the vials. The total patient census was 1,677.	C231		

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C231	Continued From page 2 Findings include: During tour of the facility on 2/23/11 at 11:00 AM it was noted that a small black locked box contained a multiple dose vial with the label of Fentanyl 2500 mcg/50 ml. This medication is used for pain management during surgery. There was no date of when this medication was opened or initials of the staff member that opened the vial. There was another multiple dose vial with the label of Midazolam 50 mg/10 ml this medication is used during surgery as an amnesiac. This was confirmed by staff A on 2/23/11 at 11:15 AM.	C231		
C247	3701-83-20 (H) Medical Gasses Each ASF shall develop and follow policies and procedures for the storage and use of medical gases in accordance with the requirement of the national fire protection association (NFPA) 99. This Rule is not met as evidenced by: C 247 Medical Gasses 3701-83-20 (H) Based on observation and staff interview the facility failed to ensure that a portable oxygen tank was secured. This had the potential to affect patients, staff, and visitors. The total patient census was 1,677. Findings include: During tour of the facility on 2/23/11 at 11:25 AM the door to the medical gas room was open and the surveyor observed a small green oxygen tank standing inside of the door, unsecured. When	C247		

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NAME OF PROVIDER OR SUPPLIER WOMEN'S MED CENTER OF DAYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 E. STROOP ROAD DAYTON, OH 45429		
(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
C247	Continued From page 3 Staff A was asked if the tank was empty she/he stated it was full. She /he immediately secured the tank. This had the potential to cause harm to patients, staff, and visitors to the facility. This was confirmed with Staff A on 2/23/11 at 11:30 AM.	C247		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/24/2011
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGION		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Initial Comments</p> <p>CMu/LR</p> <p>Re-Licensure Inspection</p> <p>Administrator: Becki Brenner</p> <p>County: Hamilton</p> <p>Capacity: 3 Operating rooms</p> <p>Planned Parenthood Southwest Ohio Region is in compliance with the rules for Ambulatory Surgery Centers at rule 3701-83-03 (A) through 3701-83-22 at the time of the re-licensure inspection completed on 2/24/11.</p>	C 000		

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/10/2012
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 000}	Initial Comments DL/LHm Post Survey Review for the Licensure Compliance Inspection from 03/14/12 Administrator: Judith Nolan County: Franklin Number of OR's: 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 post survey review of the licensure compliance inspection completed on 07/10/12.	{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.	{C 234}		

Ohio Department of Health

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/10/2012
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 234}	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: THIS IS A RE-CITE</p> <p>This Rule is not met as evidenced by:</p> <p>Based on staff interview it was determined this facility failed to have a written transfer agreement with a hospital for transfer of patients in the event of medical complications, situations or other medical needs. This facility was not a provider based entity of a hospital.</p> <p>This facility performed a total of 640 procedures since January 1, 2012.</p> <p>Findings include:</p> <p>Interview with staff A on 07/10/12 at approximately 3:00 PM reveals this facility is still waiting on the hospital legal department to finalize a transfer agreement and send it to them.</p>	{C 234}		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0600AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/30/2012
NAME OF PROVIDER OR SUPPLIER WOMEN'S MED CENTER OF DAYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 E. STROOP ROAD DAYTON, OH 45429		
(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	<p>Initial Comments</p> <p>Periodic Licensure Compliance Inspection & Complaint Inspection Complaint Number OH00066970</p> <p>Administrator: Dr. Martin Haskell, M.D.</p> <p>County: Montgomery</p> <p>Number of ORs: 2</p> <p>Services provided: Suction Dilation & Curettage and Dilation & Evacuation Procedures</p> <p>License Current: Yes</p> <p>Licensure Expiration Date: August 31, 2012; renewal application of August 1, 2012, pending</p> <p>Women's Medical Center of Dayton is in compliance with the rules for Ambulatory Surgical Facilities, Chapter 3701-83, Ohio Administrative Code at the time of the licensure compliance inspection and complaint inspection completed on 08/30/12.</p>	C 000		

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/22/2012
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 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 DL/AA Licensure Compliance Inspection Administrator: Connie Britton County: Hamilton The entrance conference was held with the administrator at 10:10 AM on 02/22/12. The following violation is a result of the licensure compliance inspection completed on 02/22/12. The facility has performed 2,735 procedures from 01/01/11 to 01/01/12. Three procedure rooms	C 000		
C 242	O.A.C. 3701-83-20 (C) Preventive Maintenance Each ASF shall establish and follow a preventive maintenance program which includes periodic calibration, cleaning and adjustment of all equipment in accordance with manufacturer's instructions. Each ASF using inhalation anesthesia shall develop and follow policies and procedures for monitoring the anesthesia machine which are consistent with the standards recommended by the American society of anesthesiologists. This Rule is not met as evidenced by: Based on equipment maintenance manual review, observation and staff interview it was determined this facility failed to ensure two	C 242		

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TITLE



(X6) DATE
02/22/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/22/2012
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIONAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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 242	<p>Continued From page 1</p> <p>ultrasound machines received preventative maintenance. This had the potential to affect all those who were treated with these medical devices. Total patients treated for the year of 2011 was 2,735.</p> <p>Findings include:</p> <p>During facility tour on 02/22/12 with staff A, observation was made of two ultrasound machines which failed to have the annual preventative maintenance sticker. The question was proposed to staff A as to when they were last calibrated and staff A stated according to staff B, they have not been calibrated since he/she has been with this facility and that has been six years. This interview confirmed this finding.</p>	C 242		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/02/2012
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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 DL/AA Complaint Inspection #OH00065769 Administrator: Chrissie France County: Cuyahoga Number of Operating Rooms: Four procedure rooms Services Provided: Surgical & Medical Abortions The following violation is a result of the complaint investigation completed on 07/02/12.	C 000		
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 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.	C 119		

Ohio Department of Health

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

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Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/02/2012
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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 119	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on interview and personnel record review this facility failed to ensure training documentation for ultrasound staff was retained in order to verify qualifications. This had the potential to affect all patients who receive ultrasound services from this facility. This facility has performed 2,404 procedures since January 1, 2012.</p> <p>Findings include:</p> <p>The medical record for patient #1 was reviewed on 07/02/12 at approximately 1:00 PM revealed that ultrasounds were completed at this facility on 05/18/12 by Staff #3 and a later ultrasound was completed on 06/09/12 by Staff #1. The personnel file for Staff #3 was reviewed on 07/02/12 and revealed a job description for an ultrasound technician. This job description requires the technician to demonstrate knowledge of and ability to perform ultrasound skills. The personnel file lacked evidence that any training was completed or that any skills were demonstrated to show knowledge of the ability to perform an ultrasound. Interview with Staff B on 07/02/12 at 2:45 PM confirmed that no training or skills demonstrations were in the personnel file for Staff #3.</p> <p>Staff # 2, 3, 5 and 6 were said to be ultrasound technicians who were trained by Staff #1 and #4 per telephone interview with the Director of Nursing on 7/02/12 at 1:30 PM. The DON stated in the interview there was documentation regarding the training and successful completion of the training and directed Staff B to retrieve it from the DON's office.</p>	C 119		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/02/2012
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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 119	<p>Continued From page 2</p> <p>The personnel files for Staff # 2, 3, 5 and 6 had documentation of a job description for ultrasound technician, however, lacked evidence that any training was completed or that any skills were demonstrated to show knowledge of the ability to perform an ultrasound.</p> <p>The personnel files for Staff #1 and 4 included job descriptions for ultrasound technician and the application for employment included the school and years attended for the study of ultrasound, however, no evidence of successful completion of training was included in the personnel file.</p> <p>At 3:20 PM Staff B stated he/she had spoke to the DON and the DON stated there is documentation of training for Staff # 4 although Staff B was not able to locate it in the DON's office. Staff B stated Staff #1 did have a skills/competency checklist but it was not available at this time. Staff B stated he/she was sure the four other ultrasound technicians went through training but was not definite about any documentation in order to verify the training.</p> <p>This finding substantiates complaint number OH00065769.</p>	C 119		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/14/2012
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 prtpreparedness plan.	C 104		

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

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STATE FORM

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/14/2012
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 122	Continued From page 2 This Rule is not met as evidenced by: 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:	C 123		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/14/2012
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 123	Continued From page 3 Based on staff interview, and review of personnel files, the facility failed to provide each staff 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	C 126		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/14/2012
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 126	Continued From page 4 schedules, with the exception of February and March 2012.	C 126		
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	C 139		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/14/2012
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 139	Continued From page 5 "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 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	C 152		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/14/2012
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 152	<p>Continued From page 6</p> <p>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;</p> <p>(5) Document and report the status of quality assessment and improvement program to the governing body every twelve months;</p> <p>(6) Document and review all unexpected complications and adverse events, whether serious injury or death, that arise during an operation or procedure; and</p> <p>(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.</p> <p>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.</p> <p>Findings include:</p>	C 152		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/14/2012
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 152	Continued From page 7 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 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.	C 157		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/14/2012
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 157	Continued From page 8 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 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;	C 201		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/14/2012
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 201	<p>Continued From page 9</p> <p>(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.</p> <p>(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.</p> <p>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.</p> <p>Findings include:</p> <p>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.</p>	C 201		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/14/2012
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 201	Continued From page 10 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. 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	C 214		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/14/2012
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 11 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		
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	C 234		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/14/2012
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1243 EAST BROAD STREET COLUMBUS, OH 43205		
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C 234	Continued From page 12 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. 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		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/15/2012
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 LR, LB Licensure Compliance Inspection Administrator: Sarah Courtney, Health Center Manager County: Franklin Number of ORs: 2 Services provided: Surgical and Medical Abortions License Current: Yes License Expiration Date: December 2012 The following violations are issued as a result of the licensure compliance inspection completed on 03/15/12.	C 000		
C 120	O.A.C. 3701-83-08 (B) T B Control Plan The 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.	C 120		4/2/12

Ohio Department of Health

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

TITLE



(X6) DATE

04/02/12

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/15/2012
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 120	Continued From page 1 This Rule is not met as evidenced by: Based on personnel record reviews, facility policy review, and staff interview, the facility failed to ensure 1 of 9 staff (Staff #10) was given a tuberculin skin test (TB test) as required by facility policy. The facility performed a total of 1,450 procedures in the past twelve months. Findings include: On 03/15/12, nine personnel files were reviewed. Staff #10 (a registered nurse) was hired on 08/01/11 to work with patients in the recovery room, and to provide intravenous sedation to patients. Staff #10's personnel file was silent to a TB test or chest x-ray. On 03/15/12, at 4:00 PM, Staff #1 and #2 verified this employee's file was silent to TB testing. When questioned as to facility policy, both employees stated TB testing is done on new employees at the time of hire, and on an annual basis.	C 120		
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 and staff interview, the facility failed to maintain a sanitary environment related to a suction machine. The facility performed a total of 1,450 procedures in the past twelve months.	C 139		4/2/12

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/15/2012
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 139	Continued From page 2 Findings include: A tour of the facility was conducted on 03/14/12, between 1:55 PM and 3:40 PM, with Staff #1 and #3. The oral suction machine was observed located next to the crash cart. The suction machine was observed uncovered at that time. The surfaces of the machine, and table on which the machine rested, were observed coated with a heavy layer of dust and dirt. This was verified with both facility staff during tour.	C 139		
C 158	O.A.C. 3701-83-13 (B) Complaints Hot Line The HCF shall post the toll free complaint hotline of the department's complaint unit in a conspicuous place in the HCF. This Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to post the toll free complaint hotline number. The facility performed a total of 1,450 procedures in the past twelve months. Findings include: A tour of the facility was conducted on 03/14/12, between 1:55 PM and 3:40 PM, with Staff #1 and #3. There was no evidence of the Ohio Department of Health's complaint hotline number posted in the facility. This was verified with Staff #1 during tour.	C 158		4/2/12
C 231	O.A.C. 3701-83-19 (B) Drug Control & Accountability	C 231		4/2/12

Ohio Dept Health

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
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C 231	<p>Continued From page 3</p> <p>The ASF shall:</p> <p>(1) Provide adequate space, equipment, and staff for storage and the administration of drugs in compliance with state and federal laws and regulations.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on observation, staff interview, and review of medication policies, the facility failed to provide a double locked storage area for controlled substances, failed to label multidose vials when opened, and failed to label medication syringes in accordance with facility policy. The facility performed a total of 1,450 procedures in the past 12 months.</p> <p>Findings include:</p> <p>A tour of the facility was conducted on 03/14/12, between 1:55 PM and 3:40 PM, with Staff #1 and #3.</p> <p>During this tour, the following areas related to medications were observed:</p> <p>a) The narcotic storage box was observed inside a locked cabinet. Staff #3 (a licensed nurse) was observed unlocking the outer cabinet door. Inside the cabinet, next to the narcotic box, 3,350 doses of a controlled substance (Versed) were stored. According to interview with Staff #3, this medication should be inside the narcotic box, and</p>	C 231		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/15/2012
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 231	<p>Continued From page 4</p> <p>should be double locked. This employee stated the narcotic box was full; therefore, the Versed was stored next to the narcotic box.</p> <p>b) Observed inside the narcotic box were three syringes of liquid medication. One syringe was observed labeled Entry, and contained 1 cc of liquid. A second syringe labeled Fentanyl was observed with 0.9 ccs of liquid and 0.1 cc of air. A third syringe was labeled Versed, and contained 1.5 ccs of liquid. These labels lacked dosages, the dates/times when drawn, and initials/name of the person who filled the syringes. Staff #3 verified these syringes were not labeled in accordance with facility policy and standards of practice, and stated he/she would be afraid to administer the medications.</p> <p>c) A multi-dose vial of medication (Midazolam) lacked a cap, and was verified by Staff #3 to be opened. The vial lacked the date and time when opened, and the initials of the person who opened the vial. A vial of Lidocaine 1% was dated 03/12/12; however, lacked initials of the person who opened the vial. This was verified with Staff #3 during tour.</p> <p>d) On 03/14/12, at 3:40 PM, unlicensed Staff #1 was observed unlocking a file cabinet at the front receptionist desk. The cabinet contained 3 drawers filled with prescription contraceptives, which was verified with Staff #1.</p> <p>A review of facility policy titled Pharmaceutical Services 1-A-2 stated controlled substances should be stored in accordance with regulations. The policy also stated if a multidose vial has been opened or accessed (e.g. needle punctured) the vial must be dated and discarded in accordance</p>	C 231		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/15/2012
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
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C 231	Continued From page 5 with manufacturer's instructions and state/local regulations. If no specific guidelines are provided, CDC recommends discarding the vial within 28 days. Staff #1 and #2 verified on 03/15/12, at 4:00 PM, the facility policy was not followed in regards to medication storage and labeling.	C 231		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0600AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/23/2012
NAME OF PROVIDER OR SUPPLIER WOMEN'S MED CENTER OF DAYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 E. STROOP ROAD DAYTON, OH 45429		
(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	<p>Initial Comments</p> <p>LR</p> <p>Licensure Compliance Inspection</p> <p>Administrator: Dr. Martin Haskell, M.D.</p> <p>County: Montgomery</p> <p>Number of ORs: 2</p> <p>Services provided: Suction Dilation & Curettage, and Dilantion & Evacuation Procedures</p> <p>License Current: Yes</p> <p>Licensure Expiration Date: August 2012</p> <p>Women's Medical Center of Dayton is in compliance with the rules at 3701-83 for Ambulatory Surgical Facility at the time of the licensure compliance inspection completed on 02/23/12.</p>	C 000		

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/21/2012
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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 JS/CS Type of inspection: Licensure Compliance Inspection Administrator: Heather Harrington. County: Cuyahoga Number of Operating Rooms: Five Services Provided: Surgical & Medical Abortion License: Current: Yes License Expiration Date: March 2012 The following violation is issued as a result of the licensure compliance inspection completed on 03/21/12.	C 000		
C 211	O.A.C. 3701-83-17 (F) MR With Patient Transport Patients transported to a hospital shall be accompanied by their medical records that are of sufficient content to ensure continuity of care. This Rule is not met as evidenced by: Based on patient medical record review, review of facility policy and staff interview and verification, the facility failed to ensure that patients transported to a hospital were accompanied by their medical records and that sufficient content was provided to ensure continuity of care. One of 6 patient medical records (Patient#1) was affected. The facility provided 4747 procedures	C 211		

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

TITLE



(X6) DATE
03/17/12

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/21/2012
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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 211	<p>Continued From page 1</p> <p>in the past 12 months.</p> <p>Findings included:</p> <p>On 03/21/12 the medical record for Patient #1 was reviewed. Patient #1 was admitted to the facility on 07/06/11 for a surgical procedure. Review of the medical record revealed that near the completion of the procedure the physician noted some increased bleeding. The physician noted observations of the surgical area in the medical record. Documentation ended with the physician's note.</p> <p>The medical record had no documentation that addressed the physician's decision to send the patient to the hospital, the patient's status prior to the transport and at the time of transport, as well as how the patient was transported to the hospital and who accompanied the patient. There was no documentation which noted if any of the patient's medical record was sent with the patient.</p> <p>Review of the facility policy regarding emergency transfer to the hospital revealed the director of nursing or charge nurse was to obtain transfer information, obtain physician charting, provide the medical record to the administrator for copying and provide the medical record to the nurse for charting of medications, vital signs, times, etc.</p> <p>The policy indicated that a patient support person was to accompany the patient to the hospital and be supportive of the patient and be a patient advocate at the hospital.</p> <p>Further review of the medical record revealed the hospital provided discharge information to the facility which described the patients condition at the time of discharge from the hospital. The</p>	C 211		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/21/2012
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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 211	Continued From page 2 record also included a summary of the event, written by the administrator after the patient's discharge and follow-up with the physician one week later. Interview of Staff A on 03/20/12 verified the medical record did not reflect the patient's condition and the preparation for the patient's transfer to the hospital. It was also verified the facility policy was not followed with regards to emergency transfer procedure.	C 211		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/23/2012
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 JS Type of inspection: Licensure Compliance Inspection Administrators: Carol Westfall County: Summit Number of Operating Rooms: One Services Provided: Women's Health Services License: Current: Current and Valid Ohio Licensure until April 2013 The following violations are issued as a result of the licensure compliance inspection completed in 02/23/12.	C 000		
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 facility observation and staff interview and verification, the facility was not maintained in a safe and sanitary manner. The facility provided services for 1853 patients in the calendar year 2011. Findings included: On 02/23/12 between 12:45 P.M. and 2:50 P.M. tour of the facility was completed with Staff A, B and C. Observation of the facility revealed the	C 139		

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TITLE



(X6) DATE
02/11/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/23/2012
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 139	<p>Continued From page 1</p> <p>following items with regards to patient safety and sanitation.</p> <ol style="list-style-type: none"> 1. The carpet in the patient waiting area was noted to be soiled and stained. 2. The walls behind patient chairs were noted to have a shiny, greasy appearance. Staff present on tour verified visitors and patients lean their heads against the wall while in the waiting room. 3. Surfaces in the operating room were noted to be dusty with white residue. The dusty white residue was noted on the drawers of the respiratory supply cart, on the light above the operating room table and on the tops of monitoring equipment. 4. A cupboard door in the operating room was observed to be taped in place with bandage tape as the hinge on the door was broken. 5. Privacy curtains in the recovery room were noted to have dried, dark colored stains and spill marks. 6. Three large red biohazard barrels approximately 32 gallons in size were stored in the recovery area. Staff B verified the barrels were filled quickly on busy surgical days and maintained in the area for convenience. <p>Interview of Staff A revealed a contractor had been secured to paint the waiting room wall in the very near future. In addition privacy curtains were to be taken to the cleaners. Staff B removed the red biohazard barrels from the recovery room.</p>	C 139		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/23/2012
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 247	Continued From page 2	C 247		
C 247	<p>O.A.C. 3701-83-20 (H) Medical Gasses</p> <p>Each ASF shall develop and follow policies and procedures for the storage and use of medical gases in accordance with the requirement of the national fire protection association (NFPA) 99.</p> <p>This Rule is not met as evidenced by: Based on facility observation and staff interview and verification, the facility failed to follow policies and procedures for the storage and use of medical gases in accordance with the requirement of the national fire protection association (NFPA) 99. The facility provided services for 1853 patients in the calendar year 2011.</p> <p>Findings included:</p> <p>On 02/23/12 between 12:45 P.M. and 2:50 P.M. tour of the facility was completed with Staff A, B and C. During tour of the operating room, storage of the medical gases used by the facility was noted.</p> <p>Eleven E-sized cylinders of oxygen were noted in a small closet like storage area. The cylinders were secured in a holder. Staff B was interviewed regarding the storage of full and empty cylinders. Staff B had to bend and lean closely to the cylinder gauges to determine which oxygen cylinders were empty. Empty oxygen cylinders were intermingled in the holder with full oxygen cylinders.</p> <p>Observation of the outside of the storage area revealed there was no signage noted to indicate the storage of oxygen in the area.</p>	C 247		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/23/2012
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP			STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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	

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/02/2013
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 Type of Inspection: Licensure Compliance Inspection Administrator: Carol Westfall County: Summit Number of Operating Rooms: One Services Provided: Women's Services The following licensure violations were issued as a result of the licensure compliance inspection completed on 05/02/13.	C 000		
C 132	O.A.C. 3701-83-09 (D) Infection Control Policies & Procedures The HCF shall establish and follow written infection control policies and procedures for the surveillance, control and prevention and reporting of communicable disease organisms by both the contact and airborne routes which shall be consistent with current infection control guidelines, issued by the United States centers for disease control. The policies and procedures shall address: (1) The utilization of protective clothing and equipment; (2) The storage, maintenance and distribution of sterile supplies and equipment; (3) The disposal of biological waste, including blood, body tissue, and fluid in accordance with Ohio law; (4) Standard precautions/body substance	C 132		

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/02/2013
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 132	<p>Continued From page 1</p> <p>isolation or equivalent; and</p> <p>(5) Tuberculosis and other airborne diseases.</p> <p>This Rule is not met as evidenced by: Based on a tour of the facility, a review of the facility's policies and procedures, and interview with the facility staff, the facility failed to follow their written policies and procedures for the storage and maintenance of instruments and supplies. The facility provided services to 1,833 patients during the twelve month period of March, 2012 through March, 2013.</p> <p>Findings include:</p> <p>During a tour of the facility on 05/01/13 observation of the operating room revealed that at least five sterilized packages of instruments and/or gauzes had not been dated or initialed as to when sterilization had been completed. Further observation of the stored sterilized packages revealed additional packs that had dried brownish stains on the outside of the packaging. Additional sterile packages had sterilization dates of 2011. This was verified by Staff A on 05/01/13 at approximately 2:00 PM.</p> <p>Interview with Staff A, at the time of tour, revealed the sterilized items were to be re-sterilized every six months after the sterilization date written on the packaging sticker.</p> <p>Review of the facility's policy on 05/02/13 entitled "Event Related Sterility-in-House Products" revealed items sterilized were to be labeled with a load sticker with the following information; item</p>	C 132		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/02/2013
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304			
(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 132	Continued From page 2 description, date of sterilization, sterilizer number, and assembler initials.	C 132			
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; (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	C 152			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/02/2013
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 152	<p>Continued From page 3</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on a review of the facility's policies and procedures and interview with the facility staff, the facility failed to ensure that their quality assessment and performance improvement program monitored and evaluated all aspects of care including effectiveness, appropriateness, accessibility, continuity, efficiency, patient outcome, and patient satisfaction; established expectations, developed plans, and implemented procedures to assess and improve the quality of care and resolve identified problems; documented and reported the status of quality assessment and improvement program to the governing body every twelve months; and held regular meetings, chaired by the medical director of the facility or designee. The facility provided services to 1,833 patients during the twelve month period of March, 2012 through March, 2013.</p> <p>Findings included:</p> <p>The facility's policy and procedure related to the quality assurance program was reviewed on 05/02/13. Review of the policy revealed that the governing board had the ultimate responsibility for the quality improvement (QI) program. The</p>	C 152		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/02/2013
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP			STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 152	<p>Continued From page 4</p> <p>activities of the QI were to be carried out by two committees under the supervision of the Director of Education and Quality Management.</p> <p>The two committees were noted to be the Operations Committee and the Quality Council. The Operations Committee was to include at least the Medical Director, the Administrator and the Director of Education and Quality Management. The Quality Council was to include the Director of Education and Quality Improvement, the Business Manger, the Administrator, the Medical Director or designee, the Director of Anesthesia, two specialty heads, and three additional patient care personnel as appointed by the Administrator.</p> <p>According to the policy, both committees were to meet at least quarterly. Review of QI minutes and activity documentation, revealed no documented evidence that either of these committees had met during the past 12 months.</p> <p>Interview of Staff A on 05/02/13 between 10:30 A.M. and 12:00 P. M. revealed there were no QI committees. Staff A stated he/she was entirely responsible for all QI activities.</p> <p>Review of the medical record review component of the QI program revealed that five percent or 30 charts, whichever was greater was to be reviewed monthly and analyzed for completeness, appropriateness of care and standard for performance. Review of the governing body meeting minutes revealed that prior to the two meetings held on 04/06/12 and 03/08/13 twenty medical records had been reviewed and no problems were identified either time. There was no evidence that five percent or 30 charts, whichever was greater had been reviewed</p>	C 152			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/02/2013
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 152	<p>Continued From page 5</p> <p>monthly as required by the facility policy.</p> <p>Review of patient medical records revealed that three of the 12 patient medical records reviewed (Patients #8, #11, and #12) did not contain accurate and/or complete documentation as to dates of care or the services provided for those patients.</p> <p>Review of information provided as part of the QI program included patient satisfaction surveys. Interview of Staff A on 05/02/13 between 10:30 A.M. and 12:00 P.M. regarding the patient satisfaction surveys revealed that patients completed these surveys while in the recovery area. The survey was then placed in the patient's medical records. Staff A stated that there was no tracking or trending of patient survey information. Staff A further stated that the most common complaint from patients was wait time. Interview of Staff A revealed that patient dissatisfaction with the pre-operative wait times was not considered as a QI project.</p> <p>Review of the governing body meeting minutes revealed meetings held on 04/06/12 and 03/08/13. The documentation of the meetings did not reveal any discussion or evidence that QI projects or program activities for the past 12 months were discussed. Further review of facility documentation revealed there was no evidence that regular meetings, chaired by the two committees addressed facility QI activities.</p> <p>Interview of Staff A on 05/02/13, regarding the QI program verified that the facility policy was not followed regarding the committees, committee memberships, and activities of the QI program.</p>	C 152		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/14/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 Licensure Compliance Inspection Health Care Manager: Sarah Courtney County: Franklin Number of Operating Rooms: Two (2) Services Provided: Surgical Abortions License Current: Yes License expiration date: 12/31/12 The following violations were issued as a result of the licensure compliance inspection completed on 02/14/13.	C 000		
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 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 medical record review and staff interview, the facility failed to ensure the time of the administration of oral medications by licensed staff was documented in the medical records for six patient's (Patient #3, 4, 12, 13, 14, and 16). The facility also failed to ensure the time of the administration of an intravenous push (IVP) medication and the dose and time of an intra-muscular injection was documented in the medical record for Patient #16. The sample size was 16. The facility performed 1610 procedures	C 129		

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TITLE



(X6) DATE

03/05/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/14/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 129	<p>Continued From page 1</p> <p>in 2012.</p> <p>Findings include:</p> <p>The medical record for Patient #3 was reviewed on 02/13/13. Documentation in the medical record dated 06/27/12 revealed that Physician A administered Misoprostol (a medication used to induce uterine contractions during a medical abortion) 200 milligrams, two (2) tablets to Patient #3. The time the medication was administered was not documented. This finding was confirmed during interview with Staff A on 02/13/13 at 4:08 PM. Staff A stated it was facility policy to document the time of medication administration. Staff A visualized the medical chart and verified the medication administration time was not documented.</p> <p>The medical record for Patient #4 was reviewed on 02/13/13. Documentation in the medical record dated 07/09/12 revealed that a licensed practical nurse recorded on the pre-operative sheet that she administered Ibuprofen (a pain medication) 400 milligrams to Patient #4. The licensed practical nurse did not document the time the medication was administered. This finding was verified with Staff A on 02/13/13 at 4:30 PM. Staff A visualized the medical chart and verified that the line for the time of the medication administration was left blank.</p> <p>The medical record for Patient #16 was reviewed on 02/14/13. Documentation in the medical record dated 12/28/12 revealed that a licensed practical nurse administered Zofran (an anti nausea medication) 4 milligrams per intravenous push according to the medication log. The licensed practical nurse did not document the time the medication was administered. In</p>	C 129		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/14/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 129	<p>Continued From page 2</p> <p>addition, review of the moderate sedation log revealed a licensed practical nurse documented the administration of Methergine (a medication used to control postpartum hemorrhage) intra-muscularly. The dose and time of the medication administration was not documented. These findings were verified with Staff D on 02/14/13 at 1:06 PM. Staff D visualized the medical record at this time and verified that the time the Zofran was administered and the dose and time that the Methergine was administered were not documented.</p> <p>The medical record for Patient #12 was reviewed on 02/13/13. Documentation in the medical record revealed a diagnosis of a positive pregnancy of approximately six weeks gestation for which a medical abortion was sought. Further review of the record revealed that the pills administered for the abortion were spaced 48 hours apart and the third day dose of (Misoprostol) was given by the physician on 04/27/12, but no time was recorded. In an interview with Staff A on 02/13/13 at 4:08 PM, Staff A confirmed that no time had been recorded for the administration of the medication. Staff A further stated that the form for the documentation did not have a space for the time to be placed, although the expectation was for staff to document the time all medications are administered.</p> <p>The medical record for Patient #13 was reviewed on 02/13/13. Documentation in the medical record revealed a diagnosis of a positive pregnancy of approximately six weeks and three days gestation for which a medical abortion was sought. Further review of the record revealed that the third day pill in the series of the medical abortion was given by the physician on 09/14/12,</p>	C 129		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/14/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 129	Continued From page 3 but no time was recorded. In an interview on 02/13/13 at 4:08 PM, Staff A stated that the expectation was for a time to be documented for the administration of all medications. The medical record for Patient #14 was reviewed on 02/14/13. Documentation in the medical record revealed a diagnosis of a positive pregnancy of approximately six weeks and one day gestation for which a medical abortion was sought. Further review of the record showed the third day pill in the series of the medical abortion was given on 09/07/12, but no time of administration was documented. In an interview on 02/13/13 at 4:08 PM, Staff A stated that the expectation was for a time to be documented for the administration of all medications.	C 129		
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 and interview with facility staff, the facility failed to ensure patient use items were stored in a sanitary fashion. There were 1610 procedures completed at the facility in the past year. Findings include: A tour of the facility was conducted on 02/14/13. During a tour of the facility's basement at approximately 9:48 AM, accompanied by Staff A and Staff D, multiple cardboard boxes with patient care supplies were noted to be stored directly on	C 139		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/14/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 139	Continued From page 4 the concrete floor. The boxes contained tubing used in aspirators, glass jars, gloves, feminine hygiene products (absorbent pads), disposable drape sheets, exam table paper rolls, pillow cases, bathroom tissue, bulk condoms, and chart folders. Staff A and Staff D verified the presence of the multiple cardboard boxes being stored directly on the concrete floor containing patient care supplies. In an interview at 9:54 AM, Staff A stated that the facility was in need of more shelving or storage to get the boxes off the floor.	C 139		
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 does not 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 review and staff interview, the facility failed to ensure four of 16 sampled patients (Patients #1, 2, 7, and 12) were discharged only if accompanied by a responsible person, unless the attending or discharging physician determined that the patients did not need to be accompanied and documented the circumstances of the discharge in the patient's medical record. The facility performed 1610 procedures in 2012. Findings include:	C 214		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/14/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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	<p>Continued From page 5</p> <p>The medical record for Patient #1 was reviewed on 02/13/13. Review of the medical record revealed that the patient's surgical procedure (surgical abortion) was performed under local anesthesia on 04/12/12. The patient was discharged home per self on 04/13/12 at 1:05 PM. 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. This finding was verified with Staff A on 02/13/13 at 4:30 PM. Staff A stated they were not aware that the physician needed to document in the medical record if the patient left without a responsible person.</p> <p>The medical record for Patient #2 was reviewed in the afternoon on 02/13/13. Review of the medical record revealed that the patient had a surgical procedure (dilation and curettage) on 04/17/12 due to an incomplete abortion on 03/24/12. The patient was discharged home on 04/17/12 at 12:15 PM and was not accompanied by a responsible person. 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. This finding was verified during interview with Staff A on 02/13/13 at 4:30 PM. Staff A stated they were not aware that the physician needed to document in the medical record if the patient left without a responsible person.</p> <p>The medical record for Patient #7 was reviewed on 02/13/13. Review of the medical record revealed that the patient received services at the facility under local anesthesia on 02/10/12. 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</p>	C 214		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/14/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 6 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. 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 214		
C 231	O.A.C. 3701-83-19 (B) Drug Control & Accountability The ASF shall: (1) Provide adequate space, equipment, and staff for storage and the administration of drugs in compliance with state and federal laws and regulations. (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. This Rule is not met as evidenced by:	C 231		3/12/13

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 231	<p>Continued From page 7</p> <p>Based on medical record review, review of the narcotic control/accountability signature logs, staff interview, and review of the facility policy entitled "Narcotic Management Protocol", the facility failed to ensure two licensed staff witnessed narcotics being wasted. The facility performed 1610 procedures in 2012.</p> <p>Findings include:</p> <p>The facility policy entitled "Narcotic Management Protocol" was reviewed on 02/13/13. The policy stated under number 1, "Wasting of any narcotic must be witnessed by two licensed staff."</p> <p>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:</p> <p>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</p> <p>These findings were confirmed with Staff B on 02/13/13 at 1:45 PM. Staff B stated that two licensed staff should have signed as witnessing the wasting of the narcotic on the narcotic count log.</p> <p>Further review of the narcotic count log revealed Fentanyl (narcotic) was not witnessed by two licensed staff when wasted on the following dates:</p>	C 231		

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 231	Continued From page 8 12/28/12 - Fentanyl 50 mcg (micrograms) 01/02/13 - Fentanyl 200 mcg 01/04/13 - Fentanyl 250 mcg 01/11/13 - Fentanyl 50 mcg 01/16/13 - Fentanyl 100 mcg These findings were verified with Staff B on 02/13/13 at 2:00 PM.	C 231		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/11/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 Licensure Compliance Inspection Administrator: Miriam Hernandez County: Cuyahoga Capacity: Six Operating Rooms The following violations are issued as a result of the licensure compliance inspection completed on 01/11/13.	C 000		
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 facility observation and staff interview and verification, the facility failed to ensure a safe and sanitary environment. Potentially all patients, visitors and staff could be affected. The facility provided services for 3618 patients in the year 2012. Findings included: On 01/10 and 01/11/13 the facility was observed and documentation was reviewed during the compliance inspection. The following observations were noted regarding safety and sanitation of the facility; 1. Upon entrance to the first floor waiting area, an automatic door release for the secured waiting room door was noted. The cover to the automatic release was noted to be out of place,	C 139		

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TITLE



(X6) DATE
01/13/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/11/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 139	<p>Continued From page 1</p> <p>exposing the inside of the box. Staff A present at the observation on 01/10 and 01/11/13 revealed the release for the secured door of the waiting area was designed especially for handicapped patients. The door was equipped with an electronic eye which would release if a person was standing in front of the door. The electronic eye may not release the door if a wheelchair patient was present, thus the need for the manual release button. Staff A verified the automatic release was not in working order and in need of repair. The door did release in case of emergency.</p> <p>2. Observation of the fire extinguishers on the first and second levels of the facility revealed the facility fire extinguishers had not been inspected monthly as evidenced by lack of documentation on the back of the tag on the extinguishers. In addition, two extinguishers, one on the first floor and one on the second floor, had not been inspected on an annual basis. The tag on the two extinguishers revealed the last annual inspection was in September 2011. Staff A present at the time of the observation verified that no monthly inspection of the extinguishers had been conducted and further verified the two fire extinguishers had not been serviced in 2012.</p> <p>3. Observation of the second floor surgical waiting area revealed very lightly colored walls. Observation of the seating area revealed darkened and discolored walls behind the chairs in the waiting areas. The discolored areas looked consistent with dirty areas left behind by persons sitting in the chairs who may had leaned or rested against the wall. Staff present on the tour verified the observation.</p> <p>Review of facility documentation on 01/11/13</p>	C 139		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/11/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 139	Continued From page 2 revealed the failure to check fire extinguishers had been identified during a safety check conducted by staff in 2012. Review of the contracted cleaning staff duties revealed cleaning of the waiting area walls was not listed.	C 139		
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. (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	C 201		

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 201	<p>Continued From page 3</p> <p>affiliated or associated with the individual. The external peer review shall consist of a quarterly audit of a random sample of surgical cases.</p> <p>This Rule is not met as evidenced by: Based on review of physician credentialing files and staff interview and verification, the facility failed to ensure the governing body at least every twenty-four months reviewed, updated, and approved the surgical procedures that may be performed at the facility. Two of four physician credentialing files (Staff CC and Staff DD) were affected. The facility provided services for 3618 patients in the year 2012.</p> <p>Findings included:</p> <p>On 01/10/13, Staff A provided four credentialing files for physicians who provided surgical services at the facility. Review of the four credentialing files on that date revealed the following;</p> <p>1. Review of the credentialing file for Staff CC revealed that privileges were last reviewed and approved by the governing body in November 2010. Interview of Staff A revealed that Staff CC no longer provided services for the facility but had not been released as no longer practicing there. Staff A verified the governing body had taken no action regarding credentialing and approval of privileges for Staff CC.</p> <p>2. Review of the credentialing file for Staff DD revealed there was no documented evidence of a</p>	C 201		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/11/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 201	Continued From page 4 list of requested and approved procedures to be performed in the facility. Interview of Staff A regarding the lack of requested procedures and approval by the governing body revealed Staff DD was the current medical director. The credentialing file contained no documented evidence to indicate that Staff DD acquired the duties of the medical director. On 01/10/13 at 4:30 P.M. Staff A verified there was no delineation of privileges and indication of governing body approval.	C 201		
C 243	O.A.C. 3701-83-20 (D) Ventilation & Humidity Levels Each ASF shall have appropriate ventilation and humidity levels in order to minimize the risk of infection and to provide for the safety of the patient. This Rule is not met as evidenced by: Based on facility observation and staff interview and verification, the facility failed to ensure appropriate ventilation and humidity levels in order to minimize the risk of infection and to provide for the safety of the patients. The facility provided services for 3618 patients in the year 2012. Findings included: On 01/10/13 tour of the facility was conducted with Staff A and B. Observation of the facility revealed the surgical and recovery areas was located on the second floor of the building. Staff A and B verified the facilities utilized only	C 243		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/11/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 243	Continued From page 5 conscious sedation of the patients and no general anesthesia was used. Interview of Staff A regarding temperature and humidity levels for the surgical and recovery areas revealed the levels were not monitored by staff. Staff A revealed the corporate policy was that humidity levels were to be monitored. A portable electric heater was observed in the patient recovery area.	C 243		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/18/2013
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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	<p>Initial Comments</p> <p>Licensure Compliance Inspection</p> <p>Administrator: Chrissie France</p> <p>County: Cuyahoga</p> <p>Capacity: Five (5) Operating Rooms</p> <p>At the time of the licensure compliance inspection, completed on 04/18/13, Preterm is in compliance with the rules at O.A.C. 3701-83 for ambulatory surgical facilities.</p>	C 000		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/11/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 Licensure Compliance Inspection Revisit Administrator: Sarah Courtney County: Franklin Capacity: One (1) Operating room The entrance conference was held on 04/11/13 at approximately 10:05 AM, the Assistant Manager was present. The exit conference was held on 04/11/13 at approximately 2:00 PM with the Operational Manager. The following violation was re-issued during a licensure post inspection revisit completed on 04/11/13.	{C 000}		
{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 and interview with facility staff, the facility failed to ensure patient use items were stored in a sanitary manner. There were 1610 procedures completed in this facility in the past year. Findings include: During a post survey revisit on 04/11/13 a tour of the basement was conducted at approximately 10:20 AM accompanied by Staff A. There were four large cardboard boxes with patient care supplies observed stored directly on the concrete	{C 139}		

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TITLE



(X6) DATE
05/07/13

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
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{C 139}	Continued From page 1 floor. The boxes contained specimen containers, hygiene products (absorbent pads), and safety guide three milliliter twenty-two gauge one and a half inches needles. Staff A verified the boxes were on the floor and stated they should have been put on the shelves. This was also confirmed with Staff B.	{C 139}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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		

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TITLE



(X6) DATE
05/06/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 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	C 119		

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NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1243 EAST BROAD STREET COLUMBUS, OH 43205		
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C 119	<p>Continued From page 2</p> <p>have an established system to verify and 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.</p> <p>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.</p> <p>Findings include:</p> <p>"Staff Member" is any individual who provides direct care to patients on a full-time, part-time, temporary, contract or voluntary basis.</p> <p>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.</p> <p>Review of the medical records revealed Cytotec 400 milligrams and Ibuprofen 600 milligrams were administered by Staff N as follows:</p> <p>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.</p>	C 119		

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C 119	<p>Continued From page 3</p> <p>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.</p> <p>Patient #5 had surgery on 03/21/13. Staff N documented administering Cytotec 400 mg and Ibuprofen 600 mg at 4:06 P.M.</p> <p>Patient #7 had surgery on 04/02/13. Staff N documented administering Cytotec 400 mg and Ibuprofen 600 mg at 10:31 P.M.</p> <p>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.</p> <p>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.</p> <p>Patient #10 had surgery on 03/18/13. Staff N documented administering Cytotec 400 mg at 10:18 A.M.</p> <p>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.</p> <p>Interview with Staff M on 05/01/13 per telephone</p>	C 119		

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NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1243 EAST BROAD STREET COLUMBUS, OH 43205		
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C 119	Continued From page 4 at 10:15 A.M. verified that there was no 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	C 123		

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C 123	Continued From page 5 facility staff (Staff D, E, F, G, H, I, J, and K) had documentation of orientation appropriate to the 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: 06/14/12 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 129	O.A.C. 3701-83-09 (A) Standards of Practice The HCF shall assure all staff members provide	C 129		

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C 129	<p>Continued From page 6</p> <p>services in accordance with:</p> <p>(1) Applicable current and accepted standards of practice and the clinical capabilities of the HCF; and</p> <p>(2) Applicable state and federal laws and regulations.</p> <p>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.</p> <p>Findings include:</p> <p>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</p>	C 129		

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C 129	Continued From page 7 understood request of Physician A, but verified there was no approved protocol/doctor's order for the administration of the second dose of Cytotec 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.	C 140		

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C 140	Continued From page 8 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 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 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,	C 152		

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C 152	<p>Continued From page 9</p> <p>accessibility, continuity, efficiency, patient outcome, and patient satisfaction;</p> <p>(2) Establish expectations, develop plans, and implement procedures to assess and improve the quality of care and resolve identified problems;</p> <p>(3) Establish expectations, develop plans, and implement procedures to assess and improve the health care facility's governance, management, clinical and support processes;</p> <p>(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;</p> <p>(5) Document and report the status of quality assessment and improvement program to the governing body every twelve months;</p> <p>(6) Document and review all unexpected complications and adverse events, whether serious injury or death, that arise during an operation or procedure; and</p> <p>(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.</p>	C 152			

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C 152	<p>Continued From page 10</p> <p>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 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.</p> <p>Findings include:</p> <p>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.</p> <p>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 :</p> <p>Monitoring and evaluating all aspects of care including effectiveness, appropriateness, accessibility, continuity, efficiency, patient outcome, and patient satisfaction;</p> <p>Establishing expectations, developing plans, and implementing procedures to assess and improve the quality of care and resolve identified problems;</p> <p>Establishing expectations, developing plans, and</p>	C 152		

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C 152	<p>Continued From page 11</p> <p>implementing procedures to assess and improve the health care facility's governance, management, clinical and support processes;</p> <p>Establishing information systems and appropriate data management processes to facilitate the collection, management, and analysis of data needed for quality assessment and performance improvement;</p> <p>Documenting and reporting the status of quality assessment and improvement program to the governing body every twelve months;</p> <p>Documenting and reviewing all unexpected complications and adverse events, whether serious injury or death, that arise during an operation or procedure; and</p> <p>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.</p> <p>There was also no evidence that any patterns that might have indicated a problem were investigated and remedied.</p> <p>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.</p>	C 152		

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C 214	Continued From page 12	C 214		
C 214	<p>O.A.C. 3701-83-17 (I) Patient Accompanied at Discharge</p> <p>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.</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>The medical record of Patient #8 was reviewed</p>	C 214		

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C 214	<p>Continued From page 13</p> <p>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 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.</p> <p>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.</p>	C 214		

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NAME OF PROVIDER OR SUPPLIER WOMEN'S MED CENTER OF DAYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 E. STROOP ROAD DAYTON, OH 45429		
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C 000	Initial Comments Licensure Compliance Inspection Administrator: Martin Haskell, MD County: Montgomery Number of Operating Rooms: 2 Services Provided: Women's Services The following violation is issued as a result of the licensure compliance inspection completed on 04/29/13.	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: Based on a review of facility documentation and interview with the facility staff , the facility failed to have a written transfer agreement with a	C 234		

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

TITLE



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0600AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/29/2013
NAME OF PROVIDER OR SUPPLIER WOMEN'S MED CENTER OF DAYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 E. STROOP ROAD DAYTON, OH 45429		
(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 234	<p>Continued From page 1</p> <p>hospital for the transfer of patients in the event of medical complications, emergency situations, and for other needs as they arise. This could affect all patients treated at this ambulatory surgical facility.</p> <p>Findings include:</p> <p>An interview was conducted with Staff L, Assistant Director, on 04/26/13 at 9:00 AM regarding the facility's transfer agreement. Staff L stated that the facility does not currently have a transfer agreement with a local hospital for the transfer of patients in the event of medical complications, emergency situations, and for other needs as they arise; however, Staff L stated that the facility has requested a variance in lieu of this agreement. Staff L stated that the facility has submitted written documentation for the variance as requested by the Ohio Department of Health.</p> <p>On 04/26/13, Staff L provided the surveyor with written documentation from two physicians who have agreed to cover the care of this facility's patients in the event of a transfer to a hospital. This documentation also included communication from the local hospital in which these two physicians have admitting privileges, stating that both physicians are active and in good standing at that hospital. Staff L also provided documentation from three local hospitals denying their request to enter into a transfer agreement with this facility.</p>	C 234		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PLANNED PARENTHOOD SOUTHWEST OHIO REGION

(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

C 000

Licensure Compliance Inspection

Administrator: Sherrie Brown, Director of Clinical Services

County: Hamilton

Number of ORs: 3 procedure rooms

The following violations are issued as a result of the licensure compliance inspection completed on 06/06/13.

C 104

O.A.C. 3701-83-03 (F) Governing Body

C 104

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 assessment and performance improvement program on an annual basis; and

(3) The development and maintenance of a disaster preparedness plan.

This Rule is not met as evidenced by:

Ohio Department of Health

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

TITLE



(X6) DATA

01/07/14

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 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 104	Continued From page 1 Based on review of governing body meeting minutes and staff interview, the governing body failed to evaluate the facility's quality assessment and performance improvement program (QAPI) on an annual basis. This affected all patients in the facility. The facility performed a total number of 2,930 procedures in the past 12 months. Findings include: On 06/06/13, a review was conducted of the governing body's meeting minutes. An interview was conducted with Staff E (Director of Quality and Risk Management) between 12:00 PM and 12:30 PM on the same date. The governing body minutes revealed meetings on 09/10/10 and 10/11/12. There was no evidence the governing body met in 2011. Review of the two previous governing body meeting minutes did not have documentation regarding the evaluation of the QAPI program. This finding was verified with Staff E during interview. Staff E verified the governing body did not evaluate the facility's QAPI every 12 months.	C 104		
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	C 119		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGION		STREET ADDRESS, CITY, STATE, ZIP CODE 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 119	<p>Continued From page 2</p> <p>have an established system to verify and 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.</p> <p>This Rule is not met as evidenced by: Based on review of personnel files, and staff interview, the governing body failed to ensure 1 of 3 professional staff members (Staff C), had a current drug enforcement administration certificate (DEA) on file in the facility. A total of 2,930 procedures were performed in the past 12 months.</p> <p>Findings include:</p> <p>On 06/06/13, a review was conducted of the privileging re-approval process and personnel files of 3 of 3 physicians (Staff A, B, and C) who perform abortions in the facility. One of the three physicians (Staff C) was employed on an as needed basis (prn).</p> <p>According to the documentation of the privileging re-approval process by the governing body, on 10/17/12 the governing body granted surgical privileges for Staff C to provide services up to 17 weeks gestation and medication abortions. The period of time for these privileges was 09/16/12 through 09/16/14. A review of Staff C's personnel file on 06/06/13 revealed Staff C's DEA certificate had expired on 12/31/08.</p> <p>Interview with Staff D at 12:00 PM on 06/06/13 verified Staff C's DEA certificate had expired and</p>	C 119		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIONAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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 119	Continued From page 3 reapproval of Staff C's privileges had not been completed by the Governing Body. Staff D stated he/she would have to contact the other facility, in which Staff C is employed, to obtain the updated information. Staff D stated this should have been verified during the most recent re-approval process.	C 119		
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 the quality assurance and performance improvement program (QAPI) documentation, and staff interview, the facility failed to establish a quality assurance program specific to the needs of the ambulatory surgery center. This could affect all patients in the facility. A total of 2,930 procedures were performed in the past 12 months. Findings include: On 06/06/13, an interview was conducted with Staff E (Director of Quality and Risk	C 150		

Ohio Dept Health

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 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 150	Continued From page 4 Management) between 12:00 PM and 12:30 PM, regarding the quality assurance and performance improvement program. The interview with Staff E revealed this facility is part of an affiliate consisting of all nine facilities, with this facility being the only surgical center in that affiliate group. Staff E stated although there are some quality assurance components related to the surgery center integrated into the affiliate quality program center, there is not a specific quality assurance and performance improvement program currently for the surgery center. Staff E stated there would be a governing body meeting next week to discuss implementation of a specific QAPI program for this surgery center.	C 150		
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	C 152		

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 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 152	<p>Continued From page 5</p> <p>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;</p> <p>(5) Document and report the status of quality assessment and improvement program to the governing body every twelve months;</p> <p>(6) Document and review all unexpected complications and adverse events, whether serious injury or death, that arise during an operation or procedure; and</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on review of the quality assurance and performance improvement program (QAPI) documentation, and staff interview, the facility failed to document and report the status of the quality assessment and improvement program to the governing body every twelve months, and failed to hold regular meetings to discuss QAPI for this facility. This could affect all patients in the facility. A total of 2,930 procedures were performed in the past 12 months.</p> <p>Findings include:</p>	C 152		

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 2314 AUBURN AVENUE CINCINNATI, OH 45219		
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C 152	<p>Continued From page 6</p> <p>On 06/06/13, an interview was conducted with Staff E (Director of Quality and Risk Management) between 12:00 PM and 12:30 PM, regarding the quality assurance and performance improvement program, meetings, and reporting the status to the governing body every 12 months.</p> <p>Staff E stated there currently is not a specific quality assurance and performance improvement program for this surgery center. Staff E stated there would be a governing body meeting next week to discuss implementation of a specific QAPI program.</p> <p>On 06/06/13, a review was conducted of the governing body meeting minutes. According to this review, the governing body met on 09/10/10 and 10/11/12. There was no evidence the governing body met in 2011. Review of the governing body meeting minutes did not have documentation the status of the QAPI program was reported to the governing body every 12 months. This finding was verified with Staff E during the aforementioned interview. Staff E verified the facility lacked a specific QAPI program and verified the status had not been reported to the governing body every 12 months.</p> <p>Staff E also stated the facility meets weekly with the Medical Director, Director of Quality and Risk Management, Clinical Services Administrator, and Director of Clinical Services to discuss various quality concerns related to this facility, but verified there are no regular meetings to discuss the overall QAPI program as there is no specific program in place for this facility. Staff E verified the facility will be meeting quarterly in the future to discuss the QAPI program they will be implementing for this facility.</p>	C 152		

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 2314 AUBURN AVENUE CINCINNATI, OH 45219		
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C 201	<p>O.A.C. 3701-83-16 (B) Governing Body Duties</p> <p>The governing body shall:</p> <p>(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;</p> <p>(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:</p> <p>(a) Current licensure and certification, if applicable;</p> <p>(b) Relevant education, training, and experience; and</p> <p>(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.</p> <p>(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.</p>	C 201		

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGION		STREET ADDRESS, CITY, STATE, ZIP CODE 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 201	<p>Continued From page 8</p> <p>This Rule is not met as evidenced by: Based on review of personnel files, governing body meeting minutes, and staff interview, the governing body failed to have documented evidence of competency performance evaluations of 3 of 3 physicians prior to re-approval of privileges. A total of 2,930 procedures were performed in the past 12 months.</p> <p>Findings include:</p> <p>On 06/06/13, a review was conducted of the privileging re-approval process and personnel files of 3 of 3 physicians (Staff A, B, and C) who perform abortions in the facility. One of the three physicians (Staff C) was employed on an as needed basis (prn).</p> <p>According to the documentation of the privileging re-approval process by the governing body, the facility lacked written evidence of Competency performance evaluations for privileges requested by these physicians prior to the re-approval.</p> <p>Review of facility documentation revealed the governing body granted privileges to Staff A (the Medical Director) on 10/16/12 to provide abortions up to eleven weeks gestation, and medication abortions from 09/16/12 through 09/16/14. Although a Clinical Performance evaluation was conducted by a non-employee person for Staff A, this was not done before the re-approval of privileges in September 2012. The review period documented for this evaluation was 04/01/12 through 04/01/13. During an interview on 06/06/13 at 4:00 PM with Staff D revealed this</p>	C 201		

Ohio Dept Health

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 2314 AUBURN AVENUE CINCINNATI, OH 45219		
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C 201	Continued From page 9 evaluation for Staff A was done on 01/18/13. Review of facility documentation for Staff B and Staff C revealed on 10/17/12 the governing body granted surgical privileges to provide up to 17 weeks gestation and medication abortions to Staff B and Staff C. The period of time for these privileges was 09/16/12 through 09/16/14. The facility lacked documented evidence of a competency performance evaluation for the privileges requested by Staff B and C. An interview was conducted with Staff B (physician) and Staff D (Health Center Manager) on 06/06/13 at 4:30 PM in regard to the lack of documented competency performance evaluations for Staff A, B, and C. Both employees verified the evaluation for Staff A was conducted after the re-approval was granted and verified the lack of this evaluation for Staff B and Staff C.	C 201		
C 211	O.A.C. 3701-83-17 (F) MR With Patient Transport Patients transported to a hospital shall be accompanied by their medical records that are of sufficient content to ensure continuity of care. This Rule is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medical record of 1 of 1 sampled patients (Patient #5) accompanied the patient to the hospital. A total number of 2,930 procedures were performed in the past 12 months. Findings include:	C 211		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIONAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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 211	Continued From page 10 On 06/06/13, an interview was conducted with Staff D regarding patient transfers to the hospital from the facility. Staff D verified there had only been one patient who was transferred to the emergency room from the facility in the past 12 months (Patient #5). A review of Patient #5's medical record revealed a dilation and evaluation (D & E) abortion was performed on 03/09/13 after the patient began bleeding during the procedure. The transfer record for this patient revealed the patient was transported by ambulance to the hospital emergency department on the same date at 12:25 PM. The medical record did not have documentation the medical record accompanied the patient to the hospital. An interview was conducted with Staff D on 06/06/13 at 11:20 AM regarding the lack of documentation the medical record was sent to the hospital with Patient #5. Staff D verified the medical record was silent to this and stated this information would be added to the medical record in the future.	C 211		
C 255	O.A.C. 3701-83-21 (A) - (E) Medical Records Each ASF medical record shall contain at least the following information as applicable for the surgery to be performed: (A) Admission data: (1) Name, address, date of birth, gender, and race or ethnicity; (2) Date and time of admission; and (3) Pre-operative diagnosis, which shall be recorded prior to or at the time of admission.	C 255		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 2314 AUBURN AVENUE CINCINNATI, OH 45219		
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C 255	<p>Continued From page 11</p> <p>(B) History and physical examination data: (1) Personal medical history, including but not limited to allergies, current medications and past adverse drug reactions; (2) Family medical history; and (3) Physical examination.</p> <p>(C) Treatment data: (1) Physician's, podiatrist's or dentist's orders; (2) Physician's, podiatrist's or dentist's notes; (3) Physician assistant's notes, if applicable; (4) Nurse's notes; (5) Medications; (6) temperature, pulse, and respiration; (7) Any special examination or report, including but not limited to, x-ray, laboratory, or pathology reports; (8) Signed informed consent form; (9) Evidence of advanced directives, if applicable; (10) Operative record; (11) Anesthesia record, if applicable; and (12) Consultation record, if applicable.</p> <p>(D) Discharge data: (1) Final diagnosis; (2) Procedures and surgeries performed; (3) Condition upon discharge; (4) Post-treatment care and instructions; and (5) Attending physician's, podiatrist's or dentist's signature.</p> <p>(E) Other information required by law.</p> <p>This Rule is not met as evidenced by: Based on medical record reviews, facility policy review, and staff interviews, the facility failed to ensure the medical records operative reports for 5 of 5 sampled patients included verification of the correct patient and procedure to be performed, and team members involved during this verification, and the abortion procedure to be conducted. These patients were Patients #1 though Patient #5. The facility performed a total of 2,930 procedures in the past 12 months.</p>	C 255		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 2314 AUBURN AVENUE CINCINNATI, OH 45219		
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C 255	<p>Continued From page 12</p> <p>Findings include:</p> <p>On 06/06/13, medical record reviews were conducted for Patients #1, #2, #3, #4, and #5. Patients #1-5 had abortions performed in the facility using either a dilation and curettage (D & C) or a dilation and evacuation (D & E) procedure.</p> <p>The dates of the abortions are as follows:</p> <p>Patient #1 had a D & C on 05/29/13. Patient #2 had a D & E on 04/26/13. Patient #3 had a D & C on 02/08/13. Patient #4 had a D & E on 02/05/13. Patient #5 had a D & C on 03/09/13 and was transported to the hospital via squad for bleeding during the procedure.</p> <p>An interview conducted with Staff B and Staff D on 06/06/13 at 4:30 PM verified the medical records for these patients did not have documentation of a time out verification of correct patient and procedure and staff members who participated during the procedure. Staff B stated this is done verbally, and agreed it would be a good idea to document this information.</p>	C 255		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 10/10/2013
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP			STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 Licensure Compliance Inspection Administrator: Carol Westfall, Executive Director County: Summit Number of ORs: 1 The following violations are issued as a result of the follow-up to the licensure compliance inspection completed on 10/10/13.	{C 000}			
{C 132}	O.A.C. 3701-83-09 (D) Infection Control Policies & Procedures The HCF shall establish and follow written infection control policies and procedures for the surveillance, control and prevention and reporting of communicable disease organisms by both the contact and airborne routes which shall be consistent with current infection control guidelines, issued by the United States centers for disease control. The policies and procedures shall address: (1) The utilization of protective clothing and equipment; (2) The storage, maintenance and distribution of sterile supplies and equipment; (3) The disposal of biological waste, including blood, body tissue, and fluid in accordance with Ohio law; (4) Standard precautions/body substance isolation or equivalent; and (5) Tuberculosis and other airborne diseases.	{C 132}			

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

TITLE



(X6) DATE

01/27/14

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/10/2013
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 132}	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: THIS IS A RECITE.</p> <p>Based on observations, staff interviews, and review of monitoring logs, the facility failed to follow their plan of correction for monthly monitoring of sterile processing of surgical instruments and the policy for dating sterilized instrument packs. This affected all patients in the facility. The facility provided services to 1,833 patients during the twelve month period of March 2012 through March 2013.</p> <p>Findings include:</p> <p>On 10/09/13, between 1:45 P.M. and 2:05 P.M., a tour was conducted with Staff E and Staff G in the operating room, sterilization processing room, and recovery room. Tour in the operating room revealed one of eight sterile surgical instrument packs lacked the staff's initials, the date of processing, and the contents of the pack, in accordance with facility policy. The remaining seven packs lacked identification of the package contents. This was verified with Staff E and Staff G on tour. Interview with Staff G at the time of the observation revealed the surgical instrument pack that had not been dated or labeled by staff was used to perform second trimester abortions on patients.</p> <p>A review of the Monthly Sterile Packaging Log used for checking dates on the sterile instrument packs revealed the logs did not have documentation of monitoring by staff for the month of September. This monitoring log was</p>	{C 132}		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 10/10/2013
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304			
(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 132}	Continued From page 2 implemented in June; however, the log lacked the day of the month and the year the staff member performed the monitoring. On 10/09/13 at 3:05 P.M., an interview was conducted with Staff A. Staff A verified the incomplete monitoring log and verified the facility policy for labeling and identifying sterilized instrument packs.	{C 132}			
C 133	O.A.C. 3701-83-09 (E) Equipment Maintenance The HCF shall maintain equipment in a safe manner and in accordance with the manufacturer's instructions. This Rule is not met as evidenced by: THIS IS A NEW VIOLATION Based on observations, staff interviews, and review of preventative maintenance logs, the facility failed to perform preventative maintenance on the facility's medical and surgical equipment. This could affect all patients in the facility. The facility provided services to 1,833 patients during the twelve month period of March 2012 through March 2013. Findings include: A tour was conducted in the operating room, sterilization processing room, and recovery room on 10/09/13 between 1:45 P.M. and 2:05 P.M. with Staff E and Staff G. During this tour, all medical and surgical equipment were observed with a preventative maintenance sticker stating	C 133			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/10/2013
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 133	Continued From page 3 maintenance was conducted in 04/13 and due in 09/13. This equipment included the anesthesia machine, suction machines (one oral and one used for abortions) weight scale, operating room lights, blood pressure cuffs, digital thermometer for taking patient temperature, both autoclaves, a table light, and a pulse oximetry machine. This was verified with both staff on tour. Staff E stated the preventative maintenance company failed to come in September 2013 when the maintenance was due on the machines, stating they would be here later this week. A review of the preventative maintenance manual revealed the last time preventative maintenance was conducted on this equipment was in April 2013.	C 133		
{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	{C 152}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 10/10/2013
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP			STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 152}	<p>Continued From page 4</p> <p>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;</p> <p>(5) Document and report the status of quality assessment and improvement program to the governing body every twelve months;</p> <p>(6) Document and review all unexpected complications and adverse events, whether serious injury or death, that arise during an operation or procedure; and</p> <p>(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.</p> <p>This Rule is not met as evidenced by: THIS IS A RECITE</p> <p>Based on a review of the facility's plan of correction, governing body minutes, medical record reviews, and staff interviews, the facility failed to ensure their quality assessment and performance improvement program (QAPI) was implemented in accordance with their plan of correction. The QAPI plan also failed to include monitoring and evaluation of all aspects of care including effectiveness, appropriateness, accessibility, continuity, efficiency, patient</p>	{C 152}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 10/10/2013
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP			STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 152}	<p>Continued From page 5</p> <p>outcome, and patient satisfaction, establishing expectations, developing plans, implementing procedures to assess and improve the quality of care and resolve identified problems, documenting and reporting the status of quality assessment and improvement program to the governing body every twelve months, and conducting a meeting chaired by the medical director of the facility or designee. The facility provided services to 1,833 patients during the twelve month period of March 2012 through March 2013.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 10/09/13, between 10:30 A.M. and 11:20 A.M., a review of the QAPI program and an interview with Staff A were conducted. Staff E was present during portions of this interview. Staff A provided documentation of an initial QAPI plan which was approved by the governing body during a meeting on 07/05/13. When questioned as to whether this plan had been implemented, Staff A stated the quality assurance plan has not been started due to one employee being on sick leave and an additional facility employee had to work in another facility. Staff A stated the first QA meeting will be conducted on 10/30/13. Staff A verified the initial QAPI plan identified only one area of focus per quarter and was not comprehensive to monitor and evaluate all aspects of patient care. 2. On 10/09/13, between 9:30 A.M. and 4:00 P.M., review of six of six medical records for Patients A1, B2, C3, D4, E5, and F6 revealed the facility did not follow its plan of correction to assure the accuracy of its medical records and to carry out a Quality Assurance Improvement Plan 	{C 152}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 10/10/2013
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304			
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{C 152}	<p>Continued From page 6</p> <p>(QAPI) for the medical records.</p> <p>*The medical record of Patient A1 had several forms that required a signature but were missing a date line and/or time of entry line. The pertinent forms were the Patient Notice of a 24 hour mandatory wait, the HIPAA form, the Notice of Patient Rights, and the Discharge Summary.</p> <p>*The medical record of Patient B2 revealed the Patient Rights form and the HIPPA forms lacked a date when the forms were signed by the patient. The statistical information form lacked the name of the patient and the date of completion.</p> <p>*The medical record of Patient C3 revealed a form titled AWMG Abortion Record signed by the physician in an inappropriate space. This form also lacked documentation regarding when the abortion was completed, and was silent to the patient's respiration rate.</p> <p>The medical record of this patient contained several misdated forms (forms titled To Our Valued Patients, Making Crucial Decisions, Mission Statement, and Sedation/Anesthesia instruction). The dates were crossed through and changed; however, lacked initials of the staff who changed the dates. An interview with Staff E, on 10/09/13 at 11:20 A.M., revealed the corrections were not completed per policy. Staff E stated the policy is for staff to draw a line through the date, put the correct date, and initial the correction.</p> <p>*The medical record of Patient D4 had an incorrectly dated Gross Exam Report. The date was the initial consult date (09/17/13) not the procedure date (09/20/13).</p> <p>*The medical record of Patient E5 had a</p>	{C 152}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 10/10/2013
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP			STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 152}	<p>Continued From page 7</p> <p>Recovery Room sheet that was misdated at the top and filled out incorrectly at the bottom. The Recovery Room sheet did not have a time the patient was discharged and left the facility.</p> <p>*The medical record of Patient F6 revealed the Patient Satisfaction Survey lacked a date of completion. The form titled AWMG Abortion Record lacked vital signs by the physician. The statistical information form lacked the name of the patient and the date of completion.</p> <p>All six medical record reviews revealed the records were missing date and time entries on the mandatory 24 hour wait form and on the discharge summary form for each of these patients.</p> <p>These aforementioned records were shared with Staff A on 10/09/13 between 10:47 A.M. and 11:20 A.M. Staff A verified the missing dates, times and misdated entries.</p> <p>During this same interview, Staff E stated a quality assurance review is conducted by the registered nurse on each patient's medical record. Review of six medical records revealed a Quality Assurance (QA) checklist completed by the registered (RN). The employee stated if problems are identified with the medical record, this employee places a post-it note on the outside of the chart as a reminder to obtain the information in order ensure the medical record is complete. Staff E stated the audit forms are then completed. Observation of these audit forms on 10/09/13 revealed these forms did not reflect any areas of concern or actions taken when problems with the medical record were identified. None of these QA checklists reflected the aforementioned discrepancies were found in the charts. Staff E</p>	{C 152}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 10/10/2013
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP			STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 152}	Continued From page 8 and Staff A verified these medical records reviews were not currently a part of the QAPI plan, and verified there are currently no methods in place to identify patterns and trends of issues in the medical records.	{C 152}			

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/01/2014
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	Initial Comments Licensure Compliance Inspection Complaint Inspection Complaint Number OH00075259 Administrator: Judy Nolan County: Franklin Number of OR's: 3 There were no violations issued related to the Complaint Inspection of Complaint Number OH00075259 completed on 7/01/14. The following violations are issued as a result of the Licensure Compliance Inspection completed on 7/01/14.	C 000		
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 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.	C 119		

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TITLE



(X6) DATE

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/01/2014
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 119	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on personnel file review, staff interview, and review of applicable job descriptions, the facility failed to ensure staff certifications and/or competency trainings were maintained. This occurred with two personnel files reviewed out of six (Staff A and Staff D). The total annual procedures were 2,145.</p> <p>Findings include:</p> <p>Review of the personnel file for Staff D included job descriptions for an ultrasound tech and a lab assistant who performs venipuncture blood draws. During an interview on 07/01/14 at 1:43 PM Staff B verbalized that Staff D lacks certification for phlebotomy and/or an ultrasound technician. Staff B reports the facility provides their own training for venipuncture blood draws and ultrasound procedures. The facility training requirements include 54 physician observed ultrasounds and 35 blood draws in order for the competency to be met. The personnel file for Staff D did not contain documentation of any certifications and/or competencies for the professional skills being performed. These findings were confirmed with Staff A and Staff B on 07/01/14 at 2:21 PM.</p> <p>Review of the personnel file for Staff A included a job description for an ultrasound tech. Interview with Staff A on 07/01/14 at 2:56 PM confirmed his/her personnel file did not contain documentation of any certifications and/or competencies for the professional skills being performed. Staff A stated he/she was hired 35</p>	C 119		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/01/2014
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 119	Continued From page 2 years ago and was trained by the manufacturer of the ultrasound machine.	C 119		
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 observation and staff interview, the facility failed to mark the path of exit egress in the recovery room. This has the potential to affect all patients serviced by the facility. The facility performed 2,145 procedures in 2013. Findings include: Tour of the facility was conducted on 7/01/14 at 10:00 AM. The recovery room is equipped with two doorways. Neither of the doorways has an exit sign above them to alert the occupants of the path of egress should an emergency evacuation situation occur. Staff E reported at 10:15 AM that a staff member is always in the recovery room if a patient is in there but confirmed the exit path is not marked above the doorways.	C 140		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0600AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/16/2014
NAME OF PROVIDER OR SUPPLIER WOMEN'S MED CENTER OF DAYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 E. STROOP ROAD DAYTON, OH 45429		
(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	<p>Initial Comments</p> <p>Complaint Inspection</p> <p>Complaint Number OH00077275</p> <p>Administrator: Martin Haskell, MD</p> <p>County: Montgomery</p> <p>Two Procedure Rooms</p> <p>Women's Med Center Dayton is in compliance with the rules for Ambulatory Surgical Facilities, at Ohio Administrative Code 3701-83, in regard to allegations pertaining to the complaint inspection OH00077275 completed on 12/16/14.</p> <p>Women's Med Center Dayton remains out of compliance regarding the OAC requirements for transfer agreement. Variance request pending.</p>	C 000		

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/11/2014
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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	<p>Initial Comments</p> <p>Licensure Compliance Inspection and Complaint Inspection</p> <p>Complaint Number OH00076205</p> <p>Administrator: Chrissie France, Executive Director</p> <p>County: Cuyahoga</p> <p>Number of ORs: 4</p> <p>A licensure compliance inspection and an investigation of complaint number OH00076205 was completed on 09/11/14. Preterm was found in compliance with the rules for Ambulatory Surgery Facilities at ASF - O.A.C. 3701-83 at the time of the Licensure Compliance Inspection and complaint investigation completed on 09/11/14.</p>	C 000		

Ohio Department of Health
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TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/13/2014
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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	<p>Initial Comments</p> <p>Licensure Compliance Inspection</p> <p>Administrator: Kathy Crawford, RN, Chief Operating Officer</p> <p>County: Franklin</p> <p>Number of ORs: Two</p> <p>The following violation is issued as a result of the licensure compliance inspection completed on 03/13/14.</p> <p>An entrance conference was conducted with Staff A (regional clinical director) at approximately 10:00am on 03/13/14.</p> <p>An exit conference was completed with Staff A (regional clinical director) and Staff B (chief operation officer) at approximately 5:15pm on 03/13/14.</p> <p>Census: 1,115 procedures within the past 12 months</p>	C 000		
C 146	<p>O.A.C. 3701-83-11 (D) Medical Records Confidentiality</p> <p>The HCF shall maintain an adequate medical record keeping system and take appropriate measures to protect medical records against theft, loss, destruction, and unauthorized use. The HCF shall have policies and procedures to ensure the confidentiality of patient medical records.</p> <p>This Rule is not met as evidenced by:</p>	C 146		

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/13/2014
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 146	<p>Continued From page 1</p> <p>Based on observation and staff interview, the facility failed to ensure the medical records were protected from fire and water damage in the event of a fire. The facility has treated 1,115 patients in the last 12 months.</p> <p>Findings include:</p> <p>During tour on 03/13/14 at 11:00 AM, the medical records area was observed to contain a mobile shelving unit with paper medical records. The shelves contained the patient medical records for the last six to twelve months. The shelving unit was open with no covering. The shelving unit was on a track system that the individual shelf units could be moved left or right with the turn of a crank. When in the most closed position, there was a gap of approximately three to four inches between the shelves as the medical records extended beyond the edges of the shelves. The room was observed to not have sprinklers.</p> <p>On 03/13/14 at 4:15 PM, Staff A stated that in the event of a fire the medical records shelving would not protect the paper medical records from fire or water damage. Staff A also stated that the medical records were only on paper and there were no back up copies or computerized copies of these medical records.</p>	C 146		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/14/2014
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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	<p>Initial Comments</p> <p>Substantial Allegation Survey</p> <p>Substantial Allegation OH00073256</p> <p>Administrator: Lindsay Marrone</p> <p>County: Summit</p> <p>Number of operating rooms: None at this time</p> <p>Based on the complaint investigation completed on 01/14/14, Northeast Ohio Women's Center was not operating as an unlicensed ambulatory surgical facility in regard to allegations contained in complaint number OH00073256.</p>	C 000		

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Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGION		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Initial Comments</p> <p>Complaint Inspection</p> <p>Complaint Number OH00073559</p> <p>Administrator: Kelli Halter, VP, Patient Services</p> <p>County: Hamilton</p> <p>Number of ORs: 3</p> <p>Planned Parenthood Southwest Ohio Region is in compliance with the rules for Ambulatory Surgical Facility at O.A.C. 3701-83 at the time of the complaint inspection completed on 02/12/14.</p>	C 000		

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Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 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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Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIONAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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 234	<p>Continued From page 1</p> <p>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.</p> <p>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.</p> <p>This finding was confirmed with Staff A on 06/26/14 at 4:40PM.</p>	C 234		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/03/2014
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 Initial Licensure Compliance Inspection Administrator: Lindsay Marrone County: Summit Number of ORs: 1 The following violations are issued as a result of the initial licensure compliance inspection completed on 02/03/13.	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 assessment and performance improvement program on an annual basis; and (3) The development and maintenance of a disaster preparedness plan. This Rule is not met as evidenced by: Based on review of governing body minutes and	C 104		

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(X6) DATE

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/03/2014
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 104	Continued From page 1 staff interview, the governing body lacked a plan to evaluate the facility's quality assessment and improvement program (QAPI) on an annual basis. This could potentially affect all patients in the facility. Findings include: On 02/03/14, a review of the governing body minutes revealed there was no discussion or plan to review the facility's QAPI program annually. This was verified with Staff B at 2:15 PM on 02/03/14.	C 104		
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 personal file review, policy review, and staff interview the facility failed to provide orientation to staff (5 of 5 nursing staff). This has the potential to affect the safety of all patients	C 123		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/03/2014
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 123	Continued From page 2 who receive surgical procedures from the facility. Findings include: Review of Staff B, C, D, E, and F's personal files completed on 02/03/14 revealed orientation was not completed. Interview with Staff A completed on 02/03/14 at 9:00 AM revealed that none of the staff have been officially hired due not wanting them to quit their other positions. "The staff have already had some training like their Advance Cardiac Life Support, but not all of it." Staff A also stated that fire drills have not been completed with staff at this time but can if it needs to be done. Review of the New Employee Information document completed on 02/03/14 revealed upon hire staff will be scheduled for a new employee orientation meeting. During the meeting the staff will receive important information about the company's policies and procedures.	C 123		
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. This Rule is not met as evidenced by: Based on review of policy and procedures and	C 151		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/03/2014
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 151	Continued From page 3 staff interview, the facility lacked a written plan for a quality assessment and improvement program (QAPI). This could potentially affect all patients in the facility. Findings include: On 02/03/14, a review of facility policies and procedures revealed there was no written QAPI plan for monitoring and evaluating all aspects of care. This was verified with Staff B at 2:10 PM on 02/03/14.	C 151		
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 interview and review of the organizational flow chart no Director of Nursing was noted. This could potentially affect all patients receiving surgical procedures from this facility. Findings include: Review of the Organizational Flow Chart completed on 02/03/14 revealed no Director of Nursing was listed. Interview with Staff B completed on 02/03/14 at 10:52 AM revealed the facility did not really have a Director of Nursing at this time. But if they did it	C 222		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/03/2014
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 222	Continued From page 4 would be Staff C but he/she does not know yet.	C 222		
C 231	O.A.C. 3701-83-19 (B) Drug Control & Accountability The ASF shall: (1) Provide adequate space, equipment, and staff for storage and the administration of drugs in compliance with state and federal laws and regulations. (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. This Rule is not met as evidenced by: Based on observations, staff interview, and policy review, the facility failed to ensure there were no expired drugs and biologicals in the facility. This has the potential to affect all patients in the facility. Findings include: A tour was conducted in the facility with Staff B between 9:50 AM and 10:30 PM. The following medications were observed expired: 1. The hallway medication cabinet, located by the eye wash station, was observed with one 50 milliliter (ml) vial of Lidocaine HCL, which contained a handwritten date of 01/18/13 and initial of a staff member from the previous employer. Staff B stated this vial was left over from the previous owner.	C 231		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/03/2014
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 231	Continued From page 5 This cabinet also contained 4 unopened 50 ml vials of the same medication. The expiration dates on these vials were 02/01/14. The cabinet also contained three 20 ml vials and one 10 ml vial each of sodium chloride solution which contained expiration dates of 10/13. 2. The supply room was observed with an outdated box of one-Step urine Hcg pregnancy test strips. The box was observed full of test strips. The expiration date on the container was 04/13. 3. The operating room was observed with a container of lubricant which had expired prior to this date of 02/03/14. These expired medications and supplies were verified with Staff B during tour.	C 231		
C 244	O.A.C. 3701-83-20 (E) Emergency Power Each ASF shall have emergency power available in operative, procedure, and recovery areas. This Rule is not met as evidenced by: Based on tour and staff verification the facility failed to have emergency power available in operating room. This could potentially affect all patients in the facility. Findings include: Tour of the facility completed on 02/03/14 at 10:30 AM revealed no emergency battery backup lighting in the operating room and the recovery	C 244		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/03/2014
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 244	Continued From page 6 room. Interview with Staff B completed on 02/03/14 at 10:40 AM revealed they do have flash lights available in all rooms for staff during an emergency.	C 244		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/03/2014
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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	<p>Initial Comments</p> <p>Complaint Inspection</p> <p>Complaint Numbers OH00074225, OH00074228, OH74193, OH00074159, OH00074154, OH00074144, OH00074148, and OH00074116</p> <p>Administrator: Chrissie France, Executive Director</p> <p>County: Cuyahoga</p> <p>Number of ORs: 5</p> <p>Preterm is in compliance with the rules for Ambulatory Surgical Facility at O.A.C. 3701-83 at the time of the complaint inspection completed on 04/03/14.</p>	C 000		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 Licensure Compliance Inspection Administrator: Sue Hirt County: Cuyahoga Number of ORs: 6 The following violations are issued as a result of the licensure compliance inspection completed on 03/11/14.	C 000		
C 109	O.A.C. 3701-83-03 (K) Contracted Services An HCF may arrange for services to be provided through a contract with an outside resource. The HCF shall retain professional management responsibility for contracted services and shall ensure that those services are furnished in a safe and effective manner. This Rule is not met as evidenced by: Based on review of facility documentation and staff interview the facility failed to provide current contracts for services. This deficient practice had the potential to negatively effect all patients that received surgical services at the facility. The facility performed 2,987 surgical procedures in the last 12 months. Findings included:	C 109		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 109	Continued From page 1 1) Review of the facility's contracts for the provision of hazardous biomedical waste removal revealed the facility had entered into a contract with the Stericycle-Sterisafe company on 09/26/11. The facility was unable to produce a more current contract than the 09/26/11 document. 2) Review of the facility's contract with Kleanland L.L.C. for the provision of general cleaning needs of the facility revealed the facility had entered into a contract with the cleaning company on 02/28/12. The contract verbiage documented the terms and conditions and remain the same except for the monthly charge and the duration of the contract. The contract was extended until March 1, 2013. The facility was unable to produce the contract that had been renewed after the expiration date of 03/01/13. These findings were verified during an interview with Staff I on 03/11/14 at 5:26 PM.	C 109		
C 120	O.A.C. 3701-83-08 (B) T B Control Plan The 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.	C 120		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 120	<p>Continued From page 2</p> <p>This Rule is not met as evidenced by: Based on review of personnel record, review of facility policies, and staff interview, the facility failed to have documented evidence a tuberculin skin test (TB) was conducted on three of three newly hired employees (Staff U, V, and W). The facility performed a total of 2987 procedures in the last 12 months.</p> <p>Findings include:</p> <p>On 03/11/14 personnel files were reviewed for Staff U, V, and W. All three employees were hired as health care assistants on the following dates:</p> <p>Staff U was hired on 02/03/14, Staff V was hired on 02/18/14, and Staff W was hired on 03/04/14.</p> <p>Review of the personnel files for these employees did not contain documentation a TB skin test had been performed. A review of the facility policy titled "Respiratory Protection Policy" stated all new hires who will work in contact with facility patients are required to provide documentation (within the past 12 months) showing their current TB status or the facility will perform a one-step TB test. The policy also stated that employment may begin after documentation has been received.</p> <p>Interview with Staff I at 5:20 PM verified the lack of documented TB skin testing for Staff U, V and W.</p>	C 120		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
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C 125	Continued From page 3	C 125		
C 125	<p>O.A.C. 3701-83-08 (G) Staff Performance Evaluation</p> <p>Each HCF shall evaluate the performance of each staff member at least every twelve months.</p> <p>This Rule is not met as evidenced by: Based on review of personnel files and staff interview, the facility failed to perform an evaluation on 1 of 4 staff at least every twelve months. This involved Staff L, Health Care Assistant. The facility performed a total of 2987 procedures in the last 12 months.</p> <p>Findings include:</p> <p>On 03/11/14, four personnel files were reviewed for staff who had been employed with the facility longer than twelve months. Staff L was hired as a Health Care Assistant on 01/11/11. There was no documented evidence an annual performance evaluation had been completed for this employee in the last twelve months.</p> <p>This finding was verified with Staff A during an interview at 4:40 PM. Staff A stated the facility policy requires an annual evaluations to be conducted on each employee.</p>	C 125		
C 139	<p>O.A.C. 3701-83-10 (B) Safety & Sanitation</p> <p>The HCF shall be maintained in a safe and sanitary manner.</p>	C 139		

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C 139	<p>Continued From page 4</p> <p>This Rule is not met as evidenced by: Based on observation, review of facility policies and procedures and staff interview the facility failed to adhere to facility policies and procedures for cleaning and disinfecting surgical equipment, disposal of urine samples and single use patient medical items. This deficient practice had the potential to negatively impact all patients who underwent surgical services at the facility. The facility performed 2,987 surgical procedures in the last 12 months.</p> <p>Findings included:</p> <p>An environmental tour of the facility was conducted on 03/11/14 from 1:10 PM until 3:34 PM. The environmental tour revealed the following findings:</p> <p>1) An tour of patient examination room #3 on 03/11/14 at 1:25 PM revealed a cupboard with six blood collection tubes which bore the expiration date of 02/2014. Also observed in the cupboard was Hemocu AB Hb 201 (used for the determination a patient's hemoglobin or as indicator of anemia prior to surgery). The manufacturer's label indicated the product was good for three months after opening; however, the product did not contain the date the product was opened.</p> <p>The drawer in examination room #3 contained a vaginal microbiological swab which was labeled with the expiration date of 11/30/13.</p> <p>2) A tour of examination room #2 on 03/11/14 at 1:36 PM revealed two vials of Hemocu AB Hb 201. The product did not contain the date the product was opened.</p>	C 139		

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C 139	<p>Continued From page 5</p> <p>3) A tour of examination room #1 on 03/11/14 at 1:45 PM revealed the room's cupboard contained a plastic specimen container with approximately 40 milliliters of an unidentified pale yellow liquid. Interview with Staff I at the time of discovery revealed these types of containers are used by the facility for urine and other specimen collections.</p> <p>The cupboard was observed to contain a brown glass vial with rubber dropper which was labeled as saline and a preparation date of 08/30/12. Interview with Staff I verified the saline was only good for 60 days after opening.</p> <p>The cupboard also contained a plastic basket of Band-Aids which had been removed from the manufacturer's protective packaging. Interview with Staff I stated staff pre-open the Band-Aids as a time saving effort.</p> <p>Inspection of the examination table's side drawers revealed the top side drawer was observed to contain a brown vial with rubber dropper which the label indicated was normal saline used for the preparation of wet mount slides (used to detect vaginal bacteria and fungus) with a date of 11/10/12. Staff I stated during interview the saline is good up to 60 days for use per facility policy.</p> <p>Observation of the second drawer of the examination table revealed clean rolls of paper that were used to cover the examination table for patient use and also observed was an unwrapped and extended condom. Staff I stated the facility used condoms for ultrasound probe covers used during vaginal ultrasounds.</p> <p>The drawer located at the foot end of the patient</p>	C 139		

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C 139	<p>Continued From page 6</p> <p>examination table was observed to have a 250 milliliter bottle of opened normal saline used for the preparation of wet mount microbiological slides. This end drawer was also observed to contain a plastic bottle with a dropper top and which contained a liquid solution the label identified as Potassium Hydroxide and an expiration date of 2/2014. Interview with Staff I at the time of finding revealed the facility performs approximately 10 wet mount slides per month. Additionally, the end drawer contained a plastic canister of Nitrazine Test strip paper used for gynecological examinations which bore the expiration date of 06/2013.</p> <p>4) Inspection of the patient use bathroom on 03/11/14 at 1:52 PM revealed the two-way door system used for the placement and retrieval of urine samples was found to have a plastic specimen container approximately one third full of unidentified yellow liquid. This bathroom was located adjacent to the facility's laboratory testing area. The outside label contained the first name of a female patient. Interview with Staff I at the time of discovery revealed the last day patients were seen by the facility was the previous Friday (03/07/14). Staff I stated the container was a urine specimen collected for analytical tests which failed to have analytical testing performed nor was the specimen properly disposed of.</p> <p>5) Inspection of the laboratory area of the facility on 03/11/14 at 1:54 PM revealed the presence of an opened and half-full 16 ounce bottle of 70% isopropyl alcohol which contained the manufacturer's expiration date of 09/2013. Additionally the laboratory area contained a chemical reagent vial of HCG (human chorionic gonadotrophin) control serum used to perform pregnancy tests. The manufacturer's printed</p>	C 139		

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C 139	<p>Continued From page 7</p> <p>material indicated once open this control reagent was only good for 90 days. The vial failed to contain the date the reagent was opened. These findings were verified at time of discovery with Staff I.</p> <p>6) Inspection of the soiled utility room and the chemical sanitation equipment on 03/11/14 at 3:34 PM revealed the presence of a chemical disinfectant used for the disinfection and reprocessing of surgical suction hoses and any medical equipment or instruments which could not tolerate exposure to high heat sterilization. Inspection of the Revital Resert XL HL gallon contained the manufacture's printed instructions which directed the product delivered a hydrogen peroxide level of 1.5% for high level medical disinfection up to 21 days after opening. The gallon jug failed to indicate the opening date or other labeling which would indicate the 21 day expiration date.</p> <p>Inspection of the test strips used to test the for the minimum recommended concentration of the Resert product for high level disinfection were observed expired as follows:</p> <p>a) one opened vial of test strip verified by Staff J as currently in use had a manufacturer's expiration date of 11/22/13. The manufacturer's label indicated the test strips were valid 90 days after opening; however, the date the vial was opened was not on the vial</p> <p>b) two full unopened boxes of vials which contained the manufacturer's expiration date of 3/9/14</p> <p>c) one full unopened box of two vials with an expiration date of 11/22/13, and</p> <p>d) one full unopened box of two vials with an expiration date of 02/02/14.</p> <p>These findings were verified at the time of</p>	C 139		

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C 139	<p>Continued From page 8</p> <p>discovery with Staff I.</p> <p>Interview with Staff P on 03/11/14 at 4:05 PM revealed he/she and another staff member were trained internally by the facility staff to reprocess reusable surgical equipment using the product Revital Resert XL HL (a hydrogen peroxide based disinfectant for high level disinfection). Staff P verbalized the process he/she followed to perform this task which included physically washing equipment, rinsing and placing reusable equipment to soak in a solution of Resert. Staff P verbalized he/she always used the test strip from the company to test the effectiveness of the Resert solution. Staff P stated after the instruments or equipment had been immersed in the solution for the directed minimum time of eight minutes the equipment was removed, dried as best as possible and the surgical suction hoses were hung in the clean utility to drip and air dry. Staff P stated surgical procedures are usually performed two days per week. Staff P was unaware of the specified expiration date of the Resert and test strips.</p> <p>Review of the Resert XL HL manufacturer's instructions directed the product must be verified by use of the Verify Chemical Monitoring Strips for Resert Solutions prior to each use. The printed instructions further directed the Resert XL HL solution was suitable for the high level disinfectant when used for a maximum of 21 days. These instructions directed the product must be discarded after 21 days even if the Verify test strip indicated a concentration above the minimum recommended concentration.</p> <p>7) Inspection of the dirty utility room on 03/11/14 at 3:34 PM revealed the presence of a refrigerator marked with a biohazard label. Staff I</p>	C 139		

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C 139	Continued From page 9 stated the freezer portion of the refrigerator was used for storage of human tissue removed during surgical procedures. The freezer compartment was observed to contain eight plastic specimen containers which contained frozen tissue. Neither the refrigerator or freezer was equipped with a thermometer. Additionally, the facility was unable to provide any documentation this unit was monitored by the facility for approved temperature ranges, malfunction or was tested as part of the biomedical preventative maintenance checks. Interview with Staff I verified this finding at the time of discovery.	C 139		
C 158	O.A.C. 3701-83-13 (B) Complaints Hot Line The HCF shall post the toll free complaint hotline of the department's complaint unit in a conspicuous place in the HCF. This Rule is not met as evidenced by: Based on observations and staff interview the facility failed to post the State of Ohio's toll free complaint hotline telephone number. This deficient practice had the potential to negatively effect all patients who received services at the facility and wanted to report to a complaint via the confidential hotline number. The facility performed 2,987 surgical procedures in the last 12 months. Findings included: The environmental tour was conducted on 03/11/14 from 1:10 PM until 3:34 PM with Staff I.	C 158		

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C 158	Continued From page 10 All of the patient care areas of the building were toured and observed for the required postings. At no time during the environmental tour was the State of Ohio's complaint hot line telephone number observed posted. Interview with Staff I on 03/11/14 at 4:55 PM stated he/she was unaware of this requirement and further queried the surveyors as to where this poster and or number could be obtained from.	C 158		
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	C 201		

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C 201	<p>Continued From page 11</p> <p>reasonable indicators of current competency.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on review of governing body minutes, personnel files, credentialing documentation, and staff interview, the governing body failed to grant privileges in writing to one of one staff who serves as a Physician and Medical Director (Staff Q), two physicians currently working an as needed basis in the facility (Staff R and S), and for a physician (Staff T) who performed abortions in the facility in 2013 but was no longer working at this facility. This could affect all patients receiving surgical services in the facility. The facility performed a total of 2987 procedures in the last 12 months.</p> <p>Findings include:</p> <p>During this visit on 03/11/14, a review was conducted of the personnel files of physicians. Also reviewed was documentation for credentialing of professional medical staff, and governing body minutes. An interview with Staff I at 5:30 PM revealed that Staff Q was hired as the physician for performing surgical abortions on 10/07/13. According to Staff I, this employee</p>	C 201		

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C 201	Continued From page 12 (Staff Q) became the Medical Director of the facility. A review of the credentialing records for Staff Q, and for 2 of 3 other physicians (Staff R and S) who performed abortions in the facility during 2013, revealed no documentation related to competence in the performance of the procedures for which the physicians provided (surgical abortions). A review of the governing body meeting minutes dated 02/17/14 revealed a discussion was held for the review of providers and of provider privileges: a) Surgical privileging every 24 months. Most MDs due 2015. b) Plan to renew privileges for current physicians c) Plan for privileging new physicians. At 5:30 PM on 03/11/14, Staff I verified the facility did not use peer review of medical records, references, or data base query to determine physician competency prior to granting privileges to Staff R and S who performed abortions in the facility in 2013, or for Staff Q who was currently performing the surgical abortions on patients. Staff A stated an additional physician (Staff T) performed abortions in 2013 but was no longer an employee of this facility. Staff I verified the governing body minutes for February 2014 lacked the names of physicians who were granted privileges to perform abortion procedures in the facility.	C 201		
C 211	O.A.C. 3701-83-17 (F) MR With Patient Transport Patients transported to a hospital shall be accompanied by their medical records that are of	C 211		

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C 211	Continued From page 13 sufficient content to ensure continuity of care . This Rule is not met as evidenced by: Based on review of the medical records, review of facility policy, and staff interview, the facility did not have documentation one patient's medical record accompanied the patient to the hospital at the time of transfer by ambulance. This affected 1 of 2 patients (Patient #2) who were transferred to the hospital since August 2013. The facility performed a total of 2987 procedures in the last 12 months. Findings include: During this visit, medical record of Patient #2 was reviewed. According to this record, the patient received a surgical abortion conducted by Staff T on 10/03/13 for uterine size fetal age of 13 weeks. According to the medical record, the patient began bleeding during the abortion and was taken to the hospital per squad on that same date at 2:55 PM. The medical record did not have documentation the medical record accompanied the patient to the hospital nor documentation the facility notified the hospital's emergency department of Patient #2's transfer. This finding was verified with Staff I at 5:30 PM. A review of the facility's policy with Staff I revealed the policy was not followed.	C 211		
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	C 222		

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C 222	<p>Continued From page 14</p> <p>be responsible for the management of nursing services.</p> <p>This Rule is not met as evidenced by: Based on facility documentation and staff interview the facility failed to employ an experienced director of nursing (DON) with operating room experience. This deficient practice had the potential to negatively effect all patients who received surgical services at the facility from September 2013 until the current date (03/11/14). The facility performed 2,987 surgical procedures in the last 12 months.</p> <p>Findings included:</p> <p>Review of the facility's nursing staff roster revealed the facility currently employed nine nurses. Interview with Staff I on 03/11/14 at 4:55 PM revealed the facility did not have a director of nursing (DON). Two of the nine nurses (Staff E and I) were advanced practice nurses and were hired as administrative nurses. Staff E was employed as Regional Director of Clinical Services and Staff I was employed as Regional Director of Quality Assurance.</p> <p>Staff E's administrative employment date was documented as November, 2012 and Staff I's administrative employment date was documented as April 2012. Staff I further verbalized that as advanced practice nurses and administrative staff neither Staff E nor I worked in the operating rooms (OR). Staff E further offered that Staff E's job duties included the reading of inconclusive and difficult ultrasounds. Staff I stated that his/her job duties encompassed quality assurance duties. Staff I verbalized that neither</p>	C 222		

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C 222	Continued From page 15 he/she nor Staff E were designated as DONs, and that neither Staff E or I possessed any prior surgical operating room experience. Staff I verbalized that the previous nurse who over saw the operating room had left the facility's employment in September of 2013 and that the facility had recently hired an experienced operating room nurse whose employment had not yet started as of the date of survey (03/11/14).	C 222		
C 255	O.A.C. 3701-83-21 (A) - (E) Medical Records Each ASF medical record shall contain at least the following information as applicable for the surgery to be performed: (A) Admission data: (1) Name, address, date of birth, gender, and race or ethnicity; (2) Date and time of admission; and (3) Pre-operative diagnosis, which shall be recorded prior to or at the time of admission. (B) History and physical examination data: (1) Personal medical history, including but not limited to allergies, current medications and past adverse drug reactions; (2) Family medical history; and (3) Physical examination. (C) Treatment data: (1) Physician's, podiatrist's or dentist's orders; (2) Physician's, podiatrist's or dentist's notes; (3) Physician assistant's notes, if applicable; (4) Nurse's notes; (5) Medications; (6) temperature, pulse, and respiration; (7) Any special examination or report, including but not limited to, x-ray, laboratory, or pathology reports; (8) Signed informed consent form; (9) Evidence of advanced directives, if applicable; (10) Operative record; (11) Anesthesia record, if applicable; and (12) Consultation record, if	C 255		

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
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C 255	<p>Continued From page 16</p> <p>applicable.</p> <p>(D) Discharge data: (1) Final diagnosis; (2) Procedures and surgeries performed; (3) Condition upon discharge; (4) Post-treatment care and instructions; and (5) Attending physician's, podiatrist's or dentist's signature.</p> <p>(E) Other information required by law.</p> <p>This Rule is not met as evidenced by: Based on medical record review, review of facility policies, and staff interview, the facility did not have legible and complete documentation in the medical records of 2 of 2 patients who were transferred to the hospital by ambulance since August 2013 to current date. This affected 2 of 2 patients (Patients #2 and #1). The facility performed a total of 2987 procedures in the last 12 months.</p> <p>Findings include:</p> <p>During this visit, a medical record review was conducted of Patient #2. According to this record, the patient received a surgical abortion conducted by Staff T on 10/03/14 for uterine size fetal age of 13 weeks. According to the medical record, the patient began bleeding during the abortion and was taken to the hospital per squad on that same date at 2:55 PM.</p> <p>The medical record was illegible and could not be deciphered by Staff I. The medical record was incomplete as follows: a) The medical record did not have documentation of which squad took the patient to the hospital</p>	C 255		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 255	<p>Continued From page 17</p> <p>b) The moderate sedation record did not have a complete date as the year was missing. A write-over was noted on the time the sedation medication was given between 1:52 PM and 2:00 PM.</p> <p>c) A progress note by a health care assistant was dated 10/24/13 for a 10/03/13 entry regarding the patient's bleeding post surgical abortion. The documentation revealed a "cath" was inserted; however, did not specify what type of catheter or where the catheter was inserted. This progress note was authored 21 days after the patient was transferred to the hospital.</p> <p>d) The medical record did not have documentation of the patient's post transfer status, in accordance with facility policy titled "First Response and Hospital Transfer". The policy stated call the client within 72 hours and obtain information about the hospitalization and its outcome. Document information on the client's medical record. This lack of documentation and failure to follow the First Response and Hospital Transfer policy was verified with Staff I at 5:30 PM.</p> <p>A review of Patient #1's medical record revealed the patient received a surgical abortion on 08/28/14 by Staff T for gestational age fetus of 14 weeks according to uterus size at 2:25 PM.</p> <p>The medical record was illegible as follows:</p> <p>a) The physician's note on the in-clinic abortion report regarding the patient's transfer to the hospital could not be interpreted by Staff I.</p> <p>b) The medical record lacked a legible name of the physician performing the abortion.</p> <p>The facility policy for transfers to the hospital stated call the patient within 72 hours and obtain information about the hospitalization and its</p>	C 255		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 255	Continued From page 18 outcome. The patient's medical record lacked this documentation within 72 hours. A progress note dated 12/03/13 (over 3 months later) stated the patient underwent laparoscopic surgical repair of confirmed uterine perforation and surgery and recovery at hospital was uncomplicated. This finding was verified with Staff I at 3:50 PM.	C 255		
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, 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 observation, review of facility policies and procedures and staff interview the facility failed to adhere to infection control policies and procedures for cleaning and disinfecting surgical equipment, the disposal of urine samples and single use patient medical items. This deficient practice had the potential to negatively affect all patients who underwent surgical services at the facility. The facility performed 2,987 surgical procedures in the last 12 months. Findings included: Environmental tour of the facility on 03/11/14 from	C 266		

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
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C 266	<p>Continued From page 19</p> <p>1:10 PM until 3:34 PM revealed the following findings:</p> <p>1) A tour of examination room #1 on 03/11/14 at 1:45 PM revealed the room's cupboard contained a plastic specimen container with approximately 40 milliliters of an unidentified pale yellow liquid. Interview with Staff I at the time of discovery revealed these types of containers are used by the facility for urine and other specimen collections.</p> <p>The cupboard also contained a plastic basket of Band-Aids which had been removed from the manufacturer's protective packaging. Interview with Staff I stated staff pre-open the Band-Aids as a time saving effort.</p> <p>Observation of the second drawer of the examination table where clean rolls of paper used to cover the examination table for patients was observed to contain an unwrapped and extended condom. Staff I stated the facility used condoms for ultrasound probe covers used during vaginal ultrasounds.</p> <p>2) Inspection of the patient use bathroom on 03/11/14 at 1:52 PM revealed the two-way door system used for the placement and retrieval of urine samples was found to have a plastic specimen container approximately one third full of unidentified yellow liquid. This bathroom was located adjacent to the facility's laboratory testing area. The outside label contained the first name of a female patient. Interview with Staff I at the time of discovery revealed the last day patients were seen by the facility was the previous Friday (03/07/14). Staff I stated the container was a urine specimen collected for analytical tests which failed to have analytical testing performed</p>	C 266		

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 266	<p>Continued From page 20</p> <p>nor was the specimen properly disposed of.</p> <p>3) Inspection of the soiled utility room and the chemical sanitation equipment on 03/11/14 at 3:34 PM revealed the presence of a chemical disinfectant used for the disinfection and reprocessing of surgical suction hoses and any medical equipment or instruments which could not tolerate exposure to high heat trivialization. Inspection of the Revital Resert XL HL gallon contained the manufacture's printed instructions which directed the product delivered a hydrogen peroxide level of 1.5% for high level medical disinfection up to 21 days after opening. The gallon jug failed to indicate the opening date or other labeling which would indicate the 21 day expiration date.</p> <p>Inspection of the test strips used to test the for the minimum recommended concentration of the Resert product for high level disinfection were observed expired as follows:</p> <p>a) one opened vial of test strip verified by Staff J as currently in use had a manufacturer's expiration date of 11/22/13. The manufacturer's label indicated the test strips were valid 90 days after opening; however, the date the vial was opened was not on the vial</p> <p>b) two full unopened boxes of vials which contained the manufacturer's expiration date of 3/9/14</p> <p>c) one full unopened box of two vials with an expiration date of 11/22/13, and</p> <p>d) one full unopened box of two vials with an expiration date of 02/02/14.</p> <p>These findings were verified at the time of discovery with Staff I.</p> <p>Interview with Staff P on 03/11/14 at 4:05 PM revealed he/she and another staff member were</p>	C 266		

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
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C 266	<p>Continued From page 21</p> <p>trained internally by the facility staff to reprocess reusable surgical equipment using the product Revital Resert XL HL (a hydrogen peroxide based disinfectant for high level disinfection. Staff P verbalized the process he/she followed to perform this task which included physically washing equipment, rinsing and placing reusable equipment to soak in a solution of Resert. Staff P verbalized he/she always used the test strip from the company to test the effectiveness of the Resert solution. Staff P stated after the instruments or equipment had been immersed in the solution for the directed minimum time of eight minutes the equipment was removed, dried as best as possible and the surgical suction hoses were hung in the clean utility to drip and air dry. Staff P stated surgical procedures are usually performed two days per week. Staff P was unaware of the specified expiration date of the Resert and test strips.</p> <p>Review of the Resert XL HL manufacturer's instructions directed the product must be verified by use of the Verify Chemical Monitoring Strips for Resert Solutions prior to each use. The printed instructions further directed the Resert XL HL solution was suitable for the high level disinfectant when used for a maximum of 21 days. These instructions directed the product must be discarded after 21 days even if the Verify test strip indicated a concentration above the minimum recommended concentration.</p>	C 266		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/14/2014
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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	<p>Initial Comments</p> <p>Complaint Investigation</p> <p>Complaint Number: OH00074964</p> <p>Administrator: Lindsay Marrone</p> <p>County: Summit</p> <p>Capacity: One Operating Room</p> <p>At the time of the complaint inspection, completed on 07/14/14, Northeast Ohio Women's Center's license is pending with regard to the rules at O.A.C. 3701-83 for ambulatory surgical facilities.</p>	C 000		

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/02/2014
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 Licensure Compliance Inspection and Second Post Inspection Revisit to the 10/10/13 Licensure Compliance Inspection Administrator: Carol Westfall, Executive Director County: Summit Number of ORs: One The following violations are issued as a result of the licensure compliance inspection completed on 07/02/14.	C 000		
C 132	O.A.C. 3701-83-09 (D) Infection Control Policies & Procedures The HCF shall establish and follow written infection control policies and procedures for the surveillance, control and prevention and reporting of communicable disease organisms by both the contact and airborne routes which shall be consistent with current infection control guidelines, issued by the United States centers for disease control. The policies and procedures shall address: (1) The utilization of protective clothing and equipment; (2) The storage, maintenance and distribution of sterile supplies and equipment; (3) The disposal of biological waste, including blood, body tissue, and fluid in accordance with Ohio law; (4) Standard precautions/body substance isolation or equivalent; and	C 132		

Ohio Department of Health

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

TITLE



(X6) DATE

10/27/14

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/02/2014
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
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C 132	<p>Continued From page 1</p> <p>(5) Tuberculosis and other airborne diseases.</p> <p>This Rule is not met as evidenced by: RECITE</p> <p>Based on observations, staff interviews, and review of product directions, the facility failed to provide a policy or procedure for prewashing and sterilizing surgical instruments. This could potentially affect all patients in the facility. A total of 1,530 procedures were performed in the most recent twelve months. There were no procedures occurring in the facility during the inspection.</p> <p>Findings include:</p> <p>On 07/02/14 at 11:50 AM, an observation was conducted of the sterilization room in which surgical instruments are processed between patient use. This observation included Staff H (medical assistant who performs sterilization of instruments). When questioned as to the process, Staff H stated the used surgical instruments are brought into the room, placed on chux on the left side of the sink, the surgical instruments are then placed into a brown basin in the sink which is filled half full with water and one scoop of powder (Regman brand). The label on the container of Regman powder directed the user to place one scoop of powder in a gallon of water to pre-wash surgical instruments. Staff H then stated after the brown basin is used to pre-wash and soak the surgical instruments, they are wrapped in blue paper and placed in the sterilizer.</p>	C 132		

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NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 132	Continued From page 2 This finding was confirmed with Staff H at the time of the observation. During the observation of this room with Staff H, it was also observed there were no directions, procedures, or policies posted in the room detailing the procedure for prewashing or sterilizing the surgical instruments. Staff H was unable to locate any information in the room for this procedure, stating all staff have been trained to perform this task. Staff H stated Staff J routinely performs the sterilization of instruments. On 07/02/14 at 2:07 PM, an interview with Staff H and J revealed they were unable to locate any procedures or policies for sterilization of surgical instruments. Staff J stated it would be a good idea to have the procedures available for all staff.	C 132		
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 and staff interview, the facility failed to maintain a safe and sanitary environment. This could potentially affect all patients in the facility. A total of 1,530 procedures were performed in the most recent twelve months. There were no procedures occurring in the facility during the inspection. Findings include: On 07/02/14 between 11:15 AM and 12:00 PM, a tour was conducted with Staff H. During the tour,	C 139		

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NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
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C 139	<p>Continued From page 3</p> <p>the following was observed and confirmed with Staff H:</p> <p>On the second floor:</p> <p>a) The staff/patient bathroom was observed with a rusty floor ventilation grill. The ceiling air grill was observed with a heavy coating of dust and dirt. A portion of the baseboard was missing from the door opening to the toilet.</p> <p>b) A ceiling tile was observed open at the top of the rear stairwell.</p> <p>On the first floor:</p> <p>c) The operating room was observed with a dusty, dirty ceiling metal air grill over the cabinets near the medical gas room. The room was also observed with a square white fan in which a coating of dust was observed on the grill and the fan blades.</p> <p>d) The laboratory area contained one open box of pipettes (plastic device used to draw in liquid so that it can be transferred to another container). This open box and three additional cardboard boxes of pipettes were observed under the sink and were not protected from potential water damage.</p> <p>e) The front stairwell first floor landing lacked an exit sign at the exit discharge. A door to the laboratory was located in the same area; however, there was no exit sign visible to direct staff, visitors, and patients to the exit discharge.</p> <p>f) The waiting room by the laboratory was observed with an upholstered metal stool on wheels. The covering of the stool was observed with a large piece of duct tape.</p> <p>g) One of three chairs (used for patients after the abortion procedure) in the recovery room was observed with approximately a one to two inch hole in the upholstered covering at the knee location.</p>	C 139		

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NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
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C 139	Continued From page 4 h) The ceiling tile over the three recovery room chairs was observed with a misshaped metal clothes hanger dangling from the ceiling tile directly above two the chairs. Staff H stated this clothes hanger had been used to hang intravenous solution (IV) the IV pole was not available. i) The medical gas room, located in the operating room, was observed locked. When Staff H was asked to unlock the door, Staff H looked for a key and confirmed there was no key available inside the facility. A review of the State Fire Marshal report, dated 01/13/14, revealed a violation in the medical gas room due to five unsecured oxygen cylinders. Staff H confirmed the observations at the time of tour.	C 139		
C 241	O.A.C. 3701-83-20 (B) OR & Recovery Room Equipment Each ASF shall have the following equipment accessible to the operating suite and recovery area: (1) Adequate resuscitation equipment: (a) ASFs providing surgical procedures under topical and local infiltration blocks with or without oral or intramuscular preoperative sedation shall have: airways, bag mask respirator, oxygen source, suction equipment, and age-appropriate resuscitative drugs; (b) ASFs providing surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs or providing surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have: airways, endotracheal	C 241		

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C 241	<p>Continued From page 5</p> <p>tubes, laryngoscope, oxygen delivery capability under positive pressure, suction equipment, and suitable resuscitative drugs.</p> <p>(2) Appropriate monitoring equipment: (a) Each ASF shall have size-specific blood pressure apparatus and stethoscopes, electrocardiogram, oscilloscopes and when pediatric patients are treated, size-specific emergency equipment and medications; (b) ASFs performing surgical procedures in conjunction with oral, parenteral, or intravenous sedation or under analgesic[sic] or dissociative drugs, or performing surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have a defibrillator, pulse oximeter with alarm, and temperature monitor. (c) ASFs using inhalation anesthesia shall have an anesthesia machine.</p> <p>(3) Each ASF shall have suitable surgical instruments customarily available for the planned surgical procedure in the operating suite.</p> <p>(4) Each ASF shall have in the recovery room, an emergency call system that is connected electronically, electrically by radio transmission or in a like manner and that effectively alerts staff.</p> <p>This Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain a list of resuscitative drugs for the emergency crash cart. This could potentially affect all patients in the facility. A total of 1,530 procedures were performed in the most recent twelve months. There were no</p>	C 241			

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C 241	Continued From page 6 procedures occurring in the facility during the inspection. Findings include: A tour was conducted in the facility on 07/01/14 between 4:00 PM and 4:40 PM with Staff E. Observation of the emergency crash cart revealed multiple drugs and supplies for use in a cardiac resuscitative emergency. When questioned as to the location of the inventory list for the emergency cart, Staff E stated the facility was in the process of making a new crash cart log as the current one was old and couldn't be used. When questioned as to the location of the new log, Staff E confirmed the new log was not available in the facility.	C 241		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/20/2014
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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	<p>Initial Comments</p> <p>Complaint Inspection</p> <p>Complaint Number OH00073676</p> <p>Administrator: Chrissie France, Executive Director</p> <p>County: Cuyahoga</p> <p>Number of ORs: 5</p> <p>Preterm is in compliance with the rules for Ambulatory Surgical Facility at O.A.C. 3701-83 at the time of the complaint inspection completed on 02/20/14.</p>	C 000		

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

TITLE



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0600AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/12/2015
NAME OF PROVIDER OR SUPPLIER WOMEN'S MED CENTER OF DAYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 E. STROOP ROAD DAYTON, OH 45429		
(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 Complaint Inspection Complaint Number OH00079475 Administrator: Martin Haskell, MD County: Montgomery Two Procedure Rooms Women's Med Center Dayton was not in compliance with the rules for Ambulatory Surgical Facility, at Ohio Administrative Code 3701-83-07(A)(2), at the time of the complaint inspection completed on 06/12/15.	C 000		
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; (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	C 114		

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C 114	<p>Continued From page 1</p> <p>(5) Each patient shall receive, if requested, a detailed explanation of facility charges including an itemized bill for services received.</p> <p>This Rule is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure a patient was allowed to refuse or withdraw consent for treatment when her physical and cognitive condition precluded her from participating in her treatment. This deficient practice affected one patient (Patient #1). The facility performed 2,522 procedures in the last year. Findings include:</p> <p>Review of the medical record for Patient #1 revealed a nurses' note dated 06/11/15 at 10:30 AM that documented "Patient arrived to facility in care of friend and was noted to be leaning on friend, walking slowly. " The note revealed a medical assistant placed Patient #1 in a wheelchair and assisted the patient to hold her head up as the patient was unable to do so. The note also documented "Patient speech noted to be slow and slurred. Patient unable to keep eyes open and noted to be twitching when open. Patient unable to hold conversation."</p> <p>Staff A confirmed in an interview Patient #1 had signs of recreational drug abuse. Staff A also stated Patient #1 had been at the clinic on 06/10/15 for an initial evaluation and was accompanied by a friend. The appointment on 06/10/15 included placement of a dilator and Patient #1 was instructed to return to have the procedure the next day on 06/11/15. Patient #1 was given six tablets of Percocet (narcotic pain</p>	C 114		

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C 114	<p>Continued From page 2</p> <p>medication).</p> <p>Review of a physician's note dated 06/11/15 revealed Patient #1 "arrived at the office in a somulent state; responsive to strong stimuli; but otherwise not able to walk, or to make coherent conversation." Also, in the physician's note "report by patient friend/driver that patient took two Soma and several Percocet and probably both Suboxone and perhaps some heroin on her way in." Further review of documentation revealed the physician consulted by phone with two other physicians, including the medical director and the designated transfer physician in the back-up physician group at a local hospital, before proceeding with the surgery. The physician note dated 06/11/15 revealed the decision was made to do the procedure and planned for post procedure admission to the hospital with a diagnosis of "suspected recreational drug overdose."</p> <p>In an interview on 06/11/15 at 11:58 AM, Staff A stated the decision was made to proceed due to the presence of the dilators. The facility had Narcan available and it was administered to Patient #1 post procedure. Staff A also stated Patient #1 never lost consciousness and was responsive to staff before and after the procedure with prompting; however, review of the facility's documentation revealed Patient #1 was semi-conscious with a low blood pressure.</p> <p>Staff A also stated during this interview that the physician performing the procedure evaluated the situation and determined Patient #1 needed to be transferred to the hospital for further evaluation, monitoring and detoxification from the suspected drug overdose after the procedure due to her level of consciousness.</p>	C 114		

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C 114	Continued From page 3 Review of the physician's note revealed the physician was aware of Patient #1's lack of cognition and inability to participate in her care prior to the procedure. There was no documentation in the medical record that Patient #1 was asked whether or not she would like to withdraw consent due to her altered state.	C 114		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/26/2015
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIONAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Initial Comments</p> <p>Complaint Inspection</p> <p>Complaint Number OH00080311</p> <p>Administrator: Jerry H. Lawson, President/CEO</p> <p>County: Hamilton</p> <p>Capacity: Three Operating Rooms</p> <p>At the time of the complaint inspection for complaint number OH00080311, completed on 08/26/15, Planned Parenthood Southwest Ohio is in compliance with the rules at O.A.C. 3701-83 and 3701-47-05.</p>	C 000		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/02/2015
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 Complaint Inspection Complaint Numbers: OH00078272 and OH00078545 Administrator: Carol Westfall County: Summit Capacity: One Operating Room The following violations are issued as a result of the complaint inspection completed on 04/02/15.	C 000		
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 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 patient medical record review and staff	C 119		

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C 119	<p>Continued From page 1</p> <p>interview and confirmation, the facility failed to ensure that personnel were utilized that had 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. Two of four sampled patient medical records (Patient #1 and #4) were affected.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the medical record on 04/01/15 for Patient #1 revealed the patient was originally seen at the women's clinic on 03/21/15 for an ultrasound pregnancy confirmation, receipt of pregnancy termination pre-procedure education and to sign informed consents. Patient #1 returned to the clinic on 03/28/15 and underwent a surgical pregnancy termination. Review of the facility's staffing schedule on 04/01/15 revealed staff assignments for the surgery date of 03/28/15 as follows: Staff F, a medical assistant was assigned to the operating room as the circulator (responsible for the operating room set up, observation for breaches in asepsis and lead health team coordinator), Staff B and C, both Registered Nurses were assigned duty in the recovery room. Interview of Staff D on 04/01/15, revealed the facility considered the Certified Nurse Anesthetist (CRNA) as the nurse in the operating room. 2. Review of the medical record for Patient #4 revealed the patient was originally seen at the women's clinic on 02/06/15 for ultrasound pregnancy confirmation, receipt of pregnancy 	C 119		

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C 119	<p>Continued From page 2</p> <p>termination pre-procedure education and to sign informed consents. Patient #4 returned to the clinic on 02/07/15 and underwent a surgical pregnancy termination procedure. The procedure resulted in the patient receiving a perforated uterus (puncture wound) and was transferred to the hospital for further evaluation.</p> <p>Review of the facility's staffing schedule during an interview with Administrative Staff D on 04/02/15 at 10:31 AM revealed staff assignments for the surgery date of 02/07/15 as follows: Staff F, a medical assistant was assigned to the operating room as the circulator (responsible for the operating room set up, observation for breaches in asepsis and lead health team coordinator), Staff G, a medical assistant, was scheduled as the scrub (maintains sterile field and handing sterile instruments to the physician). Staff B and H, both Registered Nurses, were assigned duty in the recovery room. Additionally, Staff D verbalized that the facility considered the Certified Registered Nurse Anesthetist (CRNA) as the nurse in the operating room.</p> <p>Review of the facility's policy and procedure entitled Clinical Staff Assignments with an effective date of August 2009 directed that the circulator assigned will always be a Registered Nurse (RN) or a RN supervised Licensed Practical Nurse (LPN). The scrub person assigned will be a RN, LPN, or Surgical Technologist. The policy further directed that assignments shall adhere to the clinical staffing pattern policy.</p> <p>Staff D verified during interview conducted on 04/02/15 at 10:31 AM the facility failed to follow their staffing policy and the recommendations put forth by the Association of Peri-operative</p>	C 119		

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C 119	Continued From page 3 Registered Nurses. This finding is an incidental finding during investigation of the Substantial Allegation Survey Complaint No. OH00078272 and OH00078545.	C 119		
C 131	O.A.C. 3701-83-09 (C) Adverse Events The HCF shall document and review any complications and adverse events which arise during the provision of the facility's service. This Rule is not met as evidenced by: Based on patient medical record review, review of facility policy and procedure and staff interview and confirmation, the facility failed to ensure that documentation and review of complications and adverse events which arise during the provision of the facility's service was conducted. Two of four sampled patient medical records (Patients #1 and #4) were affected. Findings include: 1. Review of the medical record on 04/01/15 for Patient #1 revealed the patient was originally seen at the women's clinic on 03/21/15 for ultrasound pregnancy confirmation, receipt of pregnancy termination pre-procedure education and to sign informed consents. Patient #1 returned to the clinic on 03/28/15 and underwent a surgical pregnancy termination. Review of documentation noted on the recovery room sheet of 03/28/15, revealed the patient was admitted to the recovery room crying. The patient	C 131		

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C 131	<p>Continued From page 4</p> <p>was also noted to be crying 15 minutes later. Further documentation on the same sheet indicated the parent of the patient was brought to the floor, to another room, in order to calm the patient from a panic attack.</p> <p>Review of staffing schedules for 03/28/15, revealed two registered nurses were present and on duty in the recovery area.</p> <p>Interview with Staff B on 04/01/15 at 3:00P.M. revealed he/she typed a brief summary statement of the patient's recovery. Review of the summary revealed the patient was described as combative, making statements regarding her own mental health and that she was prone to seizure disorders. Staff B described the patient as "hyperventilating " and "throwing a fit". The patient accused Staff B of hitting her after the patient was described as becoming non-responsive. Staff B noted the statement was made as a result of the nurse "tapping" on the patient's cheeks with the his/her hands.</p> <p>On 04/02/15, at 11:10 A.M. a telephone interview was conducted with Staff C. Staff C confirmed he/she was working in the recovery area on 03/28/15 and witnessed the interaction between Staff B and the patient.</p> <p>Staff B was requested to provide the occurrence report and any investigation notes, Staff B confirmed there was no occurrence report completed by either staff in the recovery room and no investigative information documented.</p> <p>2. Review of the medical record for Patient #4 revealed the patient was originally seen at the women's clinic on 02/06/15 for ultrasound pregnancy confirmation, receipt of pregnancy termination pre-procedure education and to sign</p>	C 131			

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C 131	<p>Continued From page 5</p> <p>informed consents. Patient #4 returned to the clinic on 02/07/15 and underwent a surgical pregnancy termination. The patient received a perforated uterus (puncture wound) resulting in the patient being transferred to the hospital for further evaluation.</p> <p>Review of the facility's policy and procedure titled "Quality Assurance Performance Improvement Plan" with an effective date of 07/23/13 directed facility staff that documented surgical cases were reviewed for patients who were transferred to other facilities. The ultimate goal was to improve the quality of care that was routinely provided to the patients of the facility.</p> <p>Interview with Staff A on 04/02/15 at 10:03 AM revealed he/she was responsible for chart review. When a request to review the quality assurance and occurrence report and any investigation notes, Staff A verbalized the chart for Patient #4 was reviewed for chart completion only. Staff A verbalized there was no formal review of the complication, there was no occurrence report or formal quality assurance review.</p> <p>Staff A verified at this time the deficient practice of no formal review of Patient #4's case despite the regulatory requirement as well as the facility's Quality Assurance Performance Improvement Plan directive to do so or per policy and procedures on completion of the occurrence report.</p> <p>Review of the facility's policy and procedure titled "Center Occurrence Reports" with an original date of August 2009 documented the reason for the report was to establish consistent guidelines to report and document any adverse care events or other accidental occurrences involving</p>	C 131		

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C 131	Continued From page 6 patients, visitors or volunteers at the center. The goal of the policy was to improve quality of services provided by identifying the cause of adverse care events and instituting corrective action as necessary to minimize or eliminate the potential for injury to patients, visitors, or volunteers. The policy directed that an Occurrence Report was to be completed for every occurrence which met the following definition: "any happening not consistent with the routine care or operation of the facility...." The procedure directed that an Occurrence Report must be completed immediately following an event which met the above mentioned reporting definition. Additionally, the Occurrence Report was to be completed by the employees who witnessed the event.	C 131		
C 143	O.A.C. 3701-83-11 (A) Medical Records The HCF shall maintain a medical record for each patient that documents, in a timely manner and in accordance with acceptable standards of practice, the patient's needs and assessments, and services rendered. Each medical record shall be legible and readily accessible to staff for use in the ordinary course of treatment. This Rule is not met as evidenced by: Based on patient medical record review, review of agency policy and procedure and staff interview and confirmation, the facility failed to ensure that a medical record was maintained for each patient that documents, in a timely manner and in accordance with acceptable standards of practice, the patient's needs and assessments,	C 143		

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C 143	<p>Continued From page 7</p> <p>and services rendered. Each medical record shall be legible. Two of four sampled medical records (Patients #1 and #4) were affected.</p> <p>Findings include;</p> <p>1. Review of the medical record on 04/01/15 for Patient #1 revealed the patient was originally seen at the women's clinic on 03/21/15 for ultrasound pregnancy confirmation, receipt of pregnancy termination pre-procedure education and to sign informed consents. Patient #1 returned to the clinic on 03/28/15 and underwent a surgical pregnancy termination.</p> <p>Review of documentation noted on the recovery room sheet of 03/28/15, revealed the patient was admitted to the recovery room crying. The patient was also noted to be crying 15 minutes later. Further documentation on the same sheet indicated the patient's parent was brought to the floor, to another room, in order to calm the patient from a panic attack. Documentation ended with the patient walking out with the parent to the car. Review of staffing schedules for 03/28/15, revealed two registered nurses (Staff B and C) were present and on duty in the recovery area.</p> <p>Interview of Staff E on 04/01/15 at 11:50 A.M. confirmed the patient was crying, yelling and suspected the patient had a panic attack during the initial recovery phase from anesthesia on 03/28/15. Staff E indicated that some patient's experience crying when "coming out of the anesthesia".</p> <p>Interview with Staff B on 04/01/15 at 3:00 P.M. revealed he/she typed a brief summary statement of the patient's recovery. Review of the summary revealed the patient was described as combative,</p>	C 143			

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NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 143	<p>Continued From page 8</p> <p>making statements regarding her own mental health and that she was prone to seizure disorders. Staff B described the patient as "hyperventilating " and "throwing a fit". The patient accused Staff B of hitting her after the patient was described as becoming non-responsive. Staff B noted the statement was made as a result of the nurse "tapping" on the patient's cheeks with the his/her hands.</p> <p>Interview of Staff C on 04/02/15 at 11:10 A.M. regarding the patient's care during the recovery phase revealed the patient arrived in the recovery room mumbling and shaking. Staff C stated that "smelling salts" were utilized to awaken the patient.</p> <p>Review of the patient's medical record documentation during the delivery of anesthesia revealed the initiation and end of anesthesia was not documented, when the surgery began or the end time and the patient's condition to the initial recovery phase was not documented.</p> <p>Review of the facility's policy and procedure titled "Post Anesthesia Care" with an original date of August 2009 was written to provide specialized nursing care to the surgical patient. The following standards were to be followed in accordance with post anesthesia care unit (PACU) standards; Item 8, all patients who received general, regional or MAC anesthesia were to be admitted to first stage recovery unless the patient met the criteria for PACU bypass and was transferred directly to second stage recovery. The nurse anesthetist caring for the patient shall retain primary medical responsibility for the patient while in the PACU; Item 11, the PACU staff shall receive advance notification of any admission and pertinent information which will improve patient care in the</p>	C 143		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/02/2015
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 143	<p>Continued From page 9</p> <p>post-anesthesia recovery period, Item 15, an oral report of the patient's condition shall be given to the PACU nursing staff by the anesthesiologist when the patient is admitted to the PACU, Item 16, the anesthesiologist shall stay with the patient in the PACU at least until the patient's vital signs are recorded by the registered nurse, Item 20, the recovery room record is to be completed by recovery personnel. The record was to include such items as respiratory efficiency, color, pain management, treatment and any other observation and Item 21, the PACU staff were to continually evaluate the condition of each patient and maintain an accurate written record of the patient's vital signs, with an objective scoring system used to track the patient's recovery from anesthesia from the time of admission to the unit discharge.</p> <p>Interview of Staff D on 04/02/15 confirmed the facility policy and procedure was not followed with regard to accurate and complete documentation of the patient's post anesthesia care.</p> <p>2. Review of the medical record for Patient #4 revealed the patient was originally seen at the women's clinic on 02/06/15 for ultrasound pregnancy confirmation, receipt of pregnancy termination pre-procedure education and to sign informed consents. Patient #4 returned to the clinic on 02/07/15 and underwent a surgical pregnancy termination procedure. The patient received a perforated uterus resulting in being transferred to the local hospital emergency department via ambulance.</p> <p>Review of the Abortion Record, operative report completed by the physician revealed an illegible and unreadable hand written narrative paragraph regarding Patient #4's complicated medical course.</p>	C 143		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/02/2015
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 143	<p>Continued From page 10</p> <p>On 04/01/15 at 2:53 PM Staff A was requested to decipher the physician's narrative note, Staff A responded with "I'm not even going to try. We all have trouble reading the doctor's writing, Staff B maybe able to read it when he/she arrives."</p> <p>Interview with Staff B on 04/01/15 at 4:10 PM when asked to decipher the physician's hand written narrative operative notes regarding Patient #4's complication during the surgical abortion replied, "I can't read that, I can't read his writing, no one can."</p> <p>Interview with the physician on 04/02/15 at 10:18 AM was conducted to decipher his/her hand written medical record note. The physician read the report to surveyors with some difficulty and then verbalized sometimes I can't read my own handwriting.</p> <p>3. Review of the facility's policy and procedure titled "Completing the Operative Record" with an original date of August 2009 directed that all records shall be completed in a uniform manner and contain all information necessary for legal documentation of the surgery performed and nursing care given. The procedure directed at item #7 that staff should list all assistants names as appropriate Item #14 directed staff to document scrub or preparation solutions used and who performed the scrub, Item 15 directed staff to document the patient's surgical positioning, Item #22 entitled Nurses Notes directed the nurse documents any pertinent information that the post op unit would find useful, including any unusual incidents in the OR (operating room) and Item #25 directed the circulator signs the intra-operative record. Additionally, review of the policy and procedure</p>	C 143		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/02/2015
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP			STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 143	Continued From page 11 titled "Documentation of Anesthesia Care" with an original date of August 2009 at Post-Anesthesia Item III - C direct anesthesia staff to document any unusual events including post-anesthesia, post procedural complications. Review of the medical record for Patient #4 revealed the Anesthesia Record failed to document Patient #4's complication of a perforated uterus per facility policy. Additionally, the medical record documentation failed to adhere to facility policy and procedure in regard to documentation of surgical preparation solutions used, surgical position of the patient, and the medical record was absent of any nursing documentation except one statement on 02/07/15 at 12:10 that documented the patient sent to Summa via ambulance. The medical record failed to document the condition of the patient at the time of transfer. The last recorded documentation of vital signs were completed by the Certified Nurse Anesthetist (CRNA) at 11:45 AM. Per review of the ambulance run report the emergency medical technicians (EMT) arrived on scene on 02/07/15 at 12:12 PM or approximately half an hour after the last facility documentation entry. These deficient practices were verified on 04/02/15 at 10:31 AM with Staff A.	C 143			
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,	C 152			

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NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP			STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 152	<p>Continued From page 12</p> <p>accessibility, continuity, efficiency, patient outcome, and patient satisfaction;</p> <p>(2) Establish expectations, develop plans, and implement procedures to assess and improve the quality of care and resolve identified problems;</p> <p>(3) Establish expectations, develop plans, and implement procedures to assess and improve the health care facility's governance, management, clinical and support processes;</p> <p>(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;</p> <p>(5) Document and report the status of quality assessment and improvement program to the governing body every twelve months;</p> <p>(6) Document and review all unexpected complications and adverse events, whether serious injury or death, that arise during an operation or procedure; and</p> <p>(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.</p>	C 152			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/02/2015
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 152	<p>Continued From page 13</p> <p>This Rule is not met as evidenced by: Based on patient medical record review, review of agency policy and procedure and staff interview and confirmation, the facility failed to ensure the quality assessment and performance improvement program did all of the following: Monitor and evaluate all aspects of care including effectiveness, appropriateness, accessibility, continuity, efficiency, patient outcome; Establish expectations, develop plans, and implement procedures to assess and improve the quality of care and resolve identified problems; Establish expectations, develop plans, and implement procedures to assess and improve the health care facility's governance, management, clinical and support processes; 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; and Document and review all unexpected complications and adverse events, whether serious injury or death, that arise during an operation or procedure. One of four sampled patient medical records (Patient #4) was affected.</p> <p>Findings include:</p> <p>Review of the medical record for Patient #4 revealed the patient was originally seen at the women's clinic on 02/06/15 for ultrasound pregnancy confirmation, receipt of pregnancy termination pre-procedure education and to sign informed consents. Patient #4 returned to the clinic on 02/07/15 and underwent a surgical pregnancy termination procedure. The patient</p>	C 152		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/02/2015
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
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C 152	<p>Continued From page 14</p> <p>incurred a complication of a perforated (puncture wound) uterus for which the patient was transferred to the hospital for further evaluation.</p> <p>Review of the facility's policy and procedure titled "Quality Assurance Performance Improvement Plan" with an effective date of 07/23/13 directed facility staff in the section headed medical staff responsibility documented surgical cases were reviewed for patients who were transferred to other facilities. The ultimate goal was to improve the quality of care that was routinely provided to the patients of the facility.</p> <p>Interview with Staff A on 04/02/15 at 10:03 AM revealed he/she was responsible for chart review. When survey requested to review the quality assurance reviewed report Staff A verbalized the chart for Patient #4 was reviewed for chart completion only. Staff A verbalized there was no formal review of the complication.</p> <p>Staff A verified at this time there was no formal review of Patient #4's case despite the regulatory requirement as well as the facility's Quality Assurance Performance Improvement Plan directive to do so.</p>	C 152		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/23/2015
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NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223
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(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	<p>Initial Comments</p> <p>Complaint Investigation</p> <p>Complaint Number: OH00077557</p> <p>Administrator: Dr. David Burkons, M.D.</p> <p>County: Summit</p> <p>Capacity: One Operating Room</p> <p>Based on the complaint investigation completed 1/23/15, at Northeast Ohio Women's Center it was determined the complaint was unsubstantiated.</p>	C 000		

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

TITLE



(X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/22/2015
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 License Compliance Inspection Administrator: Michelle Meredith County: Franklin Two Procedure Rooms The following violations are issued as a result of the license compliance inspection completed on 01/22/15.	C 000		
C 116	O.A.C. 3701-83-07 (C) Patient Satisfaction Program The HCF shall implement a patient satisfaction survey program. This Rule is not met as evidenced by: Based on record review and staff interview the facility failed to implement a patient satisfaction survey. This finding had the potential to affect all patients receiving services at the facility, with an annual census of 1,499 for the calendar year 2014. Findings include: Review of the facility's records on 01/21/15, at 11:04 AM with Staff A, included a request to review patient satisfaction survey documentation. Interview with Staff A on 01/21/15 at 12:22 PM revealed there was no survey completed for surgical service patients. The organization nor a third party conducted a survey of patients who received surgical services at the clinic.	C 116		

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TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/22/2015
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 126	<p>O.A.C. 3701-83-08 (H) Staff Schedules</p> <p>Each HCF shall retain staffing schedules, time-worked schedules, on-call schedules, and payroll records for at least two years.</p> <p>This Rule is not met as evidenced by: Based on review of the staffing schedule and facility staff interview, it was determined the facility failed to retain staffing schedules for the required time frame. The facility performed 1,499 procedures during the year 2014.</p> <p>Findings include:</p> <p>Request for staffing schedules for the past two years (2013 and 2014) revealed the facility had retained schedules for the year 2014 only with the exception of 02/01/14 and 02/16/14, which were not provided.</p> <p>During an interview with Staff B at 8:55 A.M. on 01/22/15 it was confirmed that the schedules were unable to be located. Staff B stated that actual worked time could be determined through payroll records, but there were no original work schedules or time worked schedules available for review.</p> <p>Interview with Staff A at 1:40 P.M. on 01/21/15 revealed there had been a change in administration and the facility had been unable to locate the previous manager's staffing schedules. Further interview with Staff A at 8:52 A.M. on 01/22/15 revealed the facility has no policy related to retention of the time-worked schedules.</p>	C 126		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/20/2015
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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	<p>Initial Comments</p> <p>Complaint Inspection Complaint Number: OH000080309</p> <p>Administrator: Michelle Meredith</p> <p>County: Franklin</p> <p>Capacity: Two Operating Rooms</p> <p>At the time of the complaint inspection for complaint OH00080309 completed 08/20/2015, Planned Parenthood East Health Center is in compliance with 3701-47-05.</p> <p>The following violation is issued as a result of the complaint inspection completed on 08/20/15 at 3701-83 of the O.A.C.. The violation is unrelated to the allegation in the complaint.</p>	C 000		
C 235	<p>O.A.C. 3701-83-19 (F) Documented Informed Consent</p> <p>Prior to the surgery, the physician, podiatrist, or dentist, shall obtain a statement documenting informed consent, signed by the patient or patient representative, for the performance of the specific surgical procedure or procedures. This statement shall be made part of the patient's medical record. The ASF shall ensure that informed consents for surgical procedures have been signed.</p> <p>This Rule is not met as evidenced by: Based on medical record review, staff interview, and review of the facility's informed consent policy, the facility failed to ensure that one of two medical records of patients under the age of 18</p>	C 235		

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

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Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/20/2015
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 235	<p>Continued From page 1</p> <p>contained an informed consent for a surgical procedure in accordance with facility policy (Patient #28). The facility performed a total of 1,890 procedures in the past twelve months.</p> <p>Findings include:</p> <p>On 08/20/15 at 9:07 AM, Staff B assisted with an electronic medical record review for Patient #28. This review revealed that Patient #28 had a surgical procedure on 07/17/14, at which time the gestational age was 11 weeks and one day. Patient #28 was a minor (17 years old) at the time of the surgical procedure. A review of the surgical consents revealed the patient did have a guardian (parent). The surgical consents for the surgical procedure were signed by Patient #28 and witnessed by facility staff on 07/10/14; however, the consents lacked a signature by the patient's guardian. The consents included the Client Information for Informed Consent for in-clinic abortion (CIIC) and the consent for Moderate Sedation Intravenous (IV) Sedation.</p> <p>The medical record review revealed the patient received a surgical procedure in the facility on 07/17/14 between 2:24 PM and 2:35 PM. Facility staff administered two intravenous sedation medications during the procedure.</p> <p>On 08/20/15, at 12:10 PM, a review was conducted of the facility's policy titled "Client Services, Informed Consent", revised 07/01/12, with the last approval date of 07/10/14 by the Medical Director. This policy stated the following:</p> <p>Minors</p> <p>1. Reproductive Health Services</p> <p>*Any person who signs the request for services form must sign the CIIC(s) for the corresponding procedure. For example, when the PPNEO</p>	C 235		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/20/2015
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 235	<p>Continued From page 2</p> <p>"Request for Surgery or Special Procedure" is used to document compliance with Ohio's parental consent for abortion law, the parent(s) or guardian who signs the request should sign the CII's relating the the minor's abortion procedure.</p> <p>At the time of the medical record review on 08/20/15 at 9:07 AM, Staff B confirmed the patient's guardian failed to sign the informed consents. Staff B confirmed the facility policy is for the guardian to sign these consents. On 08/20/15 at 3:25 PM, Staff B also confirmed the patient received two intravenous medications during the surgical procedure and stated the facility policy for obtaining informed consent for a minor by the guardian was not followed for Patient #28's surgical procedure.</p> <p>This violation was an unrelated finding identified during the complaint OH00080309 investigation.</p>	C 235		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2015
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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 Licensure Compliance Inspection Administrator: Heather Harrington County: Cuyahoga Number of ORs: 5 The following violation is issued as a result of the licensure compliance inspection completed on 04/30/15.	C 000		
C 231	O.A.C. 3701-83-19 (B) Drug Control & Accountability The ASF shall: (1) Provide adequate space, equipment, and staff for storage and the administration of drugs in compliance with state and federal laws and regulations. (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. This Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a Schedule II narcotic anesthesia drug was labeled with the correct dose. This involved nineteen syringes of the medication which were pre-drawn and labeled by a licensed staff member of the facility. This could potentially affect all patients who were administered the medication. The facility performed a total of 5264 procedures in the past	C 231		

Ohio Department of Health
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2015
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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 231	<p>Continued From page 1</p> <p>12 months.</p> <p>Findings include:</p> <p>On 04/30/15 at 10:55 AM, Staff B was observed counting the facility's supply of narcotic medications for accountability. The narcotic log revealed the facility should have nineteen Fentanyl 100 mcg/2 ml (microgram/milliliter) containers of this medication. Observation revealed nineteen syringes with 2 ml each of clear solution. The label on each syringe was observed with the name of the medication (Fentanyl), dated 04/27/15, times varying between 1:07 PM and 1:10 PM, Staff D's initials, and the dosage of 1 mcg/ml. The dosage on the labels were handwritten in ink.</p> <p>When questioned as to the labels, and the solution in the syringes, Staff B stated each syringe contained 2 ml of Fentanyl in the dosage of 50 mcg per milliliter. Staff B stated according to the labels on the syringes, Staff D (registered nurse) drew up the Fentanyl into each syringe, and mis-labeled the dosage of the medication on each of the nineteen syringes. Staff B stated the dosage should not be 1 mcg/ml but should be labeled as 50 mcg/ml. Staff B stated he/she would call Staff D to correct the dosage of the labels. Staff B confirmed the incorrectly labeled syringes of narcotic medication could result in potential harm to patients if administered.</p> <p>On 04/30/15 at 5:00 PM, Staff B stated that no patients have received medication from the incorrectly labeled syringes. Staff B stated the facility does not have a policy for pre-drawing medications. Staff B stated he/she spoke with the Ohio State Board of Pharmacy regarding the practice of facility staff pre-drawing medications</p>	C 231		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2015
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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 231	<p>Continued From page 2</p> <p>and labeling the syringes. When questioned as to why Fentanyl medication is pre-drawn into the syringes, Staff B replied "It helps facilitate the flow of patients." Staff B confirmed this narcotic medication is used by the Certified Registered Nurse Anesthetist (CRNA) to sedate patients during a procedure.</p> <p>On 04/30/15 at 5:00 PM, Staff C stated the incorrectly labeled syringes of narcotic medication could result in harm to the patients, and stated this is a serious matter.</p>	C 231		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/27/2015
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 Licensure Compliance Inspection and Post Licensure Compliance Inspection completed on 03/11/14. Administrator: Michelle Meredith, Senior Director of Surgical Services County: Cuyahoga Number of ORs: 6 The following violations are issued as a result of the licensure compliance inspection completed on 05/27/15.	C 000		
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; (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	C 114		

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

TITLE



(X6) DATE
10/07/15

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/27/2015
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 114	<p>Continued From page 1</p> <p>detailed explanation of facility charges including an itemized bill for services received.</p> <p>This Rule is not met as evidenced by: Based on document review and staff interview, the facility failed to develop patient care policies regarding patient rights that included the right to be treated with respect, privacy, to refuse treatment, and confidentiality of medical and financial records. This finding had the potential to affect all patients receiving services at the facility. A total of 3,253 procedures were completed in the last 12 months.</p> <p>Findings include:</p> <p>During the entrance conference on 05/26/15 at 9:56 AM, and again on 05/27/15 at 11:30 AM, Staff A was asked to provide policies on patient rights and advanced directives.</p> <p>Review of the facility's "Patient Rights and Responsibilities" form revealed that patient's had the right to be treated with dignity and respect, to have records kept confidential and the right to access their own medical record. This form also listed the patient had the right to be informed of all care and services including risks, benefits, alternatives, and refusal of treatment.</p> <p>In an interview with Staff A on 05/27/15 at 4:45 PM, Staff A verified that the facility did not have a policy that addressed patient rights. The "Patient Rights and Responsibilities" form was developed by the executive leadership in the last year and was posted in the waiting area, but has not been included in policy form at this time.</p>	C 114		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/27/2015
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 115	<p>O.A.C. 3701-83-07 (B) Patient Informed</p> <p>The HCF shall inform each patient of the following:</p> <p>(1) The HCF's policy on advance directives; and</p> <p>(2) The name of the attending physician or individual supervising the patient's care and the manner in which that individual may be contacted.</p> <p>This Rule is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop patient care policies regarding advanced directives or document discussion with the patient regarding advanced directives. This finding had the potential to affect all patients of the facility. A total of 3,253 procedures were completed in the last 12 months.</p> <p>Findings include:</p> <p>During the entrance conference on 05/26/15 at 9:56 AM, and on 05/27/15 at 11:30 AM, Staff A was asked to provide policies on patient rights and advanced directives.</p> <p>Six medical records were reviewed on the afternoon of 05/27/15. All six medical records lacked documentation regarding advanced directives, including whether or not the patient had advanced directives or would like information on advanced directives. This finding was verified by Staff A at the time of the record review.</p>	C 115		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/27/2015
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 115	Continued From page 3 In an interview with Staff A on 05/27/15 at 4:45 PM, Staff A verified that the facility did not have a policy that addressed advanced directives. Staff A stated that the electronic medical record did not have a location to document advanced directives and that it was not routine to ask a patient about advanced directives.	C 115		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2015
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Licensure Compliance Inspection Administrator: Jerry Lawson County: Hamilton (3) Procedure Rooms The following violations are issued as a result of the compliance inspection completed on 01/21/15.	C 000		
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 review of personnel records, staff interview and policy review, the facility failed to perform annual evaluations of staff. This affected four of the 10 staff (D, E, F and G) whose personnel records were reviewed: Findings include: 1. The personnel record of Staff F revealed a hire date of 09/10/12. The last performance evaluation for Staff F was dated 10/10/13. 2. The personnel record of Staff G revealed a hire date of 08/20/12. The last performance evaluation for Staff G was dated 08/28/13. 3. Review of the personnel file for Staff D	C 125		

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TITLE



(X6) DATE
10/01/15

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2015
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 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 125	Continued From page 1 revealed a hire date of 10/22/10. The last performance evaluation for Staff D was dated 11/12/13. 4. Review of the personnel file for Staff E revealed a hire date of 10/18/11. The last performance evaluation for Staff E was dated 11/12/13. Review of the facility's policy titled: "PPSWO Performance Evaluation Process" revealed: "Timing-- Beginning in January, 2015 all annual performance evaluations for all employees will be completed at the same time of the year." The policy noted: For the transition from the current system of evaluations on anniversary dates: "Employees whose anniversary dates fall in the 2014 calendar year will be evaluated on their anniversary date using the new performance evaluation process and forms with a less comprehensive update before July 1, 2015." During an interview with Staff A on 01/20/15 at 4:55 PM, Staff A confirmed the evaluations were not completed in 2014, and should have been conducted on the staff's anniversary date.	C 125		
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 and staff interview, it was determined the facility failed to ensure fans were maintained in a clean and sanitary manner. This affected two of two fans observed during tour of	C 139		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2015
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIONAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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 139	Continued From page 2 the procedure areas. This finding had the potential to affect all patients served by the facility. Findings include: 1. On 01/20/15 at 1:00 PM during the tour of the procedure areas, a fan was observed oscillating in procedure room #3. Staff H was observed carrying two suction jars into the procedure room and placed the two jars on the counter near the fan. Staff H stated the jars were clean and were going to be used during the next procedure. The fan was blowing and the outer casing of the fan was noted to have a build-up of dust on it. This finding was confirmed immediately with Staff H whom turned the fan off and removed the suction jars from the room. 2. On 01/20/15 at 1:10 PM, a large fan was observed on the floor in the pathology room. This room is also used for the processing and sterilization of surgical instruments. The fan was observed to have a build-up of dust on the front casing. This finding was confirmed with Staff C at the time the observation was made.	C 139		
C 158	O.A.C. 3701-83-13 (B) Complaints Hot Line The HCF shall post the toll free complaint hotline of the department's complaint unit in a conspicuous place in the HCF. This Rule is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure all of the	C 158		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2015
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIONAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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 158	Continued From page 3 patients were able to see the posting of the complaint hotline number. There were a total of 5,825 procedures performed in the last 12 months. Findings include: On 01/20/15 at 3:15 PM an observation was made of the complaint hotline number posted on a wall in the recovery room. Interview with Staff A and C on 01/20/15 at 3:40 PM revealed not all patients enter the recovery room. This finding was confirmed with Staff A and C on 01/20/15 whom both agreed the posting of the complaint hotline number in the recovery room does not allow all patients the ability to see the complaint hotline number.	C 158		
C 207	O.A.C. 3701-83-17 (B) Physical Examination & History Prior to each operation or procedure, each patient shall have a comprehensive medical history and physical exam performed or updated, along with associated pre-procedure studies. The different components of the history and physical may be performed by different health care professionals, consistent with the type of information required and the professionals' scope of practice, as defined by applicable law. This history and physical exam shall document the pre-operative diagnosis and the procedure to be performed and shall become part of the patient's medical record prior to surgery.	C 207		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2015
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 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 207	<p>Continued From page 4</p> <p>This Rule is not met as evidenced by: Based on medical record review and interview it was determined the facility failed to ensure for one Patient (#1) of five medical records reviewed there was a time of discharge included on the "In Clinic Operating Room Record" and for three Patients (#1, #3 and #4) of five medical records reviewed there was a pre-operative diagnosis included on the "In Clinic Operating Room Record", or the "History and Physical" form. There was a total of 5,825 procedures performed in the last 12 months.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the medical record for Patient #1 revealed a surgical procedure was performed on 01/20/15. Review of the "In Clinic Operating Room Record" and the "History and Physical" record did not include the pre-operative diagnosis. Further review of the "In Clinic Operating Room Record" did not include what time the patient was discharged to the responsible party to go home. 2. Review of the medical record for Patient #3 revealed a surgical procedure was performed on 01/20/15. Review of the "In Clinic Operating Room Record" and the "History and Physical" record did not include the pre-operative diagnosis. 3. Review of the medical record for Patient #4 revealed a surgical procedure was performed on 01/20/15. Review of the "In Clinic Operating Room Record" and the "History and Physical" record did not include the pre-operative diagnosis. 	C 207		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2015
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIONAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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 207	Continued From page 5 These findings were confirmed with Staff C on 01/21/15 at 11:00 AM whom revealed this documentation should have been included in the medical record.	C 207		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/17/2015
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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	<p>Initial Comments</p> <p>Complaint Inspection</p> <p>Complaint Number OH00080162</p> <p>Administrator: Heather Harrington</p> <p>County: Cuyahoga</p> <p>Number of ORs: 5</p> <p>Preterm is in compliance with the rules for ASF at - O.A.C. 3701-83 the time of the complaint inspection completed on 09/17/15.</p>	C 000		

Ohio Department of Health
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TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/18/2015
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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	<p>Initial Comments</p> <p>Complaint Inspection</p> <p>Complaint Number OH00080312</p> <p>Administrator: Michelle Meredith</p> <p>County: Cuyahoga</p> <p>Capacity: Three Operating Rooms</p> <p>At the time of the complaint inspection for complaint number OH00080312, completed on 08/18/15, Planned Parenthood of Greater Ohio is in compliance with the rules at O.A.C. 3701-83 and 3701-47-05.</p>	C 000		

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TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/11/2015
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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	<p>Initial Comments</p> <p>Initial Licensure Compliance Inspection</p> <p>Administrator: Michele Tredway</p> <p>County: Summit</p> <p>Capacity: One Operating Room</p> <p>At the time of the initial licensure compliance inspection, completed on 03/11/15, Northeast Ohio Women's Center, LLC, is in compliance with the rules at O.A.C. 3701-83 for ambulatory surgical facilities.</p>	C 000		

Ohio Department of Health
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TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	Initial Comments Licensure Compliance Inspection Administrator: Terrie Hubbard, RN County: Franklin Number of ORs: 3 The following violations are issued as a result of the licensure compliance inspection inspection completed on 10/22/15.	C 000		
C 102	O.A.C. 3701-83-03 (D) State & Federal Law & Regulations Each HCF shall comply with all applicable state and federal laws and regulations. This Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to post the notice required under State Law 3701.791. This affected all potential and actual patients in the facility. A total of 2694 procedures were performed in the most recent twelve months. Findings include: On 10/21/15, a tour was conducted with Staff B on 10/21/15 at 12:01 PM. This tour included two floors of the building containing waiting rooms, operating rooms and areas potential patients would use. None of these patient care areas and waiting rooms were observed with the posting. Interview with Staff B at the time of tour confirmed	C 102		

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

TITLE



(X6) DATE

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 102	Continued From page 1 the lack of this required posting. Staff B stated "I don't think we've ever posted the notice. We tell them."	C 102		
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 prtpreparedness plan. This Rule is not met as evidenced by: Based on interviews, observations, and policy review, the governing body failed to develop policies for History and Physicals, consents, re-packaging of medications, pharmacy policies, medical record content, evaluation of patients by a physician immediately before surgery, and reporting of adverse events and complications. This could affect all patients in the facility. A total of 2694 procedures were performed in the most	C 104		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 104	<p>Continued From page 2</p> <p>recent 12 months.</p> <p>Findings include:</p> <p>On 10/22/15 at 4:00 PM, an interview was conducted with Staff A and C regarding facility policies. Staff A confirmed the policies are developed and approved by the governing body. A review of the policy manual was conducted at that time in the presence of Staff A and Staff C. This review and interviews revealed there were no policies in place as follows:</p> <p>a) There was no policy for obtaining history and physicals on patients prior to surgery. A review of five patient records did not have documentation of a history and physical. Refer to C208.</p> <p>b) There was no policy for what was required in the medical records of patients. This included documented times of medications, whether the patient viewed the ultrasound or received a copy. Refer to C208 and C255.</p> <p>c) There was no policy for ensuring procedural consents were witnessed and contained a time when signed by the patient and guardian.</p> <p>d) There was no policy in place for re-packaging medications from stock to a smaller container in order to send home with the discharged patient. Observations on 10/21/15 at 12:55 PM revealed Staff G (Registered Nurse) was working in the recovery room caring for patients who had a surgical procedure. Staff G was observed with two individual clear plastic bags of medications. One of the medications was an over-the-counter pain medication and the other contained a prescription antibiotic. The packages were observed with labels containing the facility's</p>	C 104		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 104	Continued From page 3 name, medication name and dose, instructions, the patient's name, and the date. The packages did not have a lot number/serial number of the medications. Staff G stated the medications are taken from the facility's stock supply and re-packaged in these zip lock baggies to send home with discharged patients. Staff G stated the patient is given discharge instructions for the medications. Staff G also stated another Registered Nurse (Staff D) prints out the labels which are placed onto the small pill packages. e) There were no policies developed for storage and accountability of medications. f) There was no policy developed for reviewing and tracking adverse events and complications. The interview with Staff A and C on 10/22/15 at 4:00 PM revealed the facility does not have current policies for the aforementioned areas.	C 104		
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 staff interview and observations, the facility failed to maintain a safe and sanitary environment. This affected one of two floors (first floor) used by all patients and visitors. The facility performed a total of 2694 procedures in the most recent twelve months. Findings include:	C 139		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 139	Continued From page 4 A tour was conducted on 10/21/15 at 1:25 PM with Staff B. Staff B was observed testing a battery back-up light in the exit corridor outside Room 1 (doctor's office) on the first floor used by patients and visitors. The light failed to illuminate when tested. This finding was confirmed with Staff B at the time of testing. Staff B confirmed this is an emergency light used when the power goes out. On 10/22/13, at 3:32 PM, a tour was conducted in the recovery room with Staff A. One of the four patient beds was observed with tape on the side covering of the bed. Staff A stated this tape was being used to cover a slit in the covering. The tape was observed approximately two inches high and ten inches long. The edge of the tape was observed with a black sticky substance. This was confirmed with Staff A at the time of observation.	C 139		
C 208	O.A.C. 3701-83-17 (C) MR Documentation Prior to Surgery Documentation as contained in paragraphs (A) (3), (C)(1), and (C)(7) to (C)(9) of rule 3701-83-21 of the Administrative Code shall be in a patient's medical record prior to surgery. This Rule is not met as evidenced by: Based on medical record reviews and staff interview, the facility failed to ensure five of five sampled patients' (Patients #1 through #5) medical records contained required information prior to surgery. This included documentation of history and physicals, family medical history, physical examinations, times medications were administered, evidence the patient either declined	C 208		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 208	Continued From page 5 or received a copy of the ultrasound, the time the patient/guardian signed the consent for the specific procedure, and a witness signature on the consent. The facility performed a total of 2694 procedures in the most recent twelve months. Findings include: A review was conducted of Patient #1 through #5's medical records on 10/21/15. The patients' medical records lacked the required information as required by the Administrative Code. Refer to C255.	C 208		
C 255	O.A.C. 3701-83-21 (A) - (E) Medical Records Each ASF medical record shall contain at least the following information as applicable for the surgery to be performed: (A) Admission data: (1) Name, address, date of birth, gender, and race or ethnicity; (2) Date and time of admission; and (3) Pre-operative diagnosis, which shall be recorded prior to or at the time of admission. (B) History and physical examination data: (1) Personal medical history, including but not limited to allergies, current medications and past adverse drug reactions; (2) Family medical history; and (3) Physical examination. (C) Treatment data: (1) Physician's, podiatrist's or dentist's orders; (2) Physician's, podiatrist's or dentist's notes; (3) Physician assistant's notes, if applicable; (4) Nurse's notes; (5) Medications; (6) temperature, pulse, and respiration; (7) Any special examination or report, including but not	C 255		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 255	<p>Continued From page 6</p> <p>limited to, x-ray, laboratory, or pathology reports; (8) Signed informed consent form; (9) Evidence of advanced directives, if applicable; (10) Operative record; (11) Anesthesia record, if applicable; and (12) Consultation record, if applicable.</p> <p>(D) Discharge data: (1) Final diagnosis; (2) Procedures and surgeries performed; (3) Condition upon discharge; (4) Post-treatment care and instructions; and (5) Attending physician's, podiatrist's or dentist's signature.</p> <p>(E) Other information required by law.</p> <p>This Rule is not met as evidenced by: Based on record reviews, policy review, and staff interviews, the facility failed to ensure 5 of 5 sampled patients' (Patients #1-#5) medical records contained history and physicals, family medical history, physical examinations, times medications were administered, evidence the patient either declined or received a copy of the ultrasound, the time the patient/guardian signed the consent for the specific procedure, and a witness signature on the consent. The facility performed a total of 2694 procedures in the most recent twelve months.</p> <p>Findings include:</p> <p>On 10/23/15, a review was conducted for five patients (#1 through #5) who received a surgical procedure in the facility. Each of these five patients' medical records did not have documentation of a history and physical, family medical history, a physical examination by the physician immediately prior to the procedure, and</p>	C 255		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 255	<p>Continued From page 7</p> <p>whether the patient declined or chose to receive a copy of the ultrasound. The consents were not specific to the type of service performed (either a surgical or medical). Patients #1, #2, #3, #4, and #5's medical record did not have a witness signature and time the patient and/or guardian signed the consent.</p> <p>The patients' medical records revealed the following:</p> <p>a) Patient #1(minor) received a surgical procedure on 10/02/15. The medical record did not have the time a vaginal dilator was administered and removed by the physician, and the consent for the dilator did not have a time the patient signed the consent. The consent did not have a time the patient signed, nor was there a witness signature.</p> <p>b) Patient #2 received a medical procedure on 10/21/15. The medical record did not have what time the consent was obtained for the medical procedure, nor what time the medication was administered. This finding was confirmed with Staff A on 10/22/15 at 9:15 AM.</p> <p>c) Patient #3 received a surgical procedure on 10/03/15.</p> <p>d) Patient #4 received a surgical procedure on 10/14/15.</p> <p>e) Patient #5 received a surgical procedure on 09/26/15.</p> <p>Interview with Staff A on 10/22/15 at 9:05 AM confirmed Patients #1 through #5's medical records did not have a history and physical, a family history, a time the patient signed the</p>	C 255		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 255	<p>Continued From page 8</p> <p>consent, and a witness signature on the consents. Staff A confirmed there was no documentation of a physician evaluation of the patients immediately prior to the procedure. Staff A confirmed the facility needs to add a time for when the medications are administered. The aforementioned patients' medical charts contained an ultrasound report and documented the patient had been offered an opportunity to view the active ultrasound image, a physical picture of the the ultrasound image, an opportunity to visualize the heartbeat, if detected, and an ectopic information sheet if the ultrasound is inconclusive, but the medical charts did not have documentation of whether the patients chose any of these items. Staff A confirmed the lack of facility policies for required documentation in the patients' medical records.</p> <p>These finding were confirmed with Staff A on 10/22/15 at 4:00 PM.</p>	C 255		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/30/2015
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NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP	STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304
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(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 Licensure Compliance Inspection and Third Post Inspection Revisit to the 10/10/13 Licensure Compliance Inspection. Administrator: Carol Westfall, Executive Director County: Summit Number of ORs: One The following violations are issued as a result of the licensing compliance inspection completed on 1/30/15.	{C 000}		
{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, interview and policy review, the facility failed to maintain a safe and sanitary environment. This could potentially affect all patients in the facility. A total of 1,382 procedures were performed in the most recent twelve months. There were no procedures occurring in the facility during the inspection. Findings include: On 01/30/15 between 9:20 AM and 9:50 AM, a tour was conducted with Staff A. During the tour, the following was observed and confirmed with Staff A: On the second floor: a) The ceiling air grill in the staff/patient bathroom	{C 139}		

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

TITLE



(X6) DATE

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/30/2015
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 139}	Continued From page 1 was observed with a heavy coating of dust and dirt. Staff A used a feather duster and the dust was easily removed on 01/30/15 at 9:45 AM. On the first floor: b) The laboratory area contained one 16 ounce bottle of 70% Rubbing Alcohol under the sink. The Rubbing Alcohol lot # was 31263 and the bottle had an expiration date of 06/2013. The facility's Vent Cleaning policy stated all ceiling vents will be cleaned monthly. The facility's Sink Storage policy stated do not put anything under the sinks in patient areas.	{C 139}		
{C 241}	O.A.C. 3701-83-20 (B) OR & Recovery Room Equipment Each ASF shall have the following equipment accessible to the operating suite and recovery area: (1) Adequate resuscitation equipment: (a) ASFs providing surgical procedures under topical and local infiltration blocks with or without oral or intramuscular preoperative sedation shall have: airways, bag mask respirator, oxygen source, suction equipment, and age-appropriate resuscitative drugs; (b) ASFs providing surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs or providing surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have: airways, endotracheal tubes, laryngoscope, oxygen delivery capability under positive pressure, suction equipment, and suitable resuscitative drugs.	{C 241}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/30/2015
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 241}	<p>Continued From page 2</p> <p>(2) Appropriate monitoring equipment: (a) Each ASF shall have size-specific blood pressure apparatus and stethoscopes, electrocardiogram, oscilloscopes and when pediatric patients are treated, size-specific emergency equipment and medications; (b) ASFs performing surgical procedures in conjunction with oral, parenteral, or intravenous sedation or under analgesic[sic] or dissociative drugs, or performing surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have a defibrillator, pulse oximeter with alarm, and temperature monitor. (c) ASFs using inhalation anesthesia shall have an anesthesia machine.</p> <p>(3) Each ASF shall have suitable surgical instruments customarily available for the planned surgical procedure in the operating suite.</p> <p>(4) Each ASF shall have in the recovery room, an emergency call system that is connected electronically, electrically by radio transmission or in a like manner and that effectively alerts staff.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and policy review, the facility failed to ensure the list of resuscitative drugs for the emergency crash cart was monitored in accordance with the facility's policy. This could potentially affect all patients in the facility. A total of 1,382 procedures were performed in the most recent twelve months. There were no procedures occurring in the facility during the inspection.</p>	{C 241}		

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NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304			
(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 241}	<p>Continued From page 3</p> <p>Findings include:</p> <p>A tour was conducted in the facility on 1/30/15 between 9:20 AM and 9:50 AM with Staff A. Observation of the emergency crash cart revealed multiple drugs and supplies for the use in a cardiac resuscitative emergency. The crash cart log was observed. The log had not been reviewed by the facility staff during 11/2014, 12/2014 and 1/2015.</p> <p>This finding was shared with Staff A on 1/30/15 at 9:30 AM and confirmed.</p> <p>The facility's Inspection of Drug Storage Area policy was reviewed. The policy stated the nursing director or designee conducts, at least monthly, inspections of all areas where medications that are administered are stored, to assure quality control.</p>	{C 241}			

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NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 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		
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		

Ohio Department of Health

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

TITLE



(X6) DATE

01/27/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/29/2016
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
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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 on 11/29/16 at 5:30 PM.	C 104		
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		

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NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223			
(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 114	<p>Continued From page 2</p> <p>(2) Each patient shall be allowed to refuse or withdraw consent for treatment;</p> <p>(3) Each patient shall have access to his or her medical record, unless access is specifically restricted by the attending physician for medical reasons;</p> <p>(4) Each patient's medical and financial records shall be kept in confidence; and</p> <p>(5) Each patient shall receive, if requested, a detailed explanation of facility charges including an itemized bill for services received.</p> <p>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.</p> <p>Findings include:</p> <p>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'</p>	C 114			

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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		

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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		

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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 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		

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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		

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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 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		

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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 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:	C 139		

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C 139	<p>Continued From page 9</p> <p>Based on observations, review of facility documentation, and staff interviews, it was determined the facility failed to be maintained in a 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.</p> <p>Findings include:</p> <p>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."</p> <p>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.</p> <p>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"</p>	C 139		

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C 139	Continued From page 10 specimens. When interviewed as to whether the facility was monitoring the temperature of the freezer, Staff B confirmed there was currently no 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	C 150		

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C 150	Continued From page 11 and performance improvement program (QAPI) for monitoring and evaluating the quality of patient care, and to improve patient care and resolve 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 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		

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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 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.	C 153		

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C 153	Continued From page 13 This Rule is not met as evidenced by: Based on review of governing body minutes, 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 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	C 202		

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C 202	Continued From page 14 academic or vocational course completion. This Rule is not met as evidenced by: 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 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.	C 213		

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C 213	Continued From page 15 This Rule is not met as evidenced by: 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 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.	C 222		

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C 222	Continued From page 16 This Rule is not met as evidenced by: Based on personnel file review it was determined 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 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	C 225		

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NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
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C 226	Continued From page 18 (1) An established system of records sufficient for the director to ascertain that all individuals 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 266	O.R.C. 3702.30 (B) Infection Control Program	C 266		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/29/2016
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 266	<p>Continued From page 19</p> <p>An ambulatory surgical facility shall maintain an infection control program by creating and administering a plan designed to prevent, identify, 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.</p> <p>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.</p> <p>Findings include:</p> <p>On 11/29/16 at 5:30 PM, a review was completed of facility documentation that included all of the Governing Body minutes.</p> <p>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</p>	C 266		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/29/2016
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 266	Continued From page 20 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. Staff A was present during this interview with Staff B.	C 266		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/29/2016
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGION		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Initial Comments</p> <p>Licensure Compliance Inspection</p> <p>Administrator: Jerry Lawson</p> <p>County: Hamilton</p> <p>3 ORs/ Procedure Rooms</p> <p>Planned Parenthood Southwest Ohio Region is in compliance with the rules for Ambulatory Surgery Facility, O.A.C. 3701-83, at the time of the Licensure Compliance Inspection completed on 11/29/16.</p>	C 000		

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/01/2016
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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	<p>Initial Comments</p> <p>Licensure Compliance Inspection</p> <p>Administrator: Jamie Hamilton</p> <p>County: Franklin</p> <p>2 ORs/ Procedure Rooms</p> <p>Planned Parenthood East Health Center is in compliance with the rules for Ambulatory Surgery Facility, O.A.C. 3701-83, at the time of the Licensure Compliance Inspection completed on 12/01/16.</p>	C 000		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/08/2016
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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	<p>Initial Comments</p> <p>Complaint Inspection</p> <p>Complaint Number OH00082959</p> <p>Administrator: Chrissie France, Executive Director</p> <p>County: Cuyahoga</p> <p>Number of Procedure Rooms: 5</p> <p>Preterm is in compliance with the rules for ASF - O.A.C. 3701-83 at the time of the Complaint completed on 03/08/16.</p>	C 000		

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

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Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/01/2016
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 Licensure Compliance Inspection County: Cuyahoga Administrator: Marla Bridges Six Operating Rooms The following violations are issued as a result of the compliance inspection completed on 12/01/16.	C 000		
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 review of staff personnel files, physician credentialing files and staff interview and confirmation, the facility failed to follow the developed tuberculosis control plan of the facility.	C 120		

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/01/2016
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 120	Continued From page 1 The facility was to retain documentation evidencing compliance with this paragraph and was to furnish such documentation to the director upon request. One of two physician credentialing files (Physician O) and two of eight staff personnel files(Staff I and J) were affected. The facility performed a total of 3139 procedures between 12/01/15 and 11/30/16. Findings include: On 11/20/16 and 12/01/16, physician credentialing files and staff personnel files were reviewed. Staff I was hired on 08/16/16. There was no documented evidence that Staff I had been tested for exposure to tuberculosis. Staff J was hired 07/19/16. There was no documented evidence that Staff J had been tested for exposure to tuberculosis. Staff O began to provide patient care in January 2016. The credentialing file revealed the most recent documented test for tuberculosis exposure was dated 05/15/15. Interview of Staff A on 12/10/16 between 9:00 A.M. and 12:00 P.M. revealed the facility policy was that staff were to receive annual testing for tuberculosis exposure. Staff A confirmed there was no documented evidence the tuberculosis testing was conducted in the past year.	C 120		
C 132	O.A.C. 3701-83-09 (D) Infection Control Policies & Procedures Each HCF shall establish and follow written infection control policies and procedures for the surveillance, control and prevention and reporting of communicable disease organisms by both the contact and airborne routes which shall be	C 132		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/01/2016
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 132	<p>Continued From page 2</p> <p>consistent with current infection control guidelines, issued by the United States centers for disease control. The policies and procedures shall address:</p> <p>(1) The utilization of protective clothing and equipment;</p> <p>(2) The storage, maintenance and distribution of sterile supplies and equipment;</p> <p>(3) The disposal of biological waste, including blood, body tissue, and fluid in accordance with Ohio law;</p> <p>(4) Standard precautions/body substance isolation or equivalent; and</p> <p>(5) Tuberculosis and other airborne diseases.</p> <p>This Rule is not met as evidenced by: Based on observations, review of policy, and staff interviews, the facility failed to follow their policy for multi-dose medication vials. This involved one injectable medication (Lidocaine). This was observed on both survey days, and could potentially affect all patients in the facility. The facility performed a total of 3139 procedures between 12/01/15 and 11/30/16.</p> <p>Findings include:</p>	C 132		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/01/2016
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 132	<p>Continued From page 3</p> <p>On 12/01/16, at 2:00 PM, a review of the facility's policy titled Multi-dose Vials (MDVS) approved 07/15, contained the following instructions: "5. Keep multi-dose vials away from the immediate patient environment. Restrict them to a centralized medication area or for a single patient use. If a multi-dose vial enters the immediate patient treatment area, it should be dedicated to that patient only and discarded after use."</p> <p>On 11/30/16 between 11:35 A.M. and 12:10 P.M. and 12/01/16, a caddy used by staff was observed containing multi-dose vials of Lidocaine solution. On 12/01/16, at 8:45 AM, in the presence of Staff A, E, and F, a portable caddy was observed sitting on the nursing station. The caddy contained four multi-dose vials of Lidocaine medication. Observation of each vial label revealed each vial contained Lidocaine 10 mg/ml and contained multiple doses per interview with Staff A. Staff E and Staff F stated an HCA (employee) took the portable caddy with the Lidocaine vials into a different operating room for staff to draw up the Lidocaine solution for the patient. The remaining solution in the vials was placed back into the container (after wiping off the container with Hydrogen Peroxide wipes per Staff A's verbal statement), and then were carried into the operating rooms multiple times until the medication vials were empty.</p> <p>During an interview with Staff A and B at the time of the policy review, Staff B stated the facility recognized in September 2016 a need to change the way Lidocaine multi-dose vials were being used and revealed the facility was in process of updating their policies, however this had not changed yet.</p>	C 132		

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
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C 143	Continued From page 4	C 143		
C 143	<p>O.A.C. 3701-83-11 (A) Medical Records</p> <p>Each HCF shall maintain a medical record for each patient that documents, in a timely manner and in accordance with acceptable standards of practice, the patient's needs and assessments, and services rendered. Each medical record shall be legible and readily accessible to staff for use in the ordinary course of treatment.</p> <p>This Rule is not met as evidenced by: Based on review of agency policy and procedure, review of patient medical records and staff interview and confirmation, the facility failed to maintain a medical record for each patient that documented, in a timely manner and in accordance with acceptable standards of practice, the patients' needs and assessments, and services rendered. Five of seven sampled patient medical records (Patients # 1, #4, #5, #6 and #7) was affected. The facility performed a total of 3139 procedures between 12/01/15 and 11/30/16.</p> <p>Findings include:</p> <p>On 12/01/16, a review of electronic medical records was conducted for Patients #1, #4, #5, #6, and #7. These medical records reviews revealed the following incomplete documentation:</p> <p>1. Patient #4 had a surgical abortion on 11/10/16 and received intravenous (IV) sedation and cervical dilator medication. The patient received</p>	C 143		

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
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C 143	<p>Continued From page 5</p> <p>an anti-nausea medication during during that date; however, the medical record did not have documentation the time the medication was administered.</p> <p>The pre-procedure visit on 10/20/16 did not have an electronic signature by the physician for the Abortion history questions and Medical/Surgical sections of the medical record. An interview with Staff C on 12/01/16 at 4:06 PM confirmed these sections had not been electronically signed by the physician, and stated each section should be reviewed and signed electronically by the physician.</p> <p>2. Patient #5 had a surgical abortion on 08/11/16 and received an antibiotic medication in pre-op and three doses an an anti-nausea medication post-operatively. The electronic medication record did not have documentation of the medication administration times.</p> <p>3. Patient #6 (minor patient) had a surgical abortion on 03/25/16 and was transferred to the hospital via emergency squad from the operating room for excessive bleeding after the procedure. Although the patient's guardian was present at the time of admission, the medical record lacked documentation the guardian was made aware of the emergency transfer. The medical record did not have documentation of the time the patient left the facility in the emergency squad.</p> <p>4. Patient #7 was scheduled for a surgical abortion on 02/05/16. The patient received a dose of an anti-nausea medication on that date in the facility; however, the medical record did not have documentation of the time the medication was administered by the Registered Nurse. During the abortion procedure, the</p>	C 143		

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C 143	Continued From page 6 surgeon/physician made a decision to send the patient to the hospital via emergency squad. Although the patient was accompanied by a driver, there was no documentation of any notification of the emergency squad to the hospital. At the hospital, the patient was determined to have an ectopic pregnancy and surgery was done. 5. Patient #1 was scheduled for a surgical abortion on 11/10/16. Pre-operative medication included an oral anti-anxiety medication. The medical record documented the physician ordered the medication to be given 30 minutes prior to the procedure. Review of the medical record revealed there was no documentation as to when the medication was given to the patient. These aforementioned patients' medical record reviews were confirmed with Staff C at the time of the medication record review. On 12/01/16 at 5:15 PM an interview with Staff A confirmed the facility used the following policy for medical record documentation was Administrative Chapter 5: Medical Records, Documentation, and Reporting Requirements, revised 07/01/15 which contained the following documenting requirements: "5.2 Documentation in the Medical Record, 5.2.1, II, Documentation must be performed in accordance with professional standards and any applicable laws/regulations, It must A. B legible, factual, complete, concise, and professional and E. Be signed with the full name of the signer including credentials for licensed staff and titles for non-licensed staff."	C 143		
C 152	O.A.C. 3701-83-12 (C) Q A & Improvement Requirements	C 152		

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C 152	<p>Continued From page 7</p> <p>The quality assessment and performance improvement program shall do all of the following:</p> <p>(1) Monitor and evaluate all aspects of care including effectiveness, appropriateness, accessibility, continuity, efficiency, patient outcome, and patient satisfaction;</p> <p>(2) Establish expectations, develop plans, and implement procedures to assess and improve the quality of care and resolve identified problems;</p> <p>(3) Establish expectations, develop plans, and implement procedures to assess and improve the health care facility's governance, management, clinical and support processes;</p> <p>(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;</p> <p>(5) Document and report the status of quality assessment and improvement program to the governing body every twelve months;</p> <p>(6) Document and review all unexpected complications and adverse events, whether serious injury or death, that arise during an operation or procedure; and</p> <p>(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</p>	C 152		

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C 152	<p>Continued From page 8</p> <p>and report findings. Any pattern that might indicate a problem shall be investigated and remedied, if necessary.</p> <p>This Rule is not met as evidenced by: Based on review of quality assurance documentation, policy review, and staff interview, the facility failed to review 1 of 2 adverse events (hospital transfer). This affected one of two patients (Patients #6) who required transfer to a hospital. The facility performed a total of 3139 procedures between 12/01/15 and 11/30/16.</p> <p>Findings include:</p> <p>On 12/01/16 between 2:09 PM and 3:22 PM, a review was conducted of the Quality Assurance Program (QA) documentation with Staff B. A medical record review was also conducted on 12/01/16 which revealed that Patient #6 was transferred to the hospital on 03/25/16 for excessive bleeding after receiving a surgical abortion. The Quality Assurance program did not have documentation of a review of this transfer.</p> <p>The interview with Staff B revealed the review is through an electronic reporting system (AIMS incident report) of transfers, which is considered an adverse event. Staff B stated he/she was made aware, and had documentation off-site, but confirmed there was no review of the incident (hospital transfer) by the QA committee.</p> <p>Staff B verified the facility follows the policy titled Incident and Occurrence Reporting, last approved 05/20/15, which contained the following</p>	C 152		

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NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 152	Continued From page 9 documentation: "Certain events should be reported by phone immediately to the Director of Risk & quality Management or, in his/her absence, the COO. Instances that fall into this category include the following: The arrival of legal papers, e.g., summons & complaint, or a subpoena. Any Medial emergency resulting in transportation of a patient, staff member or invited guest to a hospital." Staff B verified Patient #6's hospital transfer had not, but should have been reviewed by the QA committee.	C 152		
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: Based on patient medical record review and staff interview and confirmation, the facility failed to ensure that the patient or patient's representative acknowledged, in writing, receipt of the physician's written discharge instructions. Five of seven patient medical records reviewed were affected. The facility performed a total of 3139 procedures between 12/01/15 and 11/30/16. Findings include: On 12/01/16 five medical records were reviewed	C 213		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/01/2016
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 213	Continued From page 10 for patients who had received medical or surgical abortion procedures. Interview of Staff C during the record reviews revealed that patients were provided written post-procedural information prior to discharge. The written information included how to determine if the amount of bleeding was to be expected, what to do and where to call if there were any problems, when to return to normal activities and emotional support if the patient needed to talk with someone. Review of the electronic medical record revealed there was no documented evidence the patients received the written information at the time of discharge. Staff C confirmed there was no place in the electronic record where the patient or patient's representative noted written receipt of the discharge instructions.	C 213		
C 235	O.A.C. 3701-83-19 (F) Documented Informed Consent Prior to the surgery, the physician, podiatrist, or dentist, shall obtain a statement documenting informed consent, signed by the patient or patient representative, for the performance of the specific surgical procedure or procedures. This statement shall be made part of the patient's medical record. The ASF shall ensure that informed consents for surgical procedures have been signed. This Rule is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure one of seven sampled medical records (Patient #5) contained	C 235		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/01/2016
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
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C 235	<p>Continued From page 11</p> <p>documentation of informed consent by the patient for a surgical abortion. The facility performed a total of 3139 procedures between 12/01/15 and 11/30/16.</p> <p>Findings include:</p> <p>On 12/01/16 a review was conducted of Patient #5's medical record. This review revealed the patient was a minor, and the patient's guardian signed the informed consent on 08/10/16 for the patient to have surgical abortion. The informed consent did not have evidence of the patient's signature. The patient had a surgical abortion in this facility on 08/11/16.</p> <p>On 12/01/16 at 6:00 PM, in an interview, Staff A confirmed the informed consent was not signed by the patient but by the guardian. Staff A stated an audit of this patient's chart by the facility revealed the patient did not sign her consents which violated facility policy. Staff A stated although the patient is a minor, she should have also signed the consents along with the guardian. Staff A stated this was considered egregious that the patient did not sign the consents, and stated the staff member who obtained informed consent by the patient's guardian, and not the patient, was terminated as a result.</p>	C 235		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/01/2016
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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	<p>Initial Comments</p> <p>Licensure Compliance Inspection</p> <p>Administrator: Chrisse France</p> <p>County: Cuyahoga</p> <p>Number of Procedure Rooms: 5</p> <p>Preterm is in compliance with the rules for Ambulatory Surgical Facility - O.A.C. 3701-83 at the time of the Licensure Compliance Inspection completed on 12/01/16.</p>	C 000		

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/15/2016
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 Complaint Inspection Complaint Number OH00085169 Administrator: Carol Westfall County: Summit Number of ORs: One The following violations are issued as a result of the Licensure Compliance Inspection inspection completed on 07/15/16.	C 000		
C 143	O.A.C. 3701-83-11 (A) Medical Records Each HCF shall maintain a medical record for each patient that documents, in a timely manner and in accordance with acceptable standards of practice, the patient's needs and assessments, and services rendered. Each medical record shall be legible and readily accessible to staff for use in the ordinary course of treatment. This Rule is not met as evidenced by: Based on medical record review, policy review and interview, the facility failed to maintain a medical record for each patient that documents, in a timely manner and in accordance with acceptable standards of practice, the patient's needs and assessments, and services rendered for 14 (Patient #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, and #14) of 14 medical records reviewed. This had the potential to affect	C 143		

Ohio Department of Health
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Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/15/2016
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 143	<p>Continued From page 1</p> <p>all of the patients undergoing procedures at the facility. The facility performs approximately 99 procedures a month.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The controlled substance log from an undated controlled substance log showed Patient #1 received Demerol. The medical record showed Patient #1 had a procedure during the first trimester on 09/12/15 and did not contain documentation of the Demerol administration to Patient #1. 2. The controlled substance log from an undated controlled substance log showed Patient #2 received Demerol. The medical record showed Patient #2 had a procedure during the first trimester on 09/12/15 and did not contain documentation of the Demerol administration to Patient #2. 3. The controlled substance log from an undated controlled substance log showed Patient #3 received Demerol. The medical record showed Patient #3 had a procedure during the first trimester on 09/12/15 and did not contain documentation of the Demerol administration to Patient #3. 4. The controlled substance log from an undated controlled substance log showed Patient #4 received Demerol. The medical record showed Patient #4 had a procedure during the second trimester on 09/12/15 and did not contain documentation of the Demerol administration to Patient #4. 5. The controlled substance log from an undated controlled substance log showed Patient #5 	C 143		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/15/2016
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C 143	<p>Continued From page 2</p> <p>received Demerol. The medical record showed Patient #5 had a procedure during the first trimester on 09/26/15 and did not contain documentation of the Demerol administration to Patient #5.</p> <p>6. The controlled substance log from an undated controlled substance log showed Patient #6 received Demerol. The medical record showed Patient #6 had a procedure during the first trimester on 09/26/15 and did not contain documentation of the Demerol administration to Patient #6.</p> <p>7. The controlled substance log from an undated controlled substance log showed Patient #7 received Demerol. The medical record showed Patient #7 had a procedure during the first trimester on 09/26/15 and did not contain documentation of the Demerol administration to Patient #7.</p> <p>8. The controlled substance log from an undated controlled substance log showed Patient #8 received Demerol. The medical record showed Patient #8 had a procedure during the first trimester on 09/26/15 and did not contain documentation of the Demerol administration to Patient #8.</p> <p>9. The controlled substance log from an undated controlled substance log showed Patient #9 received Demerol. The medical record showed Patient #9 had a procedure during the first trimester on 10/17/15 and did not contain documentation of the Demerol administration to Patient #9.</p> <p>10. The controlled substance log from an undated controlled substance log showed Patient #10</p>	C 143		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/15/2016
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C 143	<p>Continued From page 3</p> <p>received Demerol. The medical record showed Patient #10 had a procedure during the first trimester on 10/17/15 and did not contain documentation of the Demerol administration to Patient #10.</p> <p>11. The controlled substance log from an undated controlled substance log showed Patient #11 received Demerol. The medical record showed Patient #11 had a procedure during the second trimester on 10/17/15 and did not contain documentation of the Demerol administration to Patient #11.</p> <p>12. The controlled substance log from an undated controlled substance log showed Patient #12 received Demerol. The medical record showed Patient #12 had a procedure during the first trimester on 10/17/15 and did not contain documentation of the Demerol administration to Patient #12.</p> <p>13. The controlled substance log from an undated controlled substance log showed Patient #13 received Demerol. The medical record showed Patient #13 had a procedure during the first trimester on 10/17/15 and did not contain documentation of the Demerol administration to Patient #13.</p> <p>14. The controlled substance log from an undated controlled substance log showed Patient #14 received Demerol. The medical record showed Patient #14 had a procedure during the first trimester on 09/26/15 and did not contain documentation of the Demerol administration to Patient #14.</p> <p>15. On 07/15/16 at 2:17 PM, Staff O confirmed the medical records of the 14 patients did not</p>	C 143		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/15/2016
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C 143	<p>Continued From page 4</p> <p>contain documentation of Demerol administration and confirmed Staff R was the circulating nurse on each procedure. Staff O reported the Demerol administration would have been documented on the medical record copies provided during the survey had the Demerol been administered.</p> <p>16. The facility's Objectives of the Nursing Service policy # 01-15 was reviewed. The policy stated nursing service carries out its function consistent with the scope of nursing as defined by the Ohio Board of Nursing, and within the practices legal in the State of Ohio. Objectives of the policy included to develop and maintain an effective system of clinical and administrative nursing records and reports and assist in the determination of the facility needs, supplies, equipment as well as a system for evaluation and control.</p> <p>17. The facility's Medication Administration policy # 16-15 was reviewed. The policy stated all medications administered to patients shall be administered by a nurse and documented appropriately in the patient's medical record. A medication shall be ordered, administered and recorded according to accepted standards of practice. The Director of Nursing reports any noncompliance to these policies to the Medical Director and the Quality Assurance Committee. Documentation shall include date and time given, medication given, dosage and rout of administration, and initials of the person administering the drug.</p> <p>18. The controlled substance logs indicated Patient #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13 and #14 received Fentanyl. The medical record did not contain evidence of Fentanyl having been administered to Patient #1,</p>	C 143		

Ohio Department of Health
STATE FORM

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/15/2016																																																																																																				
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C 231	<p>Continued From page 6</p> <p>1. The facility's controlled substance logs were reviewed. The documented counts for the Demerol were as follows:</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Starting</th> <th>Add</th> <th>Given</th> <th>End Count</th> </tr> </thead> <tbody> <tr> <td>08/14/15</td> <td>0</td> <td>150</td> <td>2</td> <td>148</td> </tr> <tr> <td>08/15/15</td> <td>148</td> <td></td> <td>1</td> <td>147</td> </tr> <tr> <td>08/21/15</td> <td>147</td> <td></td> <td></td> <td></td> </tr> <tr> <td>08/22/15</td> <td>147</td> <td></td> <td>3</td> <td>144</td> </tr> <tr> <td>08/28/15</td> <td>144</td> <td></td> <td></td> <td></td> </tr> <tr> <td>08/29/15</td> <td>144</td> <td></td> <td>4</td> <td>4</td> </tr> <tr> <td>No Date</td> <td>140</td> <td></td> <td>4</td> <td>136</td> </tr> <tr> <td>No Date</td> <td>135</td> <td></td> <td>5</td> <td>130</td> </tr> <tr> <td>09/19/15</td> <td>125</td> <td></td> <td></td> <td>125</td> </tr> <tr> <td>09/25/15</td> <td>125</td> <td></td> <td></td> <td>1</td> </tr> <tr> <td>09/26/15</td> <td>110</td> <td></td> <td>5</td> <td>105</td> </tr> <tr> <td>No Date</td> <td>105</td> <td></td> <td>2</td> <td>103</td> </tr> <tr> <td>*10/10/15</td> <td>103</td> <td></td> <td>3</td> <td>85</td> </tr> <tr> <td>*No Date</td> <td>85</td> <td></td> <td>5</td> <td>75</td> </tr> <tr> <td>10/24/15</td> <td>75</td> <td></td> <td></td> <td>75</td> </tr> <tr> <td>10/31/15</td> <td>75</td> <td></td> <td>0</td> <td>60</td> </tr> <tr> <td>No Date</td> <td>60</td> <td></td> <td>5</td> <td>55</td> </tr> <tr> <td>11/14/15</td> <td>55</td> <td></td> <td></td> <td>55</td> </tr> <tr> <td>*11/20/15</td> <td>55</td> <td></td> <td></td> <td>0</td> </tr> </tbody> </table> <p>*10 vials found broken in new unopened box *5 broken *all ampules in two boxes unopened and 5 unopened broken - one box was sealed but when opened had no contents - No free fluid (all packaging dry) - Lot #4090903A</p> <p>2. The facility's calendar of procedure days was reviewed. The review showed procedures were conducted on the following days: 08/14/15 08/15/15 08/21/15 08/22/15</p>	Date	Starting	Add	Given	End Count	08/14/15	0	150	2	148	08/15/15	148		1	147	08/21/15	147				08/22/15	147		3	144	08/28/15	144				08/29/15	144		4	4	No Date	140		4	136	No Date	135		5	130	09/19/15	125			125	09/25/15	125			1	09/26/15	110		5	105	No Date	105		2	103	*10/10/15	103		3	85	*No Date	85		5	75	10/24/15	75			75	10/31/15	75		0	60	No Date	60		5	55	11/14/15	55			55	*11/20/15	55			0	C 231		
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Ohio Dept Health

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NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
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C 231	<p>Continued From page 7</p> <p>08/28/15 08/29/15 09/04/15 09/05/15 09/11/15 09/12/15 09/18/15 09/19/15 09/25/15 09/26/15 10/03/15 10/09/15 10/10/15 10/16/15 10/17/15 10/23/15 10/24/15 10/30/15 10/31/15</p> <p>3. The controlled substance logs did not contain evidence of the facility management being aware or notified of the broken vials or missing vials of Demerol, except for the discrepancy on 11/20/15.</p> <p>4. On 07/15/16 at 3:10 PM, Staff L was interviewed. Staff L confirmed the controlled substance count sheets were missing or not consistently completed on days when procedures were performed.</p> <p>5. On 07/15/16 at 10:31 AM, Staff K was interviewed via telephone. Staff K reported the facility had a problem with medications awhile back involving Staff Q and Staff R. Staff K reported Fentanyl came up missing from the operating room, Staff K reported Staff Q, and Staff R tried to cover up the missing Fentanyl by not reporting the empty Fentanyl vials to Staff K and by marking the medications as wasted. Staff</p>	C 231		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/15/2016
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C 231	<p>Continued From page 8</p> <p>K reported Staff Q has been gone from the facility since 11/03/15 and Staff R left the facility on 12/3/15.</p> <p>6. On 07/15/16 at 10:38 AM, Staff K was interviewed. Staff K reported calling the manufacturer to report medications were allegedly damaged on arrival and is awaiting a return call. Staff Q and Staff R reported the vials came empty. Staff K stated no drug screen was performed on Staff Q and Staff R at the time of this occurrence, but that random drug screens had been performed in the past on Staff Q and Staff R. Staff A reported that the facility fired Staff Q and Staff R and Staff Q and Staff R's employment was termed. Staff K reported Staff Q and Staff R are working for plastic surgeons now and the facility where Staff Q and Staff R are currently working have reportedly had to install cameras now because items have come up missing. Staff K reported the facility never had proof of anything being diverted. Staff K reported the vials, when opened, were empty and Staff Q and Staff R wrote them off as wasted, instead of reporting the incident to the facility. Staff K stated missing items were documented on the controlled substance log and there was no additional report. Staff K denied making a referral to the Ohio Board of Nursing regarding Staff Q and Staff R.</p> <p>7. On 07/15/16 at 12:45 PM, Staff O, Staff N and Staff M were interviewed. Staff O, Staff N, and Staff M reported there used to be problems with controlled substances, but none since Staff R left.</p> <p>8. On 07/15/16 at 1:15 PM, observation of a box of Demerol, which was locked in a safe, was conducted with Staff P present. All 25 of the vials appeared to be empty. The glass lids had been cracked off/open and the silver colored overlay on</p>	C 231		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/15/2016
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 231	<p>Continued From page 9</p> <p>the package of 25 appeared not to be intact on some parts of the package. Per Staff P, the facility is awaiting PCS pharmacy to contact them for return/replacement. Staff P reported the patients would not even receive Demerol unless they were in their second trimester.</p> <p>9. On 07/15/16 at 1:30 PM, Staff O verified that the controlled substance log counts of the Demerol were off from August 2015 through November 2015.</p> <p>10. On 07/15/16 at approximately 2:00 PM, Staff P was interviewed and reported having a party on 07/04/15. Staff P stated staff reported to Staff P at the party about the Fentanyl issues. Staff Q and Staff R had told Staff N not to report to Staff P about finding the empty Fentanyl vials. Staff Q and Staff R reported to Staff N that they would handle it. Staff Q and Staff R never reported the Fentanyl to Staff K or Staff P and only documented the medication as wasted on the log.</p> <p>11. The personnel files of Staff Q and Staff R were reviewed. The personnel files did not contain evidence of reeducation on controlled substances or disciplinary action.</p> <p>12. The facility's investigative records and controlled substance logs did not contain completed controlled drug discrepancy forms for the Demerol discrepancies.</p> <p>13. Staff K provided a copy of the facility's investigation reports involving controlled substances. The reports read as follows:</p> <p>"07/07/15, Staff P called Staff K to the facility to tell Staff K that Staff M and Staff N told Staff P that there were drugs missing and Staff Q</p>	C 231		

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NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
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C 231	<p>Continued From page 10</p> <p>covered it up by writing them off as missing drugs. The drugs were Fentanyl. Staff K immediately called Staff Q in and told Staff Q you cannot write off missing drugs as wasted just because you don't know what happened to them. Staff K talked to Staff R and Staff R verified that Staff Q and Staff R did write them off as missing drugs. Staff N told me that when Staff N came in the morning of 06/26/15 Staff N found the empty vials. Staff K immediately called the alarm company to have all the locks changed and new fobs issued to top employees only. Staff K went into detail with Staff Q about this incident and told Staff Q we had to investigate further." Staff K contacted the facility's certified registered nurse anesthetist to come in to do a count to see what was missing. "July 18th Staff Q resigned Staff Q's position as Director of Nursing and said Staff Q could not take this place any longer." Staff R then filled in as director of nursing until the facility could get a qualified person to fill the position. New locks were installed on 07/09/15 and 07/10/15. The facility hired Staff L on 11/28/15 because Staff R "was not taking any responsibility and the facility began to miss other supplies." The facility gave Staff R off on 11/28/15 and Staff R did not come back, so Staff R "was considered fired by company policy".</p> <p>14. An additional investigative report was reviewed and stated on 11/21/15, "Staff T was cleaning out the cabinets in the operating room and found a box of empty vials of Demerol. Staff T immediately brought them to Staff K and Staff K felt like this was an old box but not being able to verify how old, Staff K went down to speak to Staff R and Staff R just acted like Staff R had no idea either where it came from. Staff K told Staff R that Staff K would call PSS to see if they could tell when it was shipped and why all the vials</p>	C 231		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/15/2016
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP			STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 231	<p>Continued From page 11</p> <p>were empty. We felt that it had been a box that had leaked out and maybe one of the operating room people put it back into the cabinet and then forgot to call on the box.</p> <p>"Staff K contacted PSS on Monday morning and asked them to pick up and replace the medication since it looked like it had been leaked out. There were no visible puncture marks in the caps. The box was then left upstairs for pick up. "</p> <p>"December 11, Staff K noticed the box of empty vials were still in the clinic so Staff K called PSS again. They said they were not going to pick it up and would give us a credit. Staff K told the front desk to keep the empty box under safe keeping in case ever needed again. Staff K could not make a determination as to how long the box had been in the back of that cabinet so Staff K could not put the blame on anyone. Staff R was gone by this time. We have not had any further problems. "</p> <p>15. The investigative reports provided by Staff K included a Confidential Wage/Salary History form for Staff Q. The form stated Staff Q left on 07/18/15 to go to plastics - too much for Staff Q. The report contained a page which stated Staff R left without notice on 12/03/15. The page stated Staff R was in violation of company policies and drug count probation."</p> <p>16. The facility's Medication Discrepancy policy # 16-17 was reviewed. The policy's purpose was to provide a consistent means for documenting the resolution of medication discrepancies. Discrepancy is defined as when the count of a medication at the station differs from the displayed count. The nursing director is to resolve all discrepancies of controlled substances</p>	C 231			

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NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 231	<p>Continued From page 12</p> <p>or some non-controlled medications which he/she identifies and to document this resolution according to established procedure. The drug count will require two users for any discrepancy involving controlled drugs, which cannot be resolved, must be immediately reported to the director of nursing, "PSM" or "PRC". The user is expected to complete a medication administration form as well as a controlled drug discrepancy form. Discrepancies will be noted and resolved with notification of the Director of Nursing, "PSM", or "PRC". Disciplinary action will be enforced for users who are frequently responsible for discrepancies. The user must correct the charges made for discrepancies.</p> <p>17. The controlled substance log from an undated controlled substance log showed Patient #1 received Demerol. The medical record showed Patient #1 had a procedure during the first trimester on 09/12/15 and did not contain documentation of the Demerol administration to Patient #1.</p> <p>18. The controlled substance log from an undated controlled substance log showed Patient #2 received Demerol. The medical record showed Patient #2 had a procedure during the first trimester on 09/12/15 and did not contain documentation of the Demerol administration to Patient #2.</p> <p>19. The controlled substance log from an undated controlled substance log showed Patient #3 received Demerol. The medical record showed Patient #3 had a procedure during the first trimester on 09/12/15 and did not contain documentation of the Demerol administration to Patient #3.</p>	C 231		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/15/2016
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 231	<p>Continued From page 13</p> <p>20. The controlled substance log from an undated controlled substance log showed Patient #4 received Demerol. The medical record showed Patient #4 had a procedure during the second trimester on 09/12/15 and did not contain documentation of the Demerol administration to Patient #4.</p> <p>21. The controlled substance log from an undated controlled substance log showed Patient #5 received Demerol. The medical record showed Patient #5 had a procedure during the first trimester on 09/26/15 and did not contain documentation of the Demerol administration to Patient #5.</p> <p>22. The controlled substance log from an undated controlled substance log showed Patient #6 received Demerol. The medical record showed Patient #6 had a procedure during the first trimester on 09/26/15 and did not contain documentation of the Demerol administration to Patient #6.</p> <p>23. The controlled substance log from an undated controlled substance log showed Patient #7 received Demerol. The medical record showed Patient #7 had a procedure during the first trimester on 09/26/15 and did not contain documentation of the Demerol administration to Patient #7.</p> <p>24. The controlled substance log from an undated controlled substance log showed Patient #8 received Demerol. The medical record showed Patient #8 had a procedure during the first trimester on 09/26/15 and did not contain documentation of the Demerol administration to Patient #8.</p>	C 231		

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NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 231	<p>Continued From page 14</p> <p>25. The controlled substance log from an undated controlled substance log showed Patient #9 received Demerol. The medical record showed Patient #9 had a procedure during the first trimester on 10/17/15 and did not contain documentation of the Demerol administration to Patient #9.</p> <p>26. The controlled substance log from an undated controlled substance log showed Patient #10 received Demerol. The medical record showed Patient #10 had a procedure during the first trimester on 10/17/15 and did not contain documentation of the Demerol administration to Patient #10.</p> <p>27. The controlled substance log from an undated controlled substance log showed Patient #11 received Demerol. The medical record showed Patient #11 had a procedure during the second trimester on 10/17/15 and did not contain documentation of the Demerol administration to Patient #11.</p> <p>28. The controlled substance log from an undated controlled substance log showed Patient #12 received Demerol. The medical record showed Patient #12 had a procedure during the first trimester on 10/17/15 and did not contain documentation of the Demerol administration to Patient #12.</p> <p>29. The controlled substance log from an undated controlled substance log showed Patient #13 received Demerol. The medical record showed Patient #13 had a procedure during the first trimester on 10/17/15 and did not contain documentation of the Demerol administration to Patient #13.</p>	C 231		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/15/2016
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP			STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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 231	<p>Continued From page 15</p> <p>30. The controlled substance log from an undated controlled substance log showed Patient #14 received Demerol. The medical record showed Patient #14 had a procedure during the first trimester on 09/26/15 and did not contain documentation of the Demerol administration to Patient #14.</p> <p>31. On 07/15/16 at 2:17 PM, Staff O confirmed the medical records of the 14 patients did not contain documentation of Demerol administration and confirmed Staff R was the circulating nurse on each procedure. Staff O reported the Demerol administration would have been documented on the medical record copies provided during the survey had the Demerol been administered.</p> <p>32. The facility's Objectives of the Nursing Service policy # 01-15 was reviewed. The policy stated nursing service carries out its function consistent with the scope of nursing as defined by the Ohio Board of Nursing, and within the practices legal in the State of Ohio. Objectives of the policy included to develop and maintain an effective system of clinical and administrative nursing records and reports and assist in the determination of the facility needs, supplies, equipment as well as a system for evaluation and control.</p> <p>33. The facility's Medication Administration policy # 16-15 was reviewed. The policy stated all medications administered to patients shall be administered by a nurse and documented appropriately in the patient's medical record. A medication shall be ordered, administered and recorded according to accepted standards of practice. The Director of Nursing reports any noncompliance to these policies to the Medical Director and the Quality Assurance Committee.</p>	C 231			

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NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP			STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
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C 231	<p>Continued From page 16</p> <p>Documentation shall include date and time given, medication given, dosage and rout of administration, and initials of the person administering the drug.</p> <p>34. The controlled substance log from 08/21/15 showed a beginning count of Fentanyl was 241 vials, with 25 vials wasted, 9 vials administered and an ending count of 207. There was no notation for the reason the 25 vials were wasted.</p> <p>35. The controlled substance log from an undated time around 09/04/15 showed a beginning count of Fentanyl as 178, with 16 vials administered and an end count of 161. The end count should have been 162.</p> <p>36. The controlled substance log from an undated time around 09/05/15 showed a beginning count of Fentanyl as 161 with 4.5 vials administered and an end count of 155. The end count should have been 156 and the form should have shown 1 ml was wasted.</p> <p>37. The controlled substance log from 09/19/15 showed a beginning count of Fentanyl as 155 vials, with 2.8 vials administered and an end count of 150. The end count should have been 152 vials and the form should have shown 1.2 milliliters (ML) were wasted.</p> <p>38. The controlled substance log from 09/26/15 showed the beginning count of Fentanyl was 138. The ending count from the previous count on 09/25/15 was 139. There was no documentation of the discrepancy. The log showed 10 vials were administered and had an ending count of 121. The end count should have been 128.</p> <p>39. The controlled substance log from an undated</p>	C 231			

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C 231	<p>Continued From page 17</p> <p>form around 10/03/15 or 10/09/15 was reviewed. The beginning count of Fentanyl was 121 vials, and showed ".5" was administered 12 times which could have implied half of the 100 mcg/2 ml bottle or 0.5 ml which would have equaled one fourth of each vial. The ending count should have been 115 or 118, instead of the documented 114.</p> <p>40. The controlled substance log from an undated form around 10/16/15 showed a beginning count of Fentanyl was 105, with nine documented vials as administered to patients, and no end count documented. There was a write over for the total administered which appeared to change the count from nine to ten. The next available controlled substance log sheet had a beginning count documented as 95.</p> <p>41. The controlled substance logs indicated Patient #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13 and #14 received Fentanyl. The medical record did not contain evidence of Fentanyl having been administered to Patient #1, #2, #3, #4, #5, #9, #10, #12, #13 and #14.</p>	C 231			

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**

Ohio Department of Health


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

TITLE

STATE FORM

6899

YFMU12



Americans
United
for Life

(X6) DATE

04/10/17

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/15/2017
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 104}	Continued From page 1 Based on interviews and policy review, the governing body failed to develop policies for History and Physicals, consents, re-packaging of medications, pharmacy policies, medical record content, evaluation of patients by a physician immediately before surgery, and reporting of adverse events and complications. This could potentially affect all patients served by the facility. There were 2,434 procedures performed in the calendar year 2016. Findings include: The facility's Policy Manual was reviewed. The manual did not contain policies regarding History and Physicals, Re-Packaging of medications, pharmacy policies, medical record content, evaluation of patients by a physician immediately before surgery, and reporting of adverse events and complications. Staff A was interviewed on 03/15/17 at 11:48 AM. Staff A reported the facility's Governing Body has not yet met to approve the policies from the last survey. Staff A reported the Governing Body will hopefully meet by the end of March to approve the policies.	{C 104}		
{C 255}	O.A.C. 3701-83-21 (A) - (E) Medical Records Each ASF medical record shall contain at least the following information as applicable for the surgery to be performed: (A) Admission data: (1) Name, address, date of birth, gender, and race or ethnicity; (2) Date and time of admission; and (3) Pre-operative diagnosis, which shall be recorded prior to or at the time of admission.	{C 255}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/15/2017
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 255}	<p>Continued From page 2</p> <p>(B) History and physical examination data: (1) Personal medical history, including but not limited to allergies, current medications and past adverse drug reactions; (2) Family medical history; and (3) Physical examination.</p> <p>(C) Treatment data: (1) Physician's, podiatrist's or dentist's orders; (2) Physician's, podiatrist's or dentist's notes; (3) Physician assistant's notes, if applicable; (4) Nurse's notes; (5) Medications; (6) temperature, pulse, and respiration; (7) Any special examination or report, including but not limited to, x-ray, laboratory, or pathology reports; (8) Signed informed consent form; (9) Evidence of advanced directives, if applicable; (10) Operative record; (11) Anesthesia record, if applicable; and (12) Consultation record, if applicable.</p> <p>(D) Discharge data: (1) Final diagnosis; (2) Procedures and surgeries performed; (3) Condition upon discharge; (4) Post-treatment care and instructions; and (5) Attending physician's, podiatrist's or dentist's signature.</p> <p>(E) Other information required by law.</p> <p>This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure family medical history information was obtained for ten (Patients #1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) out of ten medical records reviewed. This could potentially affect all clients served by the facility. There were 2,434 procedures performed in the calendar year 2016.</p> <p>Findings include:</p>	{C 255}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/15/2017
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 255}	<p>Continued From page 3</p> <p>The medical records of Patients #1 - #10 were reviewed. The records did not contain a family medical history.</p> <p>The findings were shared with Staff A on 03/15/17 at 10:41 AM and confirmed.</p> <p>The agency's Medical Records policy, which is awaiting approval from the Governing Body, was reviewed. The policy stated the medical records shall contain family medical history.</p>	{C 255}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/11/2017
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 Follow up Licensure Compliance Inspection Administrator: Sherri Grossman County: Summit Number of ORs: 1 Please refer to the re-licensure inspection of 07/10/17 and 07/11/17 for licensure violations which were not recommended corrected at the time of the survey visit. C104, C120, C122, C123, C124, C125, C139, C150, C151, C153, C222 and C225. The following violations are issued as a result of the Follow up Licensure inspection completed on 07/11/17.	{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 preparedness plan, including evacuation procedures.	{C 104}		

Ohio Department of Health

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

TITLE

(X6) DATE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/11/2017
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
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{C 104}	Continued From page 1	{C 104}		
{C 120}	<p>O.A.C. 3701-83-08 (B) T B Control Plan</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on personnel file review, interview and policy review, the facility failed to ensure five staff members (Staff B, D, G, H and I) were tested for Tuberculosis (TB) on an annual basis. This had</p>	{C 120}		

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{C 120}	<p>Continued From page 2</p> <p>the potential to affect all of the 754 patients who had procedures completed in the last 12 months.</p> <p>Findings include:</p> <p>1. The personnel file of Staff B was reviewed. The file contained a Tuberculosis (TB) test from 10/23/13 in which Staff B tested positive for TB. The file did not contain an additional Tuberculosis test or a chest x-ray after 10/23/13.</p> <p>Staff A was interviewed on 07/10/17 at 1:40 PM and reported he was not aware of the positive Tuberculosis results.</p> <p>On 07/10/17 at 1:24 PM, the findings were shared with Staff B and confirmed. Staff B stated she did not have a current Tuberculosis test in her file.</p> <p>2. The personnel file of Staff H was reviewed. The file did not contain a TB test.</p> <p>On 07/11/17 at 2:42 PM, The finding regarding Staff H's personnel file not having a TB test was shared with Staff B and confirmed.</p> <p>3. The personnel file of Staff D was reviewed. The file did not contain evidence of a TB test.</p> <p>On 07/10/17 at 2:41 PM, the finding regarding Staff D's personnel file not containing evidence of a TB test was shared with Staff A and confirmed.</p> <p>4. The personnel file of Staff I was reviewed. The file did not contain evidence of Staff I having a current TB test in the personnel file.</p> <p>On 07/10/17 at 2:50 PM, the finding regarding Staff I not having a current TB test in her personnel file was reviewed with Staff A and</p>	{C 120}		

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{C 120}	Continued From page 3 confirmed. 5. The personnel file of Staff G was reviewed. The file did not contain evidence of Staff G having a TB test. On 07/10/17 at 3:20 PM, the finding regarding Staff G's personnel file not containing TB was shared with Staff B and confirmed. 6. The facility's Exposure Control Plan was reviewed. The plan stated employees will be tested for TB on an annual basis. Pursuant to OAC 3701-83-08 (B): All employees will have a base line PPD upon hire, unless they provide proof upon hire. A Registered nurse will administer the test. The test will be read by a Registered Nurse or Physician within 48 to 72 hours. A negative PPD requires no additional action. A positive PPD requires a chest x-ray. TB testing will be repeated on an annual basis. If an employee has a positive PPD and a negative chest x-ray the following year: Employee should undergo a health assessment. The employee's physician should complete the TB Health Assessment Form. This will be repeated on an annual basis for all affected employees.	{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.	{C 122}		

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{C 122}	<p>Continued From page 4</p> <p>This Rule is not met as evidenced by: Based on personnel file review, review of the facility's job descriptions and interview, the facility failed to ensure one staff member (Staff G) was provided with a written job description. The facility failed to ensure three registered nurses (Staff D, F and H) had current ACLS (Advance Cardiac Life Support) certification. This had the potential to affect all of the 754 patients who had procedures completed in the last 12 months.</p> <p>Findings include:</p> <p>1. The personnel file of Staff G was reviewed. Staff G was hired on 02/01/16. The file did not contain evidence of Staff G receiving a job description.</p> <p>On 07/10/17 at 3:20 PM, the finding regarding Staff G's personnel file not containing evidence of Staff G receiving a job description was shared with Staff B and confirmed.</p> <p>2. The personnel file of Staff F was reviewed. The file did not contain evidence of Staff F having current ACLS certification.</p> <p>On 07/10/17 at 3:02 PM, the findings regarding Staff F's expired ACLS were shared with Staff B and confirmed.</p> <p>3. The personnel file of Staff D was reviewed. The file did not contain evidence of Staff D having ACLS certification.</p> <p>On 07/11/17 at 1:32 PM, Staff B reported Staff D did not have current ACLS.</p>	{C 122}		

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{C 122}	Continued From page 5 On 07/10/17 at 2:41 PM, the finding regarding Staff D's personnel file not containing evidence of ACLS certification was shared with Staff A and confirmed. 4. The personnel file for Staff H was reviewed. The file did not contain evidence of Staff H having current ACLS certification. The finding regarding Staff H's personnel file missing ACLS certification was shared with Staff B and confirmed. 5. The facility's Staff RN Job Description was reviewed. The job description stated the Staff RN must be ACLS certified.	{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:	{C 123}			

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{C 123}	<p>Continued From page 6</p> <p>Based on observation, personnel file review, policy review, manufacturer's instructions and interview, the facility failed to ensure the personnel file for one staff member (Staff C) contained evidence of receiving training on the reprocessing of instruments process. This had the potential to affect all of the 754 patients who had procedures completed in the last 12 months.</p> <p>Findings include:</p> <p>1. The personnel file of Staff C was reviewed. The file did not contain evidence of Staff C receiving training on the reprocessing of surgical instruments.</p> <p>On 07/10/17 at 2:31 PM, the findings regarding Staff C not having evidence of receiving training on the reprocessing of equipment was shared with Staff A and Staff B and confirmed. Staff A reported the facility must not have documented the education.</p> <p>On 07/10/17 at 11:20 AM, Staff C was observed reprocessing surgical instruments. Staff C donned one pair of Latex gloves to place the surgical instruments in the Metricide. Staff C reported a white colored basin contained Metricide OPA Plus mixed with cold water. Staff C reported placing a "dollop" of Metricide in the basin. Staff C reported a second basin contained bleach and water. Staff C stated "I don't measure it (the bleach)". Staff C did not verify the concentration of the Metricide OPA Plus Solution.</p> <p>On 07/10/17 at 11:45 AM, Staff C confirmed the basin of Metricide OPA Plus Solution was not labeled.</p> <p>The manufacturer instructions for Metricide were</p>	{C 123}		

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{C 123}	<p>Continued From page 7</p> <p>reviewed. The instructions stated: MetriCide OPA Plus Solution is gentle on instruments, provides a broad spectrum of kill, and does not require activation or dilution. When handling disinfectants, the user should always wear appropriate safety gear. Be sure to wear protective equipment, including nitrile gloves, fluid-repelling gown and eye protection at all times when handling high-level disinfectants and contaminated instruments. The concentration of your MetriCide OPA Plus Solution must be verified by a MetriCide OPA Plus Solution Test Strip prior to each use to guard against dilution that may lower the ortho-Phthalaldehyde level of the solution below its MRC (manufacturer's recommended concentration).</p> <p>The facility's Instrument Cleaning policy was reviewed. The policy stated: Instrument cleaning is completed on a daily basis and in accordance with the following guidelines: Unwrap used tray. Dispose of syringe and vacurette in biohazard box. Dispose of used wrap and paper in biohazard bag. Soak instrument in Enzol solution (1 oz. per gallon of water) for one minute. Use steel brush and scrubby sponge to clean debris off instruments. Rinse instruments with water. Soak instruments in bleach solution (1:10 bleach/water ratio) for 20 minutes. Rinse instruments in water. Dry instruments. Wrap instruments as per Medical Director's desire.</p>	{C 123}		

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{C 124}	Continued From page 8	{C 124}			
{C 124}	<p>O.A.C. 3701-83-08 (F) Staff Orientation & Training</p> <p>All staff shall have appropriate orientation and training regarding the facility's equipment, safety guidelines, practices, and policies.</p> <p>This Rule is not met as evidenced by: Based on personnel file review and interview, the facility failed to ensure one staff member (Staff G) received orientation.</p> <p>Findings include:</p> <p>1. The personnel file of Staff G was reviewed. Staff G was hired on 02/01/16. The personnel file did not contain evidence of Staff G receiving orientation of the facility's equipment, safety, guidelines, practices and policies.</p> <p>On 07/10/17 at 3:20 PM, the finding regarding Staff G's personnel file not containing orientation was shared with Staff B and confirmed.</p>	{C 124}			
{C 125}	<p>O.A.C. 3701-83-08 (G) Staff Performance Evaluation</p> <p>Each HCF shall evaluate the performance of each staff member at least every twelve months.</p> <p>This Rule is not met as evidenced by: Based on personnel file review, interview and</p>	{C 125}			

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{C 139}	Continued From page 10	{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:	{C 150}		
{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. This Rule is not met as evidenced by:	{C 151}		
{C 153}	O.A.C. 3701-83-12 (D) Q A & Improvement - High-Risk Activities	{C 153}		

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{C 153}	Continued From page 11 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:	{C 153}		
{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: 2. The personnel file for Staff J was reviewed. The file did not contain evidence of Staff J having experience in surgical and recovery room nursing care.	{C 222}		
{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	{C 225}		

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{C 225}	<p>Continued From page 12</p> <p>patients are present;</p> <p>(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</p> <p>(3) Have sufficient and qualified additional staff present to attend to the needs of the patients.</p> <p>This Rule is not met as evidenced by: Based on review of the facility's schedule logs, personnel file review and interview, the facility failed to ensure three registered nurses (Staff D, F and H) were certified in advanced cardiac life support (ACLS) when on duty in the recovery room while patients were present. The facility failed to ensure a nurse with ACLS was scheduled on two of 19 schedules reviewed. This had the potential to affect all of the facility's patients. The facility performed 754 procedures during the last 12 month period.</p> <p>Finding include:</p> <p>1. The personnel file of Staff D was reviewed. The file did not contain evidence of Staff D having ACLS certification.</p> <p>On 07/11/17 at 1:32 PM, Staff B reported Staff D did not have current ACLS.</p> <p>On 07/10/17 at 2:41 PM, the findings regarding Staff D's personnel file not containing evidence of ACLS certification were shared with Staff A and</p>	{C 225}		

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{C 225}	<p>Continued From page 13</p> <p>confirmed.</p> <p>The facility's Schedule Logs were reviewed and revealed Staff D was the only registered nurse scheduled in the recovery room on the following dates:</p> <p>05/15/17 05/17/17 05/18/17 05/22/17 05/24/17 05/25/17 05/31/17 06/01/17 06/05/17 06/08/17 06/13/17 06/14/17 06/19/17 06/26/17 06/29/17 07/03/17 07/06/17</p> <p>2. The personnel file for Staff H was reviewed. The file did not contain evidence of Staff H having current ACLS certification.</p> <p>The findings regarding Staff H's personnel file missing ACLS certification was shared with Staff B and confirmed.</p> <p>The facility's Schedule Logs were reviewed and revealed Staff H was the only registered nurse scheduled in the recovery room on the following dates:</p> <p>05/13/17 05/27/17</p> <p>3. The facility's Schedule Logs were reviewed</p>	{C 225}		

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{C 225}	Continued From page 14 from 05/25/17 and 06/08/17 and revealed one registered nurse without ACLS certification (Staff D) and one licensed practical nurse without ACLS certification (Staff E) were the only two nurses scheduled for the day. The facility performed procedures on the 05/25/17 and 06/08/17. 4. The facility's Staff RN Job Description was reviewed. The job description stated the Staff RN must be ACLS certified. 5. On 07/11/17 at 4:30 PM, the findings regarding the facility not having an ACLS certified RN in the recovery room were shared with Staff B and confirmed.	{C 225}		

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C 000	Initial Comments Licensure Compliance Inspection and follow up to the licensure compliance inspection completed 11/29/16. Administrator: Sherri Grossman County: Summit Number of ORs: 1 The following violations are issued as a result of the licensure compliance inspection completed on 07/11/17.	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 preparedness plan, including evacuation procedures.	C 104		

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(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 104	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on review of governing body minutes, staff interview and review of facility documentation, the governing body failed to ensure development of a facility 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 754 surgical and medical procedures were conducted in the most recent twelve months.</p> <p>Findings include:</p> <p>On 07/11/17 a review of the Governing Body minutes of 01/08/17 revealed the Governing Body recommended the following:</p> <p>a) appointed Staff J as the Director of Nursing, Quality Assurance (QA) and Infection Control trainer and monitor, b) reviewed the Quality Assurance Policy at that time with a plan to review this policy at least every 12 months, and c) documented improvement is needed in documentation of QA and infection control.</p> <p>The minutes contained documentation that Staff B will develop and maintain QA and infection control logs and Staff J will train and monitor QA and infection control.</p> <p>On 07/11/17 at 10:00 AM and 3:40 PM, an interview was conducted with Staff B regarding Governing Body minutes and Quality Assurance (QA). Staff B confirmed there were no QA meetings to discuss goals, objectives and timelines for completion of goals with the</p>	C 104		

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C 104	Continued From page 2 exception of a monthly monitoring tool. Staff B also confirmed there was no QA manual in accordance with the facility policy.	C 104		
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, staff interview and policy review, the facility failed to ensure five staff members (Staff B, D, G, H and I) were tested for Tuberculosis (TB) on an annual basis. This could potentially affect all patients receiving care in the facility. A total of 754 surgical and medical procedures were conducted in the most recent twelve months. Findings include: The facility's policy titled "Exposure Control Plan"	C 120		

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C 120	<p>Continued From page 3</p> <p>was reviewed. The plan stated employees will be tested for TB on an annual basis. Pursuant to OAC 3701-83-08 (B): All employees will have a base line PPD upon hire, unless they provide proof upon hire. A Registered nurse will administer the test. The test will be read by a Registered Nurse or Physician within 48 to 72 hours. A negative PPD requires no additional action. A positive PPD requires a chest x-ray. TB testing will be repeated on an annual basis. If an employee has a positive PPD and a negative chest x-ray the following year: Employee should undergo a health assessment. The employee's physician should complete the TB Health Assessment Form. This will be repeated on an annual basis for all affected employees.</p> <p>1. The personnel file of Staff B was reviewed. The file contained a Tuberculosis (TB) test from 10/23/13 in which Staff B tested positive for TB. The file did not contain an additional Tuberculosis test or a chest x-ray after 10/23/13.</p> <p>Staff A was interviewed on 07/10/17 at 1:40 PM and reported he was not aware of the positive Tuberculosis results.</p> <p>On 07/10/17 at 1:24 PM, the findings were shared with Staff B and confirmed. Staff B stated she did not have a current Tuberculosis test in her file.</p> <p>2. The personnel file of Staff H was reviewed. The file did not contain a TB test.</p> <p>On 07/11/17 at 2:42 PM, The finding was shared with Staff B and confirmed.</p> <p>3. The personnel file of Staff D was reviewed. The file did not contain evidence of a TB test.</p>	C 120		

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C 120	Continued From page 4 On 07/10/17 at 2:41 PM, the finding was shared with Staff A and confirmed. 4. The personnel file of Staff I was reviewed. The file did not contain evidence of Staff I having a current TB test in the personnel file. On 07/10/17 at 2:50 PM, the finding was reviewed with Staff A and confirmed. 5. The personnel file of Staff G was reviewed. The file did not contain evidence of Staff G having a TB test. On 07/10/17 at 3:20 PM, the finding was shared with Staff B and confirmed.	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 personnel file review, review of the facility's job descriptions and interview, the facility failed to ensure one staff member (Staff G) was provided with a written job description. The facility failed to ensure three registered nurses (Staff D, F and H) had current ACLS (Advance Cardiac Life Support) certification. This had the potential to affect all of the 754 patients who had procedures completed in the last 12 months.	C 122		

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C 122	<p>Continued From page 5</p> <p>Findings include:</p> <p>1. The personnel file for Staff G was reviewed. Staff G was hired on 02/01/16. The file did not contain evidence of Staff G receiving a job description.</p> <p>On 07/10/17 at 3:20 PM, the finding shared with Staff B and confirmed.</p> <p>2. The personnel file for Staff F was reviewed. The file did not contain evidence of Staff F having current ACLS certification.</p> <p>On 07/10/17 at 3:02 PM, the finding was shared with Staff B and confirmed.</p> <p>3. The personnel file for Staff D was reviewed. The file did not contain evidence of Staff D having ACLS certification.</p> <p>On 07/11/17 at 1:32 PM, Staff B reported Staff D did not have current ACLS.</p> <p>On 07/10/17 at 2:41 PM, the finding was shared with Staff A and confirmed.</p> <p>4. The personnel file for Staff H was reviewed. The file did not contain evidence of Staff H having current ACLS certification.</p> <p>The finding was shared with Staff B and confirmed.</p> <p>The facility's Staff RN Job Description was reviewed. The job description stated the Staff RN must be ACLS certified.</p>	C 122		

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C 123	Continued From page 6	C 123			
C 123	<p>O.A.C. 3701-83-08 (E) Staff Orientation & Training</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation, personnel file, policy, and manufacturer's instructions and staff interview, the facility failed to ensure the personnel file for one staff member (Staff C) contained evidence of receiving training on the reprocessing of instruments. This could potentially affect all patients receiving care in the facility. A total of 754 surgical and medical procedures were conducted in the most recent twelve months.</p> <p>Findings include:</p> <p>The facility's "Instrument Cleaning" policy was reviewed. The policy stated: Instrument cleaning is completed on a daily basis and in accordance with the following guidelines: Unwrap used tray. Dispose of syringe and vacurette in biohazard</p>	C 123			

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C 123	<p>Continued From page 7</p> <p>box. Dispose of used wrap and paper in biohazard bag. Soak instrument in Enzol solution (1 oz. per gallon of water) for one minute. Use steel brush and scrubby sponge to clean debris off instruments. Rinse instruments with water. Soak instruments in bleach solution (1:10 bleach/water ratio) for 20 minutes. Rinse instruments in water. Dry instruments. Wrap instruments as per Medical Director's desire.</p> <p>The personnel file of Staff C was reviewed. The file did not contain evidence Staff C received training on the reprocessing of surgical instruments.</p> <p>On 07/10/17 at 2:31 PM, the findings was shared with Staff A and Staff B and confirmed. Staff A reported the facility must not have documented the education.</p> <p>The manufacturer instructions for MetriCide were reviewed. The instructions stated: MetriCide OPA Plus Solution is gentle on instruments, provides a broad spectrum of kill, and does not require activation or dilution. When handling disinfectants, the user should always wear appropriate safety gear. Be sure to wear protective equipment, including nitrile gloves, fluid-repelling gown and eye protection at all times when handling high-level disinfectants and contaminated instruments. The concentration of your MetriCide OPA Plus Solution must be verified by a MetriCide OPA Plus Solution Test Strip prior to each use to guard against dilution that may lower the ortho-Phthalaldehyde level of</p>	C 123		

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C 123	Continued From page 8 the solution below its MRC (manufacturer's recommended concentration). On 07/10/17 at 11:20 AM, Staff C was observed reprocessing surgical instruments. Staff C donned one pair of Latex gloves to place the surgical instruments in the MetriCide. Staff C reported a white colored basin contained Metricide OPA Plus and was mixed with cold water. Staff C reported placing a "dollop" of Metricide in the basin. Staff C reported a second basin contained bleach and water. Staff C stated "I don't measure it (the bleach)". Staff C did not verify the concentration of the MetriCide OPA Plus Solution. On 07/10/17 at 11:45 AM, Staff C confirmed the basin of MetriCide OPA Plus Solution was not labeled.	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. This Rule is not met as evidenced by: Based on personnel file review and interview, the facility failed to ensure one staff member (Staff G) received orientation. This could potentially affect all patients receiving care in the facility. A total of 754 surgical and medical procedures were conducted in the most recent twelve months. Findings include:	C 124		

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C 124	Continued From page 9 The personnel file of Staff G was reviewed. Staff G was hired on 02/01/16. The personnel file did not contain evidence of Staff G receiving orientation of the facility's equipment, safety, guidelines, practices and policies. On 07/10/17 at 3:20 PM, the finding was shared with Staff B and confirmed.	C 124		
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, staff interview and policy review, the facility failed to ensure one staff member (Staff G) received a performance evaluation every 12 months. This could potentially affect all patients receiving care in the facility. A total of 754 surgical and medical procedures were conducted in the most recent twelve months. Findings include: The facility's "Evaluation" policy was reviewed. The policy stated: Each employee will be subject to annual performance evaluations as required by OAC 3701-83-08 {G}. Evaluations will be written by the individual employee's supervisor and approved by Human Resources prior to the Supervisor reviewing the evaluation with the employee.	C 125		

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C 125	Continued From page 10 The personnel file of Staff G was reviewed. Staff G was hired on 02/01/16. The personnel file did not contain a performance evaluation. On 07/10/17 at 3:20 PM, the findings was shared with Staff B and confirmed.	C 125		
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 and staff interviews the facility failed to be maintained in a sanitary and safe manner. This could potentially affect all patients receiving care in the facility. A total of 754 surgical and medical procedures were conducted in the most recent twelve months. Findings include: On 07/10/17 between 11:40 AM and 11:53 AM, observations were conducted with Staff C of the room in which sterilization of instruments were processed. Staff C was observed placing personal protective equipment (gown, gloves, mask, face shield) while pre-cleaning and processing sterile instruments. Two large boxes were observed on the floor between the pathogen (tissue) freezer and a metal cart which contained	C 139		

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C 139	<p>Continued From page 11</p> <p>sterilized packets of instruments. One of the boxes was almost in contact with the metal cart. Clean blue colored drapes (used to wrap instruments) was observed in direct contact on top of one of the two boxes, and Staff C was observed placing her gown and face shield on top of the clean drapes which was located on top of one box. Staff C left the room, then returned and donned the same gown and face shield after lifting them off the top of the box. When asked what was in the two boxes, Staff C replied it was biohazard trash that needed to be picked up.</p> <p>An open roll of paper towels was observed underneath the dirty sink in the surgical instrument processing room.</p> <p>Later that day between 4:00 PM and 5:00 PM during a tour with Staff A, the following was observed and confirmed with Staff A:</p> <p>a) The two large biohazard boxes that were previously in the instrument processing room were observed inside the medical gas room on the floor beside two cylinders of oxygen and two cylinders of nitrous gas. The door to the medical gas room was observed standing open throughout the day on 07/10/17 although a sign was posted on the door to keep the door closed. There was no self closing device observed on the door.</p> <p>b) A 1/2 full bottle of diet soda was observed sitting on the counter next to the handwashing sink where the medication cabinets were located.</p> <p>c) The operating room table was observed with a two tone blue vinyl like covering. The lighter blue rectangular area was observed where the patient's buttocks would come into contact with</p>	C 139		

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C 139	<p>Continued From page 12</p> <p>the operating room table during an examination or procedures. The rectangular area where the lighter and dark blue surfaces met were observed covered with a blue colored tape. This tape was observed rolled up in areas and had material sticking to the sticky exposed surface of the tap. Staff A stated the table is covered only with a paper barrier during procedures.</p> <p>d) A white plastic container with a lid was observed in the staff bathroom on both days of the survey (07/10/17 and 07/11/17). The white lid of the container was observed very dirty and black colored on the top outer surface. Staff A stated the container was used to hold rock salt for snow and ice.</p> <p>e) The storage room located by the recovery room was observed with several boxes which were placed on the floor of the room underneath the shelving. These boxes were observed containing a variety of supplies and paper towels. Staff A stated most of the supplies were outdated and not in use.</p> <p>f) A dispenser of packing tape was observed on top of the pathogen (tissue) freezer. When Staff A opened the lid of the freezer to look for the thermometer, the tape was placed on the edge of the freezer and fell in two times. The tape was removed both times by Staff A who confirmed there was no good place to put the tape and it sometimes falls into the freezer.</p> <p>These observations were confirmed with Staff A during tour.</p>	C 139		
C 150	O.A.C. 3701-83-12 (A) Q A & Improvement Program	C 150		

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C 150	<p>Continued From page 13</p> <p>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.</p> <p>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 identified problems. This could potentially affect all patients receiving care in the facility. A total of 954 procedures were performed in the most recent twelve months.</p> <p>Findings include:</p> <p>On 07/11/17 at 10:00 AM and 3:40 PM, an interview was conducted with Staff B regarding Quality Assurance (QA). Staff B confirmed there were no QA meetings to discuss goals, objectives and timelines for completion of goals with the exception of a monthly monitoring tool. Staff B also confirmed there was no QA manual in accordance with the facility policy.</p> <p>During the interviews, Staff B stated the facility is collecting data in record reviews, peer reviews, and patient satisfaction surveys, and is doing a monthly audit of the facility which includes infection control; however, confirmed the facility was not conducting routine QAPI meetings to use</p>	C 150		

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C 150	Continued From page 14 these findings to establish goals or use the data to improve patient care. On 07/11/17 a review of the facility's policy titled "Quality Control", reviewed by the Governing Body in January 2017, revealed a mission statement that stated the facility is dedicated to providing the highest standards of safety and hygiene, through the use and implementation of a comprehensive Quality Assurance manual. At 3:40 PM Staff B confirmed this aforementioned policy. At 3:40 PM, Staff A was made aware of the aforementioned interview with Staff B.	C 150		
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. 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	C 151		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/11/2017
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 151	Continued From page 15 receiving care in the facility. A total of 754 surgical and medical procedures were performed in the most recent twelve months. Findings include: On 07/11/17 at 10:00 AM and 3:40 PM, a review was conducted of the governing body minutes and facility documentation. An interview was conducted with Staff B at those times regarding whether the facility had a written plan that described the QAPI program. Staff B confirmed the facility currently lacks this written plan. At 3:40 PM, Staff A was made aware of the aforementioned interview with Staff B.	C 151		
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	C 152		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/11/2017
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 152	<p>Continued From page 16</p> <p>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;</p> <p>(5) Document and report the status of quality assessment and improvement program to the governing body every twelve months;</p> <p>(6) Document and review all unexpected complications and adverse events, whether serious injury or death, that arise during an operation or procedure; and</p> <p>(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.</p> <p>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 quality assurance plan that monitored and evaluated all aspects of care, and failed to establish expectations, develop plans and implement procedures to improve the quality of care. The facility failed to hold regular meetings. This could potentially affect all patients receiving care in the facility. A total of 754 surgical and medical procedures were performed in the most recent twelve months.</p>	C 152		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/11/2017
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 152	Continued From page 17 Findings include: On 07/11/17 at 10:00 AM and 3:40 PM, a review was conducted of the governing body minutes and facility documentation. An interview was conducted with Staff B at those times regarding whether the facility had a written plan that described the QAPI program. Staff B confirmed the facility currently lacks this written plan and confirmed there were no regular meetings conducted to discuss quality of care. When asked what the facility was working on for quality, and whether there were goals and measures in place to collect and analysis data to improve quality, Staff B confirmed there was no written plan. At 3:40 PM, Staff A was made aware of the aforementioned interview with Staff B.	C 152		
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, 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	C 153		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/11/2017
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
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C 153	Continued From page 18 total of 754 surgical and medical procedures were performed in the most recent twelve months. Findings include: On 07/11/17 at 10:00 AM and 3:40 PM an interview was conducted with Staff B 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 this written program. Staff A was present during this interview.	C 153		
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 and staff interview it was determined the facility failed to show evidence the Director of Nursing met the requirements of the position. This could potentially affect all patients receiving care in the facility. A total of 754 surgical and medical procedures were conducted in the most recent twelve months. Findings include: On 07/11/17 at 3:40 PM an interview was conducted with Staff B regarding whether the facility had documented evidence of the Director	C 222		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/11/2017
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 222	Continued From page 19 of Nursing's (Staff J) previous experience in surgical and recovery room nursing care. Staff B confirmed the facility lacked this documentation. The personnel file for Staff J was reviewed. The file did not contain evidence that Staff J had experience in surgical and recovery room nursing care.	C 222		
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 present to attend to the needs of the patients. This Rule is not met as evidenced by: Based on review of the facility's schedule logs, personnel file review and staff interview, the facility failed to ensure three registered nurses (Staff D, F and H) were certified in advanced	C 225		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/11/2017
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 225	<p>Continued From page 20</p> <p>cardiac life support (ACLS) when on duty in the recovery room while patients were present. The facility failed to ensure a nurse with ACLS was scheduled on two of 19 schedules reviewed. This had the potential to affect all of the facility's patients. The facility performed 754 surgical and medical procedures in the most recent twelve months.</p> <p>Finding include:</p> <p>The facility's Staff RN Job Description was reviewed. The job description stated the Staff RN must be ACLS certified.</p> <p>1. The personnel file of Staff D was reviewed. The file did not contain evidence of Staff D having ACLS certification. On 07/11/17 at 1:32 PM, Staff B reported Staff D did not have current ACLS.</p> <p>The facility's Schedule Logs were reviewed and revealed Staff D was the only registered nurse scheduled in the recovery room on the following dates: 05/15/17, 05/17/17, 05/18/17, 05/22/17, 05/24/17, 05/25/17, 05/31/17, 06/01/17, 06/05/17, 06/08/17, 06/13/17, 06/14/17, 06/19/17, 06/26/17, 06/29/17, 07/03/17, and 07/06/17.</p> <p>On 07/10/17 at 2:41 PM, the finding was shared with Staff A and confirmed.</p> <p>2. The personnel file for Staff H was reviewed. The file did not contain evidence of Staff H having current ACLS certification.</p> <p>The facility's Schedule Logs were reviewed and revealed Staff H was the only registered nurse scheduled in the recovery room on the following dates:</p>	C 225		

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NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 225	Continued From page 21 05/13/17 and 05/27/17. The finding was shared with Staff B and confirmed. 3. The facility's Schedule Logs were reviewed from 05/25/17 and 06/08/17 and revealed one registered nurse without ACLS certification (Staff D) and one licensed practical nurse without ACLS certification (Staff E) were the only two nurses scheduled for the day. The facility performed procedures on 05/25/17 and 06/08/17. On 07/11/17 at 4:30 PM, the findings were shared with Staff B and confirmed.	C 225		
C 241	O.A.C. 3701-83-20 (B) OR & Recovery Room Equipment Each ASF shall have the following equipment accessible to the operating suite and recovery area: (1) Adequate resuscitation equipment: (a) ASFs providing surgical procedures under topical and local infiltration blocks with or without oral or intramuscular preoperative sedation shall have: airways, bag mask respirator, oxygen source, suction equipment, and age-appropriate resuscitative drugs; (b) ASFs providing surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs or providing surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have: airways, endotracheal tubes, laryngoscope, oxygen delivery capability under positive pressure, suction equipment, and suitable resuscitative drugs.	C 241		

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NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 241	<p>Continued From page 22</p> <p>(2) Appropriate monitoring equipment: (a) Each ASF shall have size-specific blood pressure apparatus and stethoscopes, electrocardiogram, oscilloscopes and when pediatric patients are treated, size-specific emergency equipment and medications; (b) ASFs performing surgical procedures in conjunction with oral, parenteral, or intravenous sedation or under an analgesic[sic] or dissociative drugs, or performing surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have a defibrillator, pulse oximeter with alarm, and temperature monitor. (c) ASFs using inhalation anesthesia shall have an anesthesia machine.</p> <p>(3) Each ASF shall have suitable surgical instruments customarily available for the planned surgical procedure in the operating suite.</p> <p>(4) Each ASF shall have in the recovery room, an emergency call system that is connected electronically, electrically by radio transmission or in a like manner and that effectively alerts staff.</p> <p>This Rule is not met as evidenced by: Based on observations, review of the crash cart (emergency box) logs and staff interviews the facility failed to ensure the equipment for emergency use was maintained with current expiration dates. This could potentially affect all patients receiving care in the facility. A total of 754 surgical and medical procedures were conducted in the most recent 12 months.</p>	C 241		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/11/2017
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 241	<p>Continued From page 23</p> <p>Findings include:</p> <p>On 07/10/17 between 4:00 PM and 5:00 PM with Staff A, observations were conducted of the emergency supply box for the Operating Room. Outdated supplies were observed and confirmed with Staff B as follows:</p> <p>a) Four intravenous catheter start kits 24 gauge by 3/4 inches, Lot 120508A, 15 ml/min, each expired 04/17.</p> <p>b) Metal forceps were observed in a reprocessed package with a processing date of 08/01/16. Staff A removed the forceps from the emergency box and stated the facility practice is to reprocess sterile instruments every six months.</p> <p>c) Three Satin S.P.U. disposable laryngoscope handles, Ref 40650, Lot 12090063, each with an expiration date of 09/16.</p> <p>A review of the crash cart (emergency box) log at the time of observation revealed the emergency box had been checked by staff on 07/03/17 for contents and expiration dates; however, these outdated supplies remained in the box. This finding was confirmed with Staff A at the time of the observation.</p>	C 241		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/13/2017
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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	<p>Initial Comments</p> <p>Licensure Compliance Inspection</p> <p>Administrator: Chrissie France</p> <p>County: Cuyahoga</p> <p>Number of Procedure Rooms: 5</p> <p>Services Provided: Medical and Surgical Abortion</p> <p>Number of Procedures Completed in 2016 Calendar Year: 4875</p> <p>Preterm is in compliance with the rules for an Ambulatory Surgical Facility at O.A.C. 3701-83 at the time of the Licensure Compliance Inspection completed on 03/13/17.</p>	C 000		

Ohio Department of Health

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0969AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/07/2017
NAME OF PROVIDER OR SUPPLIER AKRON WOMEN'S MEDICAL GROUP		STREET ADDRESS, CITY, STATE, ZIP CODE 692 EAST MARKET STREET AKRON, OH 44304		
(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	<p>Initial Comments</p> <p>Akron Women's Medical Center 0969 AS</p> <p>An onsite visit was made to the ASF on 08/07/17 to determine operational status. parking lot empty, facility locked, no response to use of call box at door from within, no visible lights from within facility. A telephone call using the phone number given on website resulted in automated response the number had been disconnected or was no longer in service. Observation was from 10:45 A.M. until 12:45 P.M. . No one arrived at the facility.</p>	C 000		

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

TITLE



(X6) DATE

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/10/2018
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	Initial Comments Complaint Inspection Complaint Number OH00098894 Administrator: Dr Schaeffer County: Franklin Number of ORs: 4 Founder's Women's Health Center is not in compliance with the rules for ambulatory surgery facilities at O.A.C. 3701-83 as a result of the complaint inspection OH00098894 completed 07/09/18.	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 preparedness plan, including evacuation procedures.	C 104		

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

TITLE



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/10/2018
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1243 EAST BROAD STREET COLUMBUS, OH 43205		
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C 104	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on staff interview and observations the facility failed to ensure there was a functioning governing body with oversight of the operations of the facility. This violation has the potential to affect any patient seeking services at the facility.</p> <p>Findings include:</p> <p>Observations on 07/09/18 revealed the facility was staffed by one administrative person.</p> <p>In an interview on 07/09/18 at 9:30 AM Staff A said the facility was not providing services for patients since the exit of the management company on 06/22/18. Staff A said the management company had taken all the documentation of significance, including quality assurance records, governing body minutes, quality program information including infection control documentation, and safety documentation including fire and emergency drills, disaster preparedness, and all policies and procedures pertaining to operation of the facility.</p> <p>There were no governing body records available for review on 07/09/18.</p> <p>There were no staff employed by the facility to organize, participate in and manage a governing body oversight group at the facility. The current staff associated with the facility was the administrative person and two physician /owners.</p>	C 104		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/10/2018
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C 104	Continued From page 2 Staff A said the management team that had left on 06/22/18 had been responsible for the day to day operations of the facility since 2012, but a disagreement over a contract had resulted in the management company's exit. The owner of the facility has pending action against the former management company, and was unable to provide services as an ambulatory surgical facility (ASF) at the time of the inspection. There was no known or projected date when the facility would be operational as an ASF. The documentation, contacts, policy, procedures and equipment would have to be replaced and new staff, contracts and suppliers would have to be acquired. Two patients/customers arrived at the facility on 07/09/18 between 9:00 AM and 12:00 PM and were re-directed to use the facility's previous phone number, which had been forwarded by the management company to the new location.	C 104		
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 staff interview and observations the facility failed to ensure there was a liability	C 105		

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NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1243 EAST BROAD STREET COLUMBUS, OH 43205		
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C 105	Continued From page 3 insurance policy for the facility. This violation has the potential to affect any patient seeking services at the facility. Findings include: Observations on 07/09/18 revealed the facility was staffed by one administrative person and the main office of the facility had been cleared of records, with empty file cabinets left behind. In an interview on 07/09/18 at 9:30 AM Staff A said the facility was not providing services for patients since the exit of the management company on 06/22/18. Staff A said the management company had taken all the documentation of significance, including liability insurance documentation. The management company had been managing the day to day operations of the facility since 2012, and the management company representatives and staff had been responsible for paying all bills for the facility, including the liability insurance. There were no records pertaining to liability insurance available for review on 07/09/18.	C 105		
C 109	O.A.C. 3701-83-03 (K) Contracted Services An HCF may arrange for services to be provided through a contract with an outside resource. The HCF shall retain professional management responsibility for contracted services and shall ensure that those services are furnished in a safe and effective manner.	C 109		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/10/2018
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 109	<p>Continued From page 4</p> <p>This Rule is not met as evidenced by: Based on staff interview the facility failed to ensure there was documentation regarding contracted services providing services for the facility. This violation has the potential to affect any patient seeking services at the facility.</p> <p>Findings include:</p> <p>In an interview on 07/09/18 beginning at 9:30 AM, including a tour of the facility, Staff A said the facility was not providing services for patients since the exit of the management company on 06/22/18. Staff A said the management company had taken all the documentation of significance, including contracted arrangements with providers. Staff A said the UPS (United Parcel Service) account and website was missing, the internet service had been removed from the facility, and all supplier phone numbers and accounts were gone. He/She said all the data in the rolodex (phone number file) on the main desk had been taken.</p> <p>Staff A said the phone number that had been associated with the clinic for 45 years had been forwarded to the location where the previous management company had moved. The facility's website was not accessible by the facility owners, but the website had the phone number that was now at the new location, under control of the management company. The management company had been managing the day to day</p>	C 109		

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C 109	Continued From page 5 operations of the facility since 2012, and the management company representatives and staff had been responsible for arranging all services for the facility, including contracted services. There were no records pertaining to contracted services available for review on 07/09/18.	C 109		
C 116	O.A.C. 3701-83-07 (C) Patient Satisfaction Program The HCF shall implement a patient satisfaction survey program. This Rule is not met as evidenced by: Based on staff interview the facility failed to ensure there was documentation regarding a patient satisfaction program for the facility. This violation has the potential to affect any patient seeking services at the facility. Findings include: In an interview on 07/09/18 at 9:30 AM Staff A said the facility was not providing services for patients after the exit of the management company on 06/22/18. Staff A said the management company had taken all the documentation of significance, including all forms and paperwork for patient admissions and services, including documentation of a patient satisfaction program. There were no records pertaining to a patient satisfaction program available for review on	C 116		

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C 116	Continued From page 6 07/09/18. The management company had been managing the day to day operations of the facility since 2012, and the management company representatives and staff had been responsible for arranging all services for the facility, including a patient satisfaction program. A disagreement over a contract had resulted in the management company's exit on 06/22/18.	C 116		
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 of records necessary for the director to ascertain that all individuals employed at the HCF who function 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 if required by law.	C 119		

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C 119	<p>Continued From page 7</p> <p>This Rule is not met as evidenced by: Based on staff interview and observations the facility failed to ensure there was qualified staff and records of the staff qualifications and training for the facility. This violation has the potential to affect any patient seeking services at the facility.</p> <p>Findings include:</p> <p>Observations on 07/09/18 revealed the facility was staffed by one administrative person, the main office of the facility had been cleared of records, with empty file cabinets and only previous patient files remaining in a second floor records storage area.</p> <p>In an interview on 07/09/18 at 9:30 AM Staff A said the facility was not providing services for patients after the exit of the management company on 06/22/18. Staff A said the management company had taken all the documentation of significance, including personnel files, staff training records and documentation, including professional licenses and certifications. The staff were all employees of the former management company and had left this facility for another location. The management company had been managing the day to day operations of the facility since 2012, and the management company representatives and staff had been responsible for hiring, managing and training all staff, and had all the records pertaining to the staff.</p> <p>There were no records available for review on 07/09/18.</p>	C 119		

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C 120	Continued From page 8	C 120		
C 120	<p>O.A.C. 3701-83-08 (B) T B Control Plan</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on staff interview and observations the facility failed to ensure there was a TB (tuberculosis) control plan for the facility. This violation has the potential to affect any patient seeking services at the facility.</p> <p>Findings include:</p> <p>Observations on 07/09/18 revealed the facility was staffed by one administrative person, the main office of the facility had been cleared of records, with empty file cabinets.</p> <p>In an interview on 07/09/18 at 9:30 AM Staff A said the facility was not providing services for patients after the exit of the management company on 06/22/18. Staff A said the</p>	C 120		

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C 120	Continued From page 9 management company had taken all the documentation of significance, including the TB control plan documentation and infection control tracking and monitoring. The management company had been managing the day to day operations of the facility since 2012, and the management company representatives and staff had been responsible for the infection control program for the facility, including the TB assessment and policy. There were no records pertaining to a TB control plan available for review on 07/09/18.	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 staff interview and observations the facility failed to ensure there were records of the staff employment, including job descriptions and human resources management documentation at the facility. This violation has the potential to affect any patient seeking services at the facility . Findings include: Observations on 07/09/18 revealed the facility was staffed by one administrative person, the main office of the facility had been cleared of records, with empty file cabinets and only	C 122		

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C 122	Continued From page 10 previous patient files remaining in a second floor records storage area. In an interview on 07/09/18 beginning at 9:30 AM Staff A said the facility was not providing services for patients after the exit of the management company on 06/22/18. Staff A said the management company had taken all the documentation of significance, including personnel files, with staff training records and documentation, including job descriptions. The staff were all employees of the former management company and had left this facility for another location. The management company had been managing the day to day operations of the facility since 2012, and the management company representatives and staff had been responsible for hiring, managing and training all staff, and had all the records pertaining to the staff. There were no personnel records available for review on 07/09/18.	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	C 123		

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C 123	<p>Continued From page 11</p> <p>meetings and seminars.</p> <p>This Rule is not met as evidenced by: Based on staff interview and observations the facility failed to ensure there were records of the staff orientation and training for the facility. This violation has the potential to affect any patient seeking services at the facility.</p> <p>Findings include:</p> <p>Observations on 07/09/18 revealed the facility was staffed by one administrative person, the main office of the facility had been cleared of records, with empty file cabinets and only previous patient files remaining in a second floor records storage area.</p> <p>In an interview on 07/09/18 beginning at 9:30 AM and including a tour of the facility, Staff A said the facility was not providing services for patients after the exit of the management company on 06/22/18. Staff A said the management company had taken all the documentation of significance, including personnel files, staff training records and documentation, including orientation materials.</p> <p>The staff were all employees of the former management company and had left this facility for another location where the management company had rented office space. The management company had been managing the day to day operations of the facility since 2012, and the management company representatives and staff had been responsible for hiring,</p>	C 123		

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C 123	Continued From page 12 orienting, managing, and training all staff, and had taken all the records pertaining to the staff. There were no personnel records pertaining to orientation and training available for review on 07/09/18.	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 staff interview and observations the facility failed to ensure there were records of the staffing schedules for the facility. This violation has the potential to affect any patient seeking services at the facility. Findings include: Observations on 07/09/18 revealed the facility was staffed by one administrative person, the main office of the facility had been cleared of records, with empty file cabinets and only previous patient files remaining in a second floor records storage area. In an interview on 07/09/18 beginning at 9:30 AM and including a tour of the facility, Staff A said the facility was not providing services for patients after the exit of the management company on 06/22/18. Staff A said the management company	C 126		

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C 126	Continued From page 13 had taken all the documentation of significance, including the staffing schedules since 2012. The staff were all employees of the former management company and had left this facility for another location where the management company had rented office space. The management company had been managing the day to day operations of the facility since 2012, and the management company representatives and staff had been responsible for hiring, orienting, managing, and training all staff, and had taken all the records pertaining to the staff. There were no staff scheduling records available for review on 07/09/18.	C 126		
C 131	O.A.C. 3701-83-09 (C) Adverse Events Each HCF, as part of the quality assessment and performance improvement program required by rule 3701-83-12 of the Ohio Administrative Code, shall document and review any complications and adverse events which arise during the provision of the facility's service. This Rule is not met as evidenced by: Based on staff interview the facility failed to ensure there were records tracking adverse events and complaints for the facility. This violation has the potential to affect any patient seeking services at the facility. Findings include:	C 131		

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C 131	Continued From page 14 In an interview on 07/09/18 beginning at 9:30 AM and including a tour of the premises Staff A said the facility was not providing services for patients after the exit of the management company on 06/22/18. Staff A said the management company had taken all the documentation of significance, including adverse event logs, complaint logs and any tracking of data related to day to day operations of the facility since 2012. There were no adverse event records or documentation about review of events available for review on 07/09/18.	C 131		
C 132	O.A.C. 3701-83-09 (D) Infection Control Policies & Procedures Each HCF shall establish and follow written infection control policies and procedures for the surveillance, control and prevention and reporting of communicable disease organisms by both the contact and airborne routes which shall be consistent with current infection control guidelines, issued by the United States centers for disease control. The policies and procedures shall address: (1) The utilization of protective clothing and equipment; (2) The storage, maintenance and distribution of sterile supplies and equipment; (3) The disposal of biological waste, including blood, body tissue, and fluid in accordance with Ohio law; (4) Standard precautions/body substance isolation or equivalent; and	C 132		

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C 132	<p>Continued From page 15</p> <p>(5) Tuberculosis and other airborne diseases .</p> <p>This Rule is not met as evidenced by: Based on staff interview the facility failed to ensure there was an infection control plan for the facility. This violation has the potential to affect any patient seeking services at the facility.</p> <p>Findings include:</p> <p>In an interview on 07/09/18 beginning at 9:30 AM and including a tour of the premises, Staff A said the facility was not providing services for patients after the exit of the management company on 06/22/18. Staff A said the management company had taken all the documentation of significance, including documentation of infection control tracking and monitoring. The management company had been managing the day to day operations of the facility since 2012, and the management company representatives and staff had been responsible for the infection control program for the facility.</p> <p>There were no records available for review on 07/09/18. There was no staff to fulfill the role of infection control manager. Staff A said all the facility's staff had left with the management company, presumably accompanying them to the new location.</p>	C 132		

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C 133	Continued From page 16	C 133		
C 133	<p>O.A.C. 3701-83-09 (E) Equipment Maintenance</p> <p>The HCF shall maintain equipment in a safe manner and in accordance with the manufacturer's instructions.</p> <p>This Rule is not met as evidenced by: Based on staff interview the facility failed to ensure there was documentation pertaining to equipment service or maintenance at the facility. This violation has the potential to affect any patient seeking services at the facility.</p> <p>Findings include:</p> <p>In an interview on 07/09/18 beginning at 9:30 AM and including a tour of the facility, Staff A said the facility was not providing services for patients after the exit of the management company on 06/22/18. Staff A said the management company had taken all the documentation of significance, including records of equipment maintenance, repairs, and some pieces of equipment had been removed. The management company had been managing the day to day operations of the facility since 2012, and the management company representatives and staff had been responsible for repair and maintenance of all the facility's equipment.</p> <p>There were no records available for review on 07/09/18.</p> <p>Staff A provided a written list of all items alleged</p>	C 133		

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C 133	Continued From page 17 to have been removed by the management company and their employees on 06/22/18. The list included two aspiration devices, computers, Internet connection devices, cameras, all compliance books, medication logs, patient care supplies, medical supplies such as gloves and personal protective gear, personnel files and medical files of patients who had received services the final week of operation at that location.	C 133		
C 140	O.A.C. 3701-83-10 (C) Disaster Planning Each HCF shall develop a disaster preparedness plan including evacuation in the event of a fire or other emergency. Each 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 staff interview the facility failed to ensure there was a disaster plan, including drills, for the facility. This violation has the potential to affect any patient seeking services at the facility. Findings include: In an interview on 07/09/18 beginning at 9:30 AM, including a tour of the facility, Staff A said the facility was not providing services for patients after the exit of the management company on 06/22/18. Staff A said the management company had taken all the documentation of significance, including safety documentation such fire and emergency drills, disaster preparedness, and all policies and procedures pertaining to the	C 140		

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C 140	Continued From page 18 operation of the facility. There were no records available for review on 07/09/18.	C 140		
C 148	O.A.C. 3701-83-11 (F) Medical Records Retention Each HCF shall maintain medical records as necessary to verify the information and reports required by statute or regulation for at least six years from the date of discharge. This Rule is not met as evidenced by: Based on staff interview and observation the facility failed to ensure medical records for patients treated at the facility had been retained at the facility. This violation has the potential to affect any patient seeking services at the facility. Findings include: In an interview on 07/09/18 beginning at 9:30 AM, and including a tour of the premises, Staff A said the facility was not providing services for patients since the exit of the management company on 06/22/18. Staff A said the management company had taken all the documentation of significance, including medical records of patients treated at the facility in the last week of operations, and potentially other records as well. Staff A said he/she had been fired by the management company in January 2018 after the owners of the facility had issued an eviction notice to the management company. Staff A had not been in the facility since January 2018, but had returned at the owner's request after 06/22/18. Staff A said the offices were found	C 148		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/10/2018
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 148	Continued From page 19 in disarray, with file drawers emptied, log books, personnel files, regulatory records, and documentation of all records pertaining to day to day operations missing. Tour of the facility on 07/09/18 revealed empty file drawers, and holes in walls where electronic equipment and cameras were alleged to have been removed. Staff A said the clutter had been cleaned up since 06/22/18, and there was no way to track what files may be missing because even digital files and electronic financial data had been removed from the facility or deleted from existing computers. No patient tracking system was present. No records were available for review on 07/09/18.	C 148		
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 staff interview and observation the facility failed to ensure there was a quality assessment and performance improvement program at the facility. This violation has the potential to affect any patient seeking services at the facility.	C 150		

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NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1243 EAST BROAD STREET COLUMBUS, OH 43205		
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C 150	Continued From page 20 Findings include: In an interview on 07/09/18 at 9:30 AM Staff A said the facility was not providing services for patients since the exit of the management company on 06/22/18. Staff A said the management company had taken all the documentation of significance, including quality assurance records, governing body minutes, quality program information including infection control documentation, and all policies and procedures pertaining to operation of the facility. Staff A said the management company had managed the quality control program and the employees involved with the program left with the management company. There were no records available for review on 07/09/18. Tour of the facility on 07/09/18 revealed empty file drawers, and holes in walls where electronic equipment and cameras were alleged to have been removed. Staff A said the clutter had been cleaned up since 06/22/18, and there was no way to track what files may be missing because even digital files and electronic financial data had been removed from the facility or deleted from existing computers.	C 150		
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:	C 157		

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NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1243 EAST BROAD STREET COLUMBUS, OH 43205		
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C 157	<p>Continued From page 21</p> <p>(1) The date complaint was received;</p> <p>(2) The identity, if provided, of the complainant;</p> <p>(3) A description of complaint;</p> <p>(4) The identity of persons or facility involved;</p> <p>(5) The findings of the investigation; and</p> <p>(6) The resolution of the complaint.</p> <p>This Rule is not met as evidenced by: Based on staff interview and observation the facility failed to ensure there was a complaint tracking system and a policy and procedure for complaints at the facility. This violation has the potential to affect any patient seeking services at the facility.</p> <p>Findings include:</p> <p>In an interview on 07/09/18 at 9:30 AM Staff A said the facility was not providing services for patients since the exit of the management company on 06/22/18. Staff A said the management company had taken all the documentation of significance, including complaint log or documentation pertaining to complaints or incidents, and all policies and procedures pertaining to operation of the facility. Staff A said the management company had managed the facility complaint program and the employees involved with the program left with the management company.</p>	C 157		

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C 157	Continued From page 22 There were no records available for review on 07/09/18. Tour of the facility on 07/09/18 revealed empty file drawers, and holes in walls where electronic equipment and cameras were alleged to have been removed. Staff A said the clutter had been cleaned up since 06/22/18, and there was no way to track what files may be missing because even digital files and electronic financial data had been removed from the facility or deleted from existing computers.	C 157		
C 220	O.A.C. 3701-83-18 (A) Sufficient Staff to Meet Patient Needs Each ASF shall maintain qualified nursing and physician staff, and qualified dental staff, as appropriate for the services provided. Each ASF shall, based on the services provided and the number of patients served, maintain a sufficient number of staff and other personnel and an appropriate schedule of staff time to meet the needs of its patients in a timely manner. This Rule is not met as evidenced by: Based on staff interview and observation the facility failed to ensure there were sufficient staff employed to operate the facility. This violation has the potential to affect any patient seeking services at the facility. Findings include: Observations on 07/09/18 revealed the facility	C 220		

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C 220	Continued From page 23 was staffed by only one administrative person , the main office of the facility had been cleared of records, with empty file cabinets and only previous patient files remaining in a second floor records storage area. In an interview on 07/09/18 beginning at 9:30 AM and including a tour of the facility, Staff A said the facility had not been providing services for patients since the exit of the management company on 06/22/18. Staff A said the management company had taken all the documentation of significance, including personnel files and staffing schedules. Staff A said no other persons were employed by the physician owners since the management company had left with all the previous employees who had staffed and managed the facility. The current staff associated with the facility were the administrative person and two physician /owners. The facility staff were all employees of the former management company and had left this facility for another location where the management company had rented office space. The management company had been managing the day to day operations of the facility since 2012, and the management company representatives and staff had been responsible for hiring, orienting, managing, and training all staff, and had taken all the records pertaining to the staff. There were no records available for review on 07/09/18.	C 220		
C 221	O.A.C. 3701-83-18 (B) Medical Director & Administrator Each ASF shall have a medical director and an	C 221		

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C 221	<p>Continued From page 24</p> <p>administrator as defined in rule 3701-83-01 of the Administrative Code. If the ASF limits it services:</p> <p>(1) To dental/oral and maxillofacial surgery, a dentist may serve as the medical director; or</p> <p>(2) To podiatric surgery, a podiatrist may serve as the medical director.</p> <p>This Rule is not met as evidenced by: Based on staff interview and observation the facility failed to ensure there was an administrator employed at the facility. This violation has the potential to affect any patient seeking services at the facility.</p> <p>Findings include:</p> <p>Observations on 07/09/18 revealed the facility was staffed by one administrative person, the main office of the facility had been cleared of records, with empty file cabinets and only previous patient files remaining in a second floor records storage area.</p> <p>In an interview on 07/09/18 beginning at 9:30 AM and including a tour of the facility, Staff A said the facility had not been providing services for patients since the exit of the management company on 06/22/18. Staff A said the management company had taken all the documentation of significance, and all the staff had been employed by the management company had left on 06/22/18.</p> <p>Staff A said no other persons were employed by the physician owners since the management</p>	C 221		

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C 221	Continued From page 25 company had left with all the previous employees who had staffed and managed the facility. The current staff associated with the facility were the administrative person and two physician /owners, one of whom had acted as medical director. The management company had been managing the day to day operations of the facility since 2012, and included all the management staff. There was no one functioning as an administrator since 06/22/18.	C 221		
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 staff interview the facility failed to ensure there was a director of nursing employed at the facility. This violation has the potential to affect any patient seeking services at the facility. Findings include: In an interview on 07/09/18 beginning at 9:30 AM and including a tour of the facility, Staff A said the facility had not been providing services for patients since the exit of the management company on 06/22/18. Staff A said the management company had taken all the documentation of significance, and all the staff had been employed by the management company, including a director of nursing, had left	C 222		

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C 222	Continued From page 26 on 06/22/18. Staff A said no other persons were employed by the physician owners since the management company had left with all the previous employees who had staffed and managed the facility. The current staff associated with the facility were the administrative person and two physician /owners. The management company had been managing the day to day operations of the facility since 2012, and included all the management staff. There was no one functioning as a director of nursing since 06/22/18.	C 222		
C 231	O.A.C. 3701-83-19 (B) Drug Control & Accountability Each ASF shall: (1) Provide adequate space, equipment, and staff for storage and the administration of drugs in compliance with state and federal laws and regulations. (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. This Rule is not met as evidenced by: Based on staff interview and observation the facility failed to ensure there was a system for	C 231		

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C 231	<p>Continued From page 27</p> <p>drug control and accountability at the facility. This violation has the potential to affect any patient seeking services at the facility.</p> <p>Findings include:</p> <p>In an interview on 07/09/18 beginning at 9:30 AM, and including a tour of the facility, Staff A said the facility was not providing services for patients since the exit of the management company on 06/22/18. Observations on 07/09/18 revealed the facility was staffed by only one administrative person, the main office of the facility had been cleared of records, with empty file cabinets, and medications were in locked drawers in a clinical area. Staff A said the management company had taken all the documentation of significance, including tracking and monitoring logs for medications present in the facility. The management company had been managing the day to day operations of the facility since 2012, and the management company representatives and staff had been responsible for the drug control and accountability program for the facility.</p> <p>There were no records available for review on 07/09/18.</p> <p>Staff A said the facility had been stripped of its identity and records. Staff A said all medication logs including the Ohio Pharmacy information were gone. He/She said the woman who had been the director of nursing for the management company had attempted to pack up medications from a storage area, but she was stopped from doing so by the physician /owner. Staff A said she was unsure if any medications were missing because she had not had access to the clinical storage, nor privy to where medications were stored.</p>	C 231		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/18/2018
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 Follow Up Inspection to Licensure Compliance Inspection completed on 07/11/17 and the second follow up inspection to the Licensure Compliance Inspection completed on 11/29/16. The following violations are based on the follow up inspection completed 01/18/18. Northeast Ohio Women's Center, 1081AS, is not in compliance with the rules for Ambulatory Surgical Facility - O.A.C. 3701-83.	{C 000}		
{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, interview, and policy review, the facility failed to ensure two staff members (Staff E and Staff F) were tested for Tuberculosis on an annual basis and on hire. This could potentially affect all patients receiving care	{C 120}		

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

TITLE



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{C 120}	Continued From page 1 in the facility. A total of 1001 surgical and medical procedures were conducted in the most recent twelve months. Findings include: The facility's TB policy was reviewed. The policy stated all employees will have a TB test on hire and employees with a positive PPD and a negative chest x-ray the following year should undergo a health assessment. This will be repeated on an annual basis for all affected employees. 1. The personnel file for Staff E was reviewed. The personnel file contained a chest x-ray completed in 09/2014. There have been no reassessments since then. 2. The personnel file for Staff F was reviewed. Staff F had a date of hire of 12/02/17. The personnel file did not contain evidence that a TB test was administered. The findings were shared with Staff A on 01/18/18 at 12:00 PM and confirmed.	{C 120}		
{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, policy review and	{C 125}		

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{C 125}	Continued From page 2 interview, the facility failed to ensure performance evaluations were conducted annually for three staff members (Staff B, C, and D). This could potentially affect all patients receiving care in the facility. A total of 1001 surgical and medical procedures were conducted in the most recent twelve months. Findings include: The facility's Performance policy was reviewed. The policy stated that the facility will conduct annual, or as needed, reviews of individual employee performance. 1. The personnel file for Staff B was reviewed. The personnel file contained a performance evaluation on 12/04/16. The personnel file did not contain a performance evaluation after 12/04/16. 2. The personnel file for Staff C was reviewed. Staff C was hired on 11/22/16. The personnel file did not contain a performance evaluation. 3. The personnel file for Staff D was reviewed. Staff D was hired on 01/02/14. The personnel file contained a performance evaluation on 12/04/16. The personnel file did not contain a performance evaluation for 2017 or 2018. On 01/18/18 at 10:17 AM, the findings were shared with Staff A and confirmed.	{C 125}			
{C 139}	O.A.C. 3701-83-10 (B) Safety & Sanitation The HCF shall be maintained in a safe and sanitary manner.	{C 139}			

Ohio Department of Health
STATE FORM

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{C 000}	Initial Comments Follow Up Inspection to follow up inspection completed on 07/11/17 to licensure compliance inspection completed on 11/29/16. The following violations are based on the second follow up inspection completed 01/18/18. Northeast Ohio Women's Center, 1081AS, is not in compliance with the rules for Ambulatory Surgical Facility - O.A.C. 3701-83.	{C 000}		
{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, interview, and policy review, the facility failed to ensure two staff members (Staff E and Staff F) were tested for Tuberculosis on an annual basis and on hire. This could potentially affect all patients receiving care in the facility. A total of 1001 surgical and medical	{C 120}		

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

TITLE



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{C 120}	Continued From page 1 procedures were conducted in the most recent twelve months. Findings include: The facility's TB policy was reviewed. The policy stated all employees will have a TB test on hire and employees with a positive PPD and a negative chest x-ray the following year should undergo a health assessment form. This will be repeated on an annual basis for all affected employees. 1. The personnel file for Staff E was reviewed. The personnel file contained a chest x-ray completed in 09/2014. There have been no reassessments since then. 2. The personnel file for Staff F was reviewed. Staff F had a date of hire of 12/02/17. The personnel file did not contain evidence that a TB test was administered. The findings were shared with Staff A on 01/18/18 at 12:00 PM and confirmed.	{C 120}		
{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, policy review and interview, the facility failed to ensure performance	{C 125}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/17/2018
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 125}	Continued From page 2 evaluations were conducted annually for three staff members (Staff B, C, and D). This could potentially affect all patients receiving care in the facility. A total of 1001 surgical and medical procedures were conducted in the most recent twelve months. Findings include: The facility's Performance policy was reviewed. The policy stated we conduct annual, or as needed, reviews of individual employee performance. 1. The personnel file for Staff B was reviewed. The personnel file contained a performance evaluation on 12/04/16. The personnel file did not contain a performance evaluation after 12/04/16. 2. The personnel file for Staff C was reviewed. Staff C was hired on 11/22/16. The personnel file did not contain a performance evaluation. 3. The personnel file for Staff D was reviewed. Staff D was hired on 01/02/14. The personnel file contained a performance evaluation on 12/04/16. The personnel file did not contain a performance evaluation for 2017 or 2018. On 01/18/18 at 10:17 AM, the findings were shared with Staff A and confirmed.	{C 125}		
{C 139}	O.A.C. 3701-83-10 (B) Safety & Sanitation The HCF shall be maintained in a safe and sanitary manner.	{C 139}		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/17/2018
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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 139}	<p>Continued From page 3</p> <p>This Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to be maintained in a sanitary and safe manner. This could potentially affect all patients receiving care in the facility. A total of 1001 surgical and medical procedures were conducted in the most recent twelve months.</p> <p>Findings include:</p> <p>Observations of the facility's ultrasound room were conducted on 01/18/18 at 9:47 AM. The ultrasound room table was observed with a piece of black duct tape adhered to the vinyl covering.</p> <p>The findings were shared with Staff A at the time of the observation and confirmed.</p>	{C 139}		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/26/2018
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NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223
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(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	<p>Initial Comments</p> <p>Complaint Inspection</p> <p>Complaint Number OH00098189</p> <p>Administrator: Sherri Grossman</p> <p>County: Summit</p> <p>Number of Procedure Rooms: 1</p> <p>Northeast Ohio Women's Center is in compliance with the rules for Ambulatory Surgical Facilities at O.A.C. 3701-83 related to the allegations contained in Complaint OH00098189 completed on 06/26/18.</p>	C 000		

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

TITLE



(X6) DATE

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/02/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 Licensure Compliance Inspection Administrator: Naneesha Pitts County: Cuyahoga Number of ORs: 3 The following violations are issued as a result of the licensure compliance inspection completed on 05/02/18..	C 000		
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 and staff interview, the facility failed to ensure products used as skin dressings, for hand hygiene and disinfection of surfaces were not expired, and failed to ensure cardboard boxes were stored in a safe manner. This could potentially affect all patients in the facility. The facility conducted a total of 6,213 surgical procedures between 04/01/17-03/31/18. Findings include: On 05/01/18 between 9:02 AM and 10:35 AM a tour was conducted with Staff A, B and C. The following was observed on tour and confirmed	C 139		

Ohio Department of Health

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/02/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 139	Continued From page 1 with Staff A, B and C at the time of observations. a) In the first floor receptionist office a container of Hydrogen Peroxide disinfectant wipes was observed with an expiration date of 01/15/17. Staff C confirmed the expiration date and stated the wipes were used to disinfect surfaces in the receptionist area and waiting room. b) An alcohol based hand rub container used for hand hygiene was observed expired in examination room 3 on the second floor. The expiration date on the container was July 2017. c) Two unused transparent dressings were observed in Operating room #2. The packaging of the dressings had an expiration date of 04/18. d) On the second floor in the operating room hallway the storage/electrical room was observed with a battery backup (UPS) system and a circuit breaker box electrical panel on the wall. Large unused cardboard boxes were observed in direct contact with the UPS system and the bottom 2-3 inches of the electrical panel.	C 139		
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	C 201		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/02/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 201	<p>Continued From page 2</p> <p>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:</p> <p>(a) Current licensure and certification, if applicable;</p> <p>(b) Relevant education, training, and experience; and</p> <p>(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.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on personnel file review and staff interviews, the facility failed to provide documented evidence one of three practicing physicians was privileged to provide clinical services for a period of time. This affected Staff F and 440 procedures performed.</p>	C 201		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/02/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 201	<p>Continued From page 3</p> <p>Findings include:</p> <p>Review of Staff F's (physician) credentialing and privileging was begun the afternoon of 04/30/18. Review of said documents revealed privileges were granted to Staff F for the period 04/22/15 to 04/22/17 by a representative of the Governing Body on 04/22/15. Clinical privileges were then granted to Staff F for the period 07/01/17-07/01/19 by a representative of the Governing Body on 08/08/17. There was no documented evidenced Staff F was privileged to provide services for the interim period of 04/23/17 to 06/30/17.</p> <p>During a Governing Body Meeting held on 06/28/17 the re-privileging of Staff F, and other facility physicians, was discussed. The Governing Body then voted and approved said privileges on 07/05/17.</p> <p>Staff A, interim Practice Manager, was made aware of the apparent lapse in Staff F's privileging on 05/01/18 at 12:31 PM. At that time Staff A was shown the privileging documents in question.</p> <p>At 2:15 PM on 05/01/18 Staff A and Staff D were asked about the lapse in Staff F's privileging. Staff A stated she had Staff F's file, at which time she was asked to locate within the file evidence that Staff F was privileged for the period 04/23/17-06/30/17. No supporting documentation was provided.</p> <p>On 5/2/18 at 9:32 AM Staff A was asked again about the lapse in Staff F's clinical privileging. Staff F stated there was nothing more documented related to the lapse. Staff A was then asked if Staff F was providing services during that</p>	C 201		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/02/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
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C 201	Continued From page 4 time (04/23/17-06/30/17) and stated yes. Staff A was then asked to determine the total number of procedures Staff F performed during that time. Staff A provided a list of procedures performed by Staff F between 04/23/17 and 06/30/17 that revealed a total of 440 procedures were performed.	C 201		
C 231	O.A.C. 3701-83-19 (B) Drug Control & Accountability Each ASF shall: (1) Provide adequate space, equipment, and staff for storage and the administration of drugs in compliance with state and federal laws and regulations. (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. This Rule is not met as evidenced by: Based on observations, interviews and policy review the facility failed to ensure unauthorized persons were unable to access narcotic medications and failed to follow their policy for repacking of medications. This could potentially affect all patients who receive services. The facility conducted a total of 6,213 surgical procedures between 04/01/17-03/31/18.	C 231		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/02/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 231	<p>Continued From page 5</p> <p>Findings include:</p> <p>a) On 05/02/18 a review of the facility policy titled "Narcotics Management", approved 10/06/17, revealed the following documentation:</p> <p>"Only licensed staff may have access tot he narcotic cabinet, keys and medications."</p> <p>b) On 05/01/18 between 9:02 AM and 10:35 AM a tour was conducted with Staff A and B. The second floor was observed with a lock box on the wall near the recovery room. The lock box contained keys which were used to unlock the narcotic storage lock box located inside a cabinet behind an open rolling metal cage door. According to Staff B the metal rolling cage door could be locked in place to keep unauthorized persons from accessing the medications. Staff B was observed using the keypad on the lock box to obtain keys for the locked narcotic storage container. Narcotic medications were observed inside the box. When asked who has access to the keys for the narcotic and medication storage, Staff B stated the former Practice Manager and the Security Guard knew the code of the lock box and could access the keys.</p> <p>Staff B confirmed these persons were not licensed or authorized to access the narcotics and medications.</p> <p>c) On 05/02/18 at 9:40 AM a review of the facility policy titled "Drug Control System", approved 10/06/17, contained the following documentation: " Clinicians may repackage multiple containers of a particular drug from a bulk container (for example, repackaging a bottle of 21</p>	C 231		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/02/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
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C 231	<p>Continued From page 6</p> <p>metronidazole pills from a bottle of 100 pills) to dispense to individual patients."</p> <p>"Each container must have the following information and labels applied: Standard PPGOH labeling with patient name, name & address of affiliate, name and strength of drug, directions for usage, date dispensed, and name of prescribing clinician."</p> <p>On 05/01/18 at 10:00 AM the interior of the narcotic storage container was observed with ten amber colored medication bottles which each contained ten pills of medication. An eleventh amber colored medication bottle contained two additional pills. The medication containers were observed with a strip of security tape and were labeled with the lot number, name and strength of medication and the employee's initials and date when the repacking occurred. There was no patient information or prescribing clinician, or directions for usage information on the containers of pills.</p> <p>Staff B stated the pills were Vicodin 5 mg/325 mg and were repackaged from a container of 100 pills into the containers in order to count the medications easier during narcotic drug count reconciliation and this process had been in effect since November 2017.</p> <p>In an additional interview on 05/02/18 at 9:40 AM with Staff B, the employee stated the repackaging was for convenience due to the medication had not been ordered correctly.</p> <p>Staff B was made aware the facility policy provided for review was not followed by the facility for repackaging of the Vicodin medication.</p>	C 231		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/02/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 255	Continued From page 7	C 255		
C 255	<p>O.A.C. 3701-83-21 (A) - (E) Medical Records</p> <p>Each medical record required by paragraph (A) of rule 3701-83-11 of the Administrative Code shall contain at least the following information as applicable for the surgery to be performed:</p> <p>(A) Admission data: (1) Name, address, date of birth, gender, and race or ethnicity; (2) Date and time of admission; and (3) Pre-operative diagnosis, which shall be recorded prior to or at the time of admission.</p> <p>(B) History and physical examination data: (1) Personal medical history, including but not limited to allergies, current medications and past adverse drug reactions; (2) Family medical history; and (3) Physical examination.</p> <p>(C) Treatment data: (1) Physician's, podiatrist's or dentist's orders; (2) Physician's, podiatrist's or dentist's notes; (3) Physician assistant's notes, if applicable; (4) Nurse's notes; (5) Medications; (6) temperature, pulse, and respiration; (7) Any special examination or report, including but not limited to, x-ray, laboratory, or pathology reports; (8) Signed informed consent form; (9) Evidence of advanced directives, if applicable; (10) Operative record; (11) Anesthesia record, if applicable; and (12) Consultation record, if applicable.</p> <p>(D) Discharge data: (1) Final diagnosis; (2) Procedures and surgeries performed; (3) Condition upon discharge; (4) Post-treatment care and instructions; and (5) Attending physician's, podiatrist's or dentist's signature.</p> <p>(E) Other information required by law.</p>	C 255		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/02/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 255	<p>Continued From page 8</p> <p>This Rule is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 5 of 5 sampled patients' (Patients #1, #2, #3, #4, and #5) medical records were accurate and complete. The facility conducted a total of 6,213 surgical procedures between 04/01/17-03/31/18.</p> <p>Findings include:</p> <p>On 05/01/18 medical record reviews were conducted with and confirmed by Staff I.</p> <p>This review revealed the following:</p> <p>a) Four of four sampled patients (Patients #2-#5) had surgical abortions performed by Staff F in the facility. Patient #2's abortion was on 04/19/18. Patient #3's abortion was on 04/20/18. Patient #4's abortion was on 01/30/18, and Patient #5 (minor patient) was on 03/09/18. This review revealed a timeout verification was conducted prior to the procedure; however, the medical record listed only the physician (Staff F) as performing the timeout. Staff I stated the timeout was conducted with all staff present in the operating room but the electronic record would only permit documentation of one person's name.</p> <p>b) Patient #4 had a D & C surgical abortion on 1/30/18. Although the discharge information was given to the patient at 11:24 AM on that date, the medical record did not document the time of discharge from the facility.</p> <p>c) Patient #1 had a medical abortion on 02/12/18</p>	C 255		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/02/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 255	Continued From page 9 by Staff H. The medical record was silent to vital sign assessment on that date. This finding was confirmed by Staff I during the medical record review who verified vital signs should have been obtained on that date.	C 255		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/27/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIONAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Initial Comments</p> <p>Licensure Compliance Inspection</p> <p>Administrator: Jerry H. Lawson</p> <p>County: Hamilton</p> <p>3 ORs</p> <p>Planned Parenthood of Southwest Ohio is in compliance with the rules for Ambulatory Surgery Facility, O.A.C. 3701-83, at the time of the Licensure Inspection completed on 09/27/18.</p>	C 000		

Ohio Department of Health

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/05/2018
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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	<p>Initial Comments</p> <p>Complaint Inspection</p> <p>Complaint OH00101484 and OH00101622</p> <p>Administrator: Chrisse France</p> <p>County: Cuyahoga</p> <p>Number of ORs: none</p> <p>Number of Procedure Rooms: 5</p> <p>No licensure violations were issued as a result of the complaint inspection completed on 12/05/18.</p>	C 000		

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

TITLE



(X6) DATE

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0600AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/12/2018
NAME OF PROVIDER OR SUPPLIER WOMEN'S MED CENTER OF DAYTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 E. STROOP ROAD DAYTON, OH 45429		
(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	<p>Initial Comments</p> <p>Complaint Inspection</p> <p>Complaint Number OH00095513</p> <p>Administrator: Aeran Trick</p> <p>County: Montgomery</p> <p>2 ORs/ Procedure Rooms</p> <p>Women's Med Center of Dayton was in compliance with the rules for Ambulatory Surgery Facility, O.A.C. 3701-83, related to the allegations in complaint OH00095513 completed on 2/12/18.</p>	C 000		

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

TITLE



(X6) DATE

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1081AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/01/2018
NAME OF PROVIDER OR SUPPLIER NORTHEAST OHIO WOMEN'S CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2127 STATE ROAD CUYAHOGA FALLS, OH 44223		
(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	<p>Initial Comments</p> <p>Licensure Compliance Inspection</p> <p>Administrator: Sherri Grossman</p> <p>County: Summit</p> <p>Number of Procedure Rooms: One</p> <p>Northeast Ohio Women's Center is in compliance with the rules for Ambulatory Surgical Facilities at O.A.C. 3701-83 at the time of the Licensure Compliance Inspection completed on 05/01/18.</p>	C 000		

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/08/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 Licensure Compliance Inspection Administrator: Jamie Hamilton County: Franklin Number of Procedure Rooms: 2 The following violations are issued as a result of the licensure compliance inspection completed on 05/08/18.	C 000		
C 106	O.A.C. 3701-83-03 (H) Smoking Policy No HCF shall permit any person to smoke inside the HCF. The HCF shall post a notice in a conspicuous place within the HCF stating that smoking is prohibited inside the HCF. This Rule is not met as evidenced by: Based on observation and interview it was determined a smoking sign was not posted in a conspicuous area. The facility performed 6835 procedures in the last year. This has the potential to affect all individuals entering the facility. Findings including:	C 106		

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

TITLE



(X6) DATE
07/11/18

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/08/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 106	Continued From page 1 A tour was conducted on 05/07/18 at 3:30 PM and it was determined a no smoking sign was not posted in the main lobby area. Staff A reported the facility replaced the front door and the sign was removed and was not replaced.	C 106		
C 132	O.A.C. 3701-83-09 (D) Infection Control Policies & Procedures Each HCF shall establish and follow written infection control policies and procedures for the surveillance, control and prevention and reporting of communicable disease organisms by both the contact and airborne routes which shall be consistent with current infection control guidelines, issued by the United States centers for disease control. The policies and procedures shall address: (1) The utilization of protective clothing and equipment; (2) The storage, maintenance and distribution of sterile supplies and equipment; (3) The disposal of biological waste, including blood, body tissue, and fluid in accordance with Ohio law; (4) Standard precautions/body substance isolation or equivalent; and (5) Tuberculosis and other airborne diseases.	C 132		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0530AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/08/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD EAST HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3255 EAST MAIN STREET COLUMBUS, OH 43213		
(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 132	<p>Continued From page 2</p> <p>This Rule is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure exam tables were kept in good repair to enable proper sanitation. The facility performed 6835 procedures in the last year. This has the potential to affect all individuals receiving services from the facility.</p> <p>Findings include:</p> <p>A tour was conducted in the procedure area on 05/07/18 at 3:45 PM. Observation of Room 112 exam bed revealed the bed had a large tear in the vinyl covering exposing foam and preventing the bed from being properly sanitized. Staff A reported the facility identified the infection control issue in April 2018. The facility has yet to make the repair and the exam bed is still in use.</p>	C 132		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/18/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIONAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Licensure Compliance Inspection Complaint Inspection Complaint Number OH00095591 Administrator: Jerry Lawson County: Hamilton 3 Procedure Rooms The following violations are issued as a result of the Licensure Compliance Inspection completed on 01/18/18. No violations were cited in regard to the Complaint Inspection, Complaint Number OH00095591, completed on 01/18/18.	C 000		
C 132	O.A.C. 3701-83-09 (D) Infection Control Policies & Procedures Each HCF shall establish and follow written infection control policies and procedures for the surveillance, control and prevention and reporting of communicable disease organisms by both the contact and airborne routes which shall be consistent with current infection control guidelines, issued by the United States centers for disease control. The policies and procedures shall address: (1) The utilization of protective clothing and equipment; (2) The storage, maintenance and distribution of sterile supplies and equipment; (3) The disposal of biological waste, including blood, body tissue, and fluid in accordance with	C 132		

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

TITLE



(X6) DATE
02/11/18

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/18/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIONAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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 132	<p>Continued From page 1</p> <p>Ohio law;</p> <p>(4) Standard precautions/body substance isolation or equivalent; and</p> <p>(5) Tuberculosis and other airborne diseases.</p> <p>This Rule is not met as evidenced by: Based on observations, staff interview and review of manufacturers instructions, the facility failed to ensure devices were re-processed per the manufacturer's directions. This had the potential to affect any patient receiving services at the facility. The facility had an annual census of 3,186 patients.</p> <p>Findings include:</p> <p>Observations were made on tour of the patient care areas, including the waiting room, education room, procedure rooms and reprocessing room on 01/16/18 beginning at 9:00 AM. The re-processing room was located on the first floor. The reprocessing room had storage cabinets and drawers for the surgical instruments used for all procedures, three open shelves, two steam sterilization devices, and an L-shaped counter with sinks. One item in the storage cabinet was a white plastic aspiration device, used for manual vacuum aspiration of products of conception, for patients diagnosed with a nine week or less gestation period.</p>	C 132		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/18/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 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 132	<p>Continued From page 2</p> <p>Six of these aspiration devices were observed in a tray on a shelf in a storage cabinet in the room. The devices were white plastic, with the appearance of an extra large syringe and review of a manufacturer insert diagram revealed it had seven pieces, including a plunger, a plunger O-ring, a valve, a cap, a cylinder, a liner and a collar stop.</p> <p>In an interview during the tour on 01/16/18 at 9:00 AM Staff C stated the six devices in the storage cabinet tray were clean, not sterile, and each item had been re-processed and was ready for re-use. Staff C provided a manufacturer instruction brochure that was packaged with each device.</p> <p>In an interview on 01/17/18 on a second tour of the re-processing area Staff C stated the aspiration devices were disassembled and placed unwrapped in a steam autoclave at 270 degrees Fahrenheit for three minutes.</p> <p>Review of the manufacturer insert dated 03/2010 for the product revealed reprocessing procedures involved disassembly of the device, and placing the components, unwrapped, not touching each other, in a steam sterilizer at 250 degrees Fahrenheit for 30 minutes. A second, updated manufacturer insert was provided on 01/18/18 at 8:55 AM and revealed the aspiration device re-processing procedure was "Steam autoclave at 121 degrees Celsius/ 250 degrees Fahrenheit for 30 minutes. Place disassembled Ipas MVA Plus (aspirator device) on linen, paper, or other autoclave compatible pouch with biological indicator. Steam must penetrate all surfaces. Parts should not touch and should be arranged so openings are not obstructed, permitting drainage."</p>	C 132		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/18/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 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 132	Continued From page 3 In an interview on 01/17/18 at 12:50 PM Staff A and Staff B confirmed that the facility's method for re-processing the aspiration device was 270 degrees Fahrenheit for three minutes. Staff A and Staff B acknowledged that the manufacturer's insert instructions for re-processing was for steam sterilization at 250 degrees Fahrenheit for 30 minutes. Staff B said the aspiration device had been in use at the clinic for "many years." In an interview on 01/18/18 at 8:55 AM with Staff A, Staff B, and Staff D presented updated manufacturer's instructions, which revealed guidance for re-processing of the device at 250 degrees Fahrenheit for 30 minutes, unchanged from the 03/2010 version of the manufacturer's insert.	C 132		
C 133	O.A.C. 3701-83-09 (E) Equipment Maintenance The HCF shall maintain equipment in a safe manner and in accordance with the manufacturer's instructions. This Rule is not met as evidenced by: Based on observations, staff interview and review of manufacturer instructions, the facility failed to ensure devices were monitored related to re-use. This violation had the potential to affect any patient receiving services at the facility. The facility had an annual census of 3,186 patients. Findings include:	C 133		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/18/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 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 133	<p>Continued From page 4</p> <p>Observations were made on tour of patient care areas, including the waiting room, procedure rooms and reprocessing room beginning on 01/16/18 at 9:00 AM. The re-processing room was located on the first floor. The reprocessing room had an L-shaped counter with sinks, storage cabinets, two steam sterilizers, and drawers for the surgical instruments used for all procedures. One item was a white plastic aspiration device, used for manual vacuum aspiration of products of conception, for patients diagnosed with a nine week or less gestation period.</p> <p>Six of these devices were observed in a tray on a shelf in a storage cabinet in the room. The devices were white plastic, with the appearance of an extra large syringe, and review of a manufacturer insert diagram revealed it had seven pieces, including a plunger, a plunger O-ring, a valve, a cap, a cylinder, a liner and a collar stop. Review of the manufacturer insert for the product revealed "when aspirators are processed using the recommended methods, the number of uses can be expected to be up to 25. Actual number of uses may vary."</p> <p>In an interview during the tour on 01/16/18 at 9:00 AM Staff C said the six devices in the storage cabinet tray were clean, not sterile, and each item had been re-processed and was ready for re-use. Staff C showed there were also new, still packaged devices, that were in a box in the storage cabinet. The device packages were labeled "Ipas MVA Plus." Each new device was packaged in clear plastic with an exterior label on the packaging, but no distinct markings on the device itself to distinguish one from another. Once opened, used and re-processed the devices were placed in the storage cabinet or in a</p>	C 133		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/18/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 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 133	<p>Continued From page 5</p> <p>procedure room drawer until used again.</p> <p>In an interview on 01/17/18 Staff C said that the re-processed aspirators were kept in the storage cabinet in the re-processing room, and in each of two procedure rooms, in a drawer, available for use. Staff C said the items were kept in use until the item failed to pass a post processing inspection where each was evaluated for such things as function related to holding a vacuum, cracks or malfunction of operation. There was no identification or tracking system to monitor how many times each had been used. The post processing evaluation was conducted by the reprocessing technician after steam sterilization and reassembly of the device. If a device failed to pass inspection, it was disposed as medical waste.</p> <p>Interview with Staff B at 11:38 AM revealed the aspiration devices were used for patients under nine weeks gestation, with an estimated use amount of 15-20 patients per week. Interview with Staff C on 01/17/18 at 11:39 AM revealed the items did not have any distinct marking or identification method to track the use for each device. Staff C said the determination of the quality of each device was made in each post re-processing inspection, the facility was not tracking or documenting the number of uses for each device. On 01/18/18 at 9:18 AM Staff A confirmed the facility did not track the devices for numbers of uses.</p>	C 133		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0596AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/19/2018
NAME OF PROVIDER OR SUPPLIER FOUNDER'S WOMEN'S HEALTH CENTER THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	<p>Initial Comments</p> <p>Complaint Inspection</p> <p>Complaint Number OH00096998</p> <p>Founder's Women's Health Center is in compliance with the rules for Ambulatory Surgery Facility, O.A.C. 3701-83, related to the allegation in complaint number OH00096998 completed on 4/19/18.</p>	C 000		

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/05/2018
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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	<p>Initial Comments</p> <p>Licensure Compliance Inspection</p> <p>Administrator: Chrissie France</p> <p>County: Cuyahoga</p> <p>Number of Procedure Rooms 5</p> <p>Preterm is in compliance with the rules for Ambulatory Surgical Facility - O.A.C. 3701-83 at the time of the Licensure Compliance Inspection completed on 09/05/18.</p>	C 000		

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/19/2018
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Initial Comments</p> <p>Complaint Investigation Complaint Number OH00100769</p> <p>Administrator: Jerry H. Lawson</p> <p>County: Hamilton</p> <p>3 ORs</p> <p>No licensure violations were issued as a result of the Complaint Investigation completed on 11/19/18.</p>	C 000		

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

TITLE



(X6) DATE

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1214AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/08/2018
NAME OF PROVIDER OR SUPPLIER CAPITAL CARE NETWORK OF TOLEDO		STREET ADDRESS, CITY, STATE, ZIP CODE 1160 WEST SYLVANIA AVENUE TOLEDO, OH 43612		
(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	<p>Initial Comments</p> <p>Initial Licensure Compliance Inspection</p> <p>Administrator: Schuyler Beckwith</p> <p>County: Lucas</p> <p>Number of Procedure Rooms: Two</p> <p>Capital Care Network of Toledo is in compliance with the rules for ambulatory surgical facilities at O.A.C. 3701-83 at the time of the Initial Licensure Compliance Inspection completed on 05/08/18.</p>	C 000		

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/30/2019
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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 Licensure Compliance Inspection Complaint Inspection Complaint Number OH00104425 Administrator: Chrissie France County: Cuyahoga Number of OR's: 5 The following violations are issued as a result of the licensure compliance inspection completed on 5/30/19. No violations are related to the complaint number OH00104425.	C 000		
C 143	O.A.C. 3701-83-11 (A) Medical Records Each HCF shall maintain a medical record for each patient that documents, in a timely manner and in accordance with acceptable standards of practice, the patient's needs and assessments, and services rendered. Each medical record shall be legible and readily accessible to staff for use in the ordinary course of treatment. This Rule is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure documentation of emergency medications given (Patient #'s 1 and 2), document physician orders for emergency medications and order to transfer (Patient #'s 1 and 2) and physician signature of	C 143		

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/30/2019
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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 143	<p>Continued From page 1</p> <p>operative notes (Patient #s 4 and 5). The sample size was six medical records reviewed. The facility has performed 1,709 surgical procedures thus far in 2019.</p> <p>Findings include:</p> <p>Patient #1 came to the facility on 4/17/19 for a scheduled surgical procedure. The procedure started at 4:31 PM and ended at 5:08 PM. At 5:11 PM the operating physician noted the patient was having increased bleeding after the procedure. The physician also noted the attending certified registered nurse anesthetist (CRNA) reported the patient's vital signs remained stable. A form titled, "Patient Transfer Report Form" under the section "Medications Administered" listed two medications, the dose of each medication, and the route the medications were given, but did not document the time the medications were given, nor who had administered them.</p> <p>The patient was transferred non-emergently via emergency medical services (EMS) on 4/17/19 at 6:35 PM to the hospital due to excessive bleeding. No physician order was found in the medical record for the transfer, nor for the emergency medications given as a result of the patient's bleeding.</p> <p>These findings were confirmed during interview with Staff B on 5/30/19 at 2:00 PM.</p> <p>Patient #2 came to the facility on 4/05/19 for a scheduled surgical procedure. The procedure started at 10:10 AM and ended at 10:22 AM. Documentation authored by the operating physician at 12:11 PM noted the patient was bleeding during and after the procedure. A form</p>	C 143		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/30/2019
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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 143	<p>Continued From page 2</p> <p>titled, "Patient Transfer Report Form" under the section "Medications Administered" listed six medications, the dose of each medication, the route by which the medications were given and the times given, but did not document who had administered the six medications.</p> <p>The patient was transferred emergently via EMS on 4/05/19 at 10:54 AM to the hospital due to excessive bleeding. No physician order was found in the medical record for the transfer, nor for the emergency medications given as a result of the patient's bleeding.</p> <p>These findings were confirmed during interview with Staff B on 5/30/19 at 2:00 PM. Patient #4 was admitted to the facility on 4/05/19 for a scheduled surgical procedure. Review of Patient #4's surgical procedure notes revealed no documented evidence the physician signed the surgical procedure notes.</p> <p>Interview with Staff B on 5/30/19 at 10:50 AM confirmed the above finding.</p> <p>Patient #5 was admitted to the facility on 05/21/19 for a scheduled surgical abortion. Review of Patient #4's surgical procedure notes revealed no documented evidence the physician signed the surgical procedure notes.</p> <p>Interview with Staff B on 05/30/19 at 10:50 AM confirmed the above finding.</p>	C 143		
C 266	<p>O.R.C. 3702.30 (B) Infection Control Program</p> <p>An ambulatory surgical facility shall maintain an infection control program by creating and administering a plan designed to prevent, identify,</p>	C 266		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/30/2019
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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 266	<p>Continued From page 3</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on staff interview and personnel file review the facility failed to ensure a qualified professional trained in infection control directed the infection control program. This has the potential to affect all patients receiving care from the facility. The facility performed 1,709 surgical procedures thus far in 2019.</p> <p>Findings include:</p> <p>Interview with Staff A was conducted on 5/29/19 at 3:20 PM. Staff A informed the surveyor that she directed the infection control program for the facility. The personnel file for Staff A was reviewed on 5/30/19 at 12:30 PM. The job description in Staff A's personnel file was titled "Director of Clinic Operations" and did not list as part of the responsibilities to direct the infection control program. The personnel file did not contain documented evidence that Staff A had and/or participated in infection control training.</p> <p>These findings were confirmed with Staff A and Staff C on 5/30/19 at 2:00 PM.</p>	C 266		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0288AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/30/2019
NAME OF PROVIDER OR SUPPLIER PRETERM		STREET ADDRESS, CITY, STATE, ZIP CODE 12000 SHAKER BOULEVARD CLEVELAND, OH 44120		
(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 267	<p>O.R.C. 3702.30 (G) Signage</p> <p>An ambulatory surgical facility that performs or induces abortions shall comply with section 3701.791 of the Revised Code.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility failed to have the required signage posted in three of three waiting rooms observed. This had the potential to affect all patients receiving services from the facility. The facility had performed 1709 surgical procedures thus far in 2019.</p> <p>On 5/30/19 at 1:25 PM observation of the waiting areas on the second, third, and forth floor, with Staff C, failed to reveal evidence of the required signage which stated "No one can force you to have an abortion, No one--not a parent, not a husband, not a boyfriend.-- No one, if someone is trying to force you to have an abortion against your will: Do not sign the consent form, If you are at an abortion facility, tell an employee of the facility that someone is trying to force you to have an abortion".</p> <p>Interview with Staff C on 5/30/19 at 1:30 PM confirmed the signs were not posted in facility waiting rooms at the time of the observation.</p>	C 267		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1214AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER CAPITAL CARE NETWORK OF TOLEDO		STREET ADDRESS, CITY, STATE, ZIP CODE 1160 WEST SYLVANIA AVENUE TOLEDO, OH 43612		
(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 Complaint Inspection Complaint Number OH00104804 Administrator: Marlena Ainslie County: Lucas Number of OR's: 2 The following violations are issued as a result of the complaint inspection completed on 6/25/19.	C 000		
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. This Rule is not met as evidenced by: Based on review of personnel files, the facility organization chart, and policy and procedures and staff interview the facility failed to maintain current personnel files which included orientation to their jobs and failed to contain evidence of facility orientation. This deficient practice had the potential to negatively affect any patient who received surgical procedures at the facility. The facility provided 824 surgical procedures in the previous 12 months. Findings included: Review of the facility's policy and procedures titled "Personnel and Staff" with a revision date of	C 124		

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

TITLE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1214AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER CAPITAL CARE NETWORK OF TOLEDO		STREET ADDRESS, CITY, STATE, ZIP CODE 1160 WEST SYLVANIA AVENUE TOLEDO, OH 43612		
(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 124	<p>Continued From page 1</p> <p>05/04/17 directed that staff with appropriate training will be utilized and copies of licenses, registrations and certificates shall be placed in the employee personnel file. The owner, director and medical director shall have the competence to perform their required duties. Training for equipment, safety guidelines, practices and policies will be provided.</p> <p>1) Review of the facility's organization chart revealed Staff A was listed as the facility co-administrator. Review of the personnel file revealed a hire date of 07/11/18. The file failed to contain any orientation to the role of co-administrator.</p> <p>2) Review of the Personnel file for Staff C revealed a hire date of 06/30/18. The file contained job descriptions for the following facility roles for sonogram technician, clerical, patient advocate, and clinical assistant. The personnel failed to contain orientation to these duties.</p> <p>3) Review of the Personnel file for Staff D revealed a hire date of 09/2010. The file contained job descriptions for the following facility roles for staff nurse, preoperative nurse, recovery room nurse and ultrasound tech. The personnel failed to contain orientation to these duties.</p> <p>4) Review of the personnel file for Staff F revealed a hire date of 12/07/14 and documented the staff was hired as a prn (as needed) supplemental staff/volunteer nurse. The file contained no evidence of an orientation to the facility.</p> <p>5) Review of the personnel file for Staff G revealed a hire date of 02/9/19 and documented</p>	C 124		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1214AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER CAPITAL CARE NETWORK OF TOLEDO		STREET ADDRESS, CITY, STATE, ZIP CODE 1160 WEST SYLVANIA AVENUE TOLEDO, OH 43612		
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C 124	Continued From page 2 the staff was hired as a prn (as needed) supplemental staff/volunteer nurse. The file contained no evidence of an orientation to the facility. These findings were confirmed in interview with Staff B on 06/24/19 at 12:14 PM.	C 124		
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 review of personnel files, the facility organization chart, and policy and procedures and staff interview the facility failed to maintain current personnel files which included performance evaluations. This deficient practice had the potential to negatively affect any patient who received surgical procedures at the facility. The facility provided 824 surgical procedures in the previous 12 months. Findings included: Review of the facility's policy and procedure titled "Personnel and Staff" with a revision date of 05/04/17 directed that each staff member will be evaluated at least annually. 1) Review of the personnel file for Staff D revealed a hire date of 09/2010. The file contained job descriptions for the following facility	C 125		

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NAME OF PROVIDER OR SUPPLIER CAPITAL CARE NETWORK OF TOLEDO		STREET ADDRESS, CITY, STATE, ZIP CODE 1160 WEST SYLVANIA AVENUE TOLEDO, OH 43612		
(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 125	Continued From page 3 roles for staff nurse, preoperative nurse, recovery room nurse and ultrasound tech. The personnel file failed to contain any annual performance evaluation. 2) Review of the personnel file for Staff F revealed a hire date of 12/07/14 documented the staff was hired as a prn (as needed) supplemental staff/volunteer nurse. The file contained no evidence of an annual performance evaluation. These findings were confirmed in interview with Staff B on 06/24/19 at 12:14 PM.	C 125		
C 132	O.A.C. 3701-83-09 (D) Infection Control Policies & Procedures Each HCF shall establish and follow written infection control policies and procedures for the surveillance, control and prevention and reporting of communicable disease organisms by both the contact and airborne routes which shall be consistent with current infection control guidelines, issued by the United States centers for disease control. The policies and procedures shall address: (1) The utilization of protective clothing and equipment; (2) The storage, maintenance and distribution of sterile supplies and equipment; (3) The disposal of biological waste, including blood, body tissue, and fluid in accordance with Ohio law; (4) Standard precautions/body substance	C 132		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1214AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER CAPITAL CARE NETWORK OF TOLEDO		STREET ADDRESS, CITY, STATE, ZIP CODE 1160 WEST SYLVANIA AVENUE TOLEDO, OH 43612		
(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 132	<p>Continued From page 4</p> <p>isolation or equivalent; and</p> <p>(5) Tuberculosis and other airborne diseases.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interview the facility failed to ensure a fluid used to cleanse the skin and chemical test strips were not used after expiration. This has the potential to affect all patients receiving services in the facility. The facility performed 824 surgical abortions in the recent 12 months.</p> <p>Findings include:</p> <p>The facility was toured on 6/24/19 at 4:20 PM. During tour in operating room one, a four ounce bottle of Hibiclens (a skin cleansing agent) was found with an open date of 10/29/18 and was available for patient use. Staff in attendance on the tour remarked, "that should probably be thrown out, it's pretty old." No facility policy was found with regard to expiration dates on open bottle's of solution. No manufacturer's instruction for the length of use date for Hibiclens was found by the facility and provided to the surveyor.</p> <p>In the sterile processing room a bottle of chemical indicators (Rapicide OPA Test Strips) was marked opened 10/29/18. The manufacturer's label indicated once opened they expired in six months. The use log maintained by</p>	C 132		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1214AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER CAPITAL CARE NETWORK OF TOLEDO			STREET ADDRESS, CITY, STATE, ZIP CODE 1160 WEST SYLVANIA AVENUE TOLEDO, OH 43612		
(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 132	Continued From page 5 the facility revealed the expired test strips had been used 15 times since 4/29/19. These findings were confirmed during interview on 6/24/19 at 4:35 PM with Staff C and D.	C 132			
C 143	O.A.C. 3701-83-11 (A) Medical Records Each HCF shall maintain a medical record for each patient that documents, in a timely manner and in accordance with acceptable standards of practice, the patient's needs and assessments, and services rendered. Each medical record shall be legible and readily accessible to staff for use in the ordinary course of treatment. This Rule is not met as evidenced by: Based on review of medical records and policy and procedures and staff interview the facility failed to maintain accuracy of medical records as it relates to witnessing the patient's signature. This affected two of five (Patient #'s 1 and 4) patient medical records reviewed. The facility performed 824 surgical procedures in the recent 12 months. Findings include: Review of the facility policy titled, "Informed Consent", last revised on 5/12/17 revealed "Prior to the performance or induction of the abortion, the patient advocate will provide the patient with an informed consent form. If the patient chooses to have an abortion procedure, she must read,	C 143			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1214AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER CAPITAL CARE NETWORK OF TOLEDO		STREET ADDRESS, CITY, STATE, ZIP CODE 1160 WEST SYLVANIA AVENUE TOLEDO, OH 43612		
(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 143	Continued From page 6 sign, and date the consent form and the form must be witnessed and dated by a staff member...." 1) Patient #1 came to the facility for a surgical abortion on 6/18/19. Patient #1 was first seen on 6/13/19. The medical record for Patient #1 included a form, "State of Ohio Consent and Certification" that was signed by the patient but no date or time of the signature. The signature was witnessed by facility staff on 6/13/19 at 12:40 PM. The medical record contained a form titled, "Risks and Complications" that was witnessed by facility staff (Staff C) on 6/13/19 at 12:35 PM, but is not signed by the patient. 2) Patient #4 came to the facility for a surgical abortion on 5/31/19. Patient #4 was first seen on 5/10/19. The medical record for Patient #4 included a form titled, "State of Ohio Consent and Certification" that was signed and dated by the patient on 5/31/19. The patient's signature was witnessed by facility staff (Staff C) on 5/10/19 at 10:30 AM. These findings were confirmed with Staff C and D on 6/25/19 at 12:00 PM.	C 143		
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	C 225		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1214AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER CAPITAL CARE NETWORK OF TOLEDO		STREET ADDRESS, CITY, STATE, ZIP CODE 1160 WEST SYLVANIA AVENUE TOLEDO, OH 43612		
(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 225	<p>Continued From page 7</p> <p>patients are present;</p> <p>(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</p> <p>(3) Have sufficient and qualified additional staff present to attend to the needs of the patients.</p> <p>This Rule is not met as evidenced by: Based on personnel file review, facility organization chart, staff interview and review of policy and procedure the facility failed to ensure recovery room nurse maintained Advanced Cardiac Life Support certification. The facility provided 824 surgical procedures in the previous 12 months.</p> <p>Findings included:</p> <p>Review of the facility organization chart identified Staff D as the Director of Nursing (DON). The file contained a job description for the recovery room nurse which indicated the registered nurse must maintain current Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS). The file contained a certification for BLS with an issue date of 01/2017 and a recommended renewal date of 01/2019 and the ACLS with an issue date of 05/20/2016 and a recommended renewal date of 05/20/18.</p> <p>Interview with Staff D on 06/24/19 at 4:35 PM confirmed the lapsed ACLS and BLS</p>	C 225		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1214AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER CAPITAL CARE NETWORK OF TOLEDO		STREET ADDRESS, CITY, STATE, ZIP CODE 1160 WEST SYLVANIA AVENUE TOLEDO, OH 43612		
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C 225	Continued From page 8 certifications. Staff D verbalized she needed to work on these.	C 225		

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NAME OF PROVIDER OR SUPPLIER CAPITAL CARE NETWORK OF TOLEDO		STREET ADDRESS, CITY, STATE, ZIP CODE 1160 WEST SYLVANIA AVENUE TOLEDO, OH 43612		
(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 Capital Care Network of Toledo was found to be open for business on 09/10/19 at 10:48 AM. Clinic escorts monitored the facility's locked entrance door and escorted patients into the facility. The facility name, address, hours of operation and staff were confirmed with the office manager. Seated patients were observed waiting in the facility's lobby area. The office manager stated the facility no longer operated as a surgical center and had not performed any surgical procedures since 06/28/19. The office manager verbalized the facility only provided medication under the direction of a physician. A request for the Ohio Department of Health license was made and granted. The license was removed from the premises by Ohio Department of Health staff.	C 000		

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

TITLE



(X6) DATE

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2019
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Licensure Compliance Inspection Administrator: Vanessa Hinsdale County: Hamilton 3 ORs/ Procedure Rooms Planned Parenthood Southwest Ohio is not in compliance with the rules for Ambulatory Surgery Facility, O.A.C. 3701-83, at the time of the Licensure Inspection completed on 08/06/19.	C 000		
C 133	O.A.C. 3701-83-09 (E) Equipment Maintenance The HCF shall maintain equipment in a safe manner and in accordance with the manufacturer's instructions. This Rule is not met as evidenced by: Based on observation and staff verification it was determined the facility failed to ensure all equipment was maintained in order to promote sufficient infection control. This had the potential to affect all those utilizing services in the operating rooms. The patient census for the past twelve months was 3,602. Findings include: Facility tour took place the afternoon of 08/05/19 with staff A and B. Observation was made in operating room #1 of a vinyl clad examination table that was noted to have a sizeable split in the	C 133		

Ohio Department of Health
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Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2019
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGION		STREET ADDRESS, CITY, STATE, ZIP CODE 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 133	Continued From page 1 top area of the cover where the patient sits/lays. In operating room # 3 another vinyl clad examination table was noted to have two small splits in the top area of the cover where the patient lays. This finding was verified by both staff A and B during the tour.	C 133		
C 241	O.A.C. 3701-83-20 (B) OR & Recovery Room Equipment Each ASF shall have the following equipment accessible to the operating suite and recovery area: (1) Adequate resuscitation equipment: (a) ASFs providing surgical procedures under topical and local infiltration blocks with or without oral or intramuscular preoperative sedation shall have: airways, bag mask respirator, oxygen source, suction equipment, and age-appropriate resuscitative drugs; (b) ASFs providing surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs or providing surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have: airways, endotracheal tubes, laryngoscope, oxygen delivery capability under positive pressure, suction equipment, and suitable resuscitative drugs. (2) Appropriate monitoring equipment: (a) Each ASF shall have size-specific blood pressure apparatus and stethoscopes, electrocardiogram, oscilloscopes and when pediatric patients are treated, size-specific emergency equipment and medications; (b) ASFs performing surgical procedures in conjunction with oral, parenteral, or intravenous	C 241		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2019
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIOI		STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	<p>Continued From page 2</p> <p>sedation or under an analgesic[sic] or dissociative drugs, or performing surgical procedures that require general or regional block anesthesia and support of vital bodily functions shall have a defibrillator, pulse oximeter with alarm, and temperature monitor. (c) ASFs using inhalation anesthesia shall have an anesthesia machine.</p> <p>(3) Each ASF shall have suitable surgical instruments customarily available for the planned surgical procedure in the operating suite.</p> <p>(4) Each ASF shall have in the recovery room, an emergency call system that is connected electronically, electrically by radio transmission or in a like manner and that effectively alerts staff.</p> <p>This Rule is not met as evidenced by: Based on observation and staff verification it was determined the facility failed to ensure an emergency call system was in place for the recovery room. This had the potential to affect all those utilizing services in this area of the facility. The patient census for the past twelve months was 3,602.</p> <p>Findings include:</p> <p>Facility tour took place the afternoon of 08/05/19 with staff A and B. At approximately 2:45 PM observation was made in the pre/post op area of no emergency call system in place. This finding was verified by both staff A and B during the tour.</p>	C 241		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0286AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2019
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD SOUTHWEST OHIO REGIONAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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 249	Continued From page 3	C 249		
C 249	<p>O.A.C. 3701-83-20 (J) IV Fluids & Equipment</p> <p>Each ASF shall have appropriate intravenous fluids and administration equipment.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure its intravenous equipment was not outdated.</p> <p>Findings include:</p> <p>On 08/05/19 at 1:45 PM a tour was taken of the facility with Staff A and B. Observation in the cabinet space in operating room two revealed an open box of individually wrapped intravenous catheters. Observation of the expiration date on 10 of the 22 gauge catheters was April 2019 and two other 22 gauge catheters was March 2019.</p> <p>On 08/06/19 at 2:45 PM in an interview Staff A confirmed the finding.</p>	C 249		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2019
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 Licensure Compliance Inspection Administrator: Holly Myers County: Cuyahoga Capacity: Three operating rooms. The following violations are issued as a result of the licensure compliance inspection completed on 04/30/19.	C 000		
C 143	O.A.C. 3701-83-11 (A) Medical Records Each HCF shall maintain a medical record for each patient that documents, in a timely manner and in accordance with acceptable standards of practice, the patient's needs and assessments, and services rendered. Each medical record shall be legible and readily accessible to staff for use in the ordinary course of treatment. This Rule is not met as evidenced by: Based on record review and staff interview the facility failed to ensure medication administration was documented timely and that medical record authentication was accurately captured in regard to date and time. This deficient practice affected three patients (Patients #1, #3 and #5) of five patients reviewed for medication administration documentation and medical record authentication. The facility performed 2546 procedures in the preceding 12 months.	C 143		

Ohio Department of Health

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

TITLE

(X6) DATE



Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2019
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 143	<p>Continued From page 1</p> <p>Findings include:</p> <p>Review of the facility's policy and procedure titled "Medication Administration Documentation in the Health Center" directed that documenting the administration of medications in the health center must include who administered the medication, what time the medication was given, the route and location the medication was given, and the lot number and expiration date of the medication administered to the patient. Every medication administered to a patient must have the administration time documented.</p> <p>1. Review of the medical record for Patient #1 revealed the patient underwent a surgical procedure at the facility on 02/15/19. The medical record had documentation Patient #1 was discharged from the facility on 02/15/19 at 3:03 PM. Review of the electronic medication administration record (eMar) documented the pain medication Ketorolac (a non steroidal anti-inflammatory drug) was administered by Staff B on 02/15/19 at 4:33 PM or approximately 1.5 hours after the patient was discharged from the facility.</p> <p>This deficient practice was confirmed in interview with Staff B on 04/30/19 at 4:20 PM.</p> <p>Further review of the medical record for Patient #1 also revealed the patient underwent a surgical procedure at the facility on 02/15/19 and was discharged on 02/15/19 at 3:03 PM. The documentation review revealed the electronic medical record was not signed by Medical Staff D until 02/19/19 at 8:05 AM or four days after the completion of the surgical procedure.</p> <p>Interview with Staff C on 04/30/19 at 4:40 PM</p>	C 143		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2019
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 143	Continued From page 2 confirmed the facility's software only captured the electronic signature of the last person who reviewed the medical record during routine quality checks for completeness of the medical record. Staff C explained that the last person who entered the medical record and digitally signed then over-wrote any previous date and time of electronic signatures of staff who had completed documentation prior to that quality check. Staff C verbalized the facility was unable to provide documentation the medical record documentation was accurately completed with respect to date, time or at the time of delivery of services. 2. The medical record for Patient #3 revealed the patient underwent a medical procedure at the facility on 04/06/19 and was discharged that same date. The documentation review revealed the electronic medical record was not signed by Medical Staff D until 04/10/19 at 5:29 AM or on the fourth day after the medical procedure was performed at the facility. 3. The medical record for Patient #5 revealed the patient underwent a surgical procedure at the facility on 03/08/19 and was discharged that same date. The documentation review revealed the electronic medical record was not signed by Medical Staff D until 03/11/19 at 12:46 PM or on the third day after the surgical procedure was performed at the facility. These findings were confirmed by Staff B and Staff C during interview on 04/30/19 at 4:40 PM.	C 143		
C 231	O.A.C. 3701-83-19 (B) Drug Control & Accountability Each ASF shall:	C 231		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2019
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 231	<p>Continued From page 3</p> <p>(1) Provide adequate space, equipment, and staff for storage and the administration of drugs in compliance with state and federal laws and regulations.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on facility observations and staff interview the facility failed to remove expired medications from medication carts and failed to label medications in accordance with facility policy and procedures. This deficient practice had the potential to affect any patient who required use of medications. The facility performed 2546 procedures in the preceding 12 months.</p> <p>Findings include:</p> <p>1. An observational tour conducted on 04/30/19 between 9:01 AM and 10:05 AM revealed the medication cart located in the facility's operation room (OR) #2 contained a box of 10 ammonium respiratory stimulant ampules (used to revive or prevent fainting in patients). The manufacturer's printed expiration date read the ampules had expired on 11/2018. Inspection of the medication cart located in OR# 1 revealed this medication contained seven ampules of the ammonia</p>	C 231		

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1014AS	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/30/2019
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD BEDFORD HEIGHTS REGIC		STREET ADDRESS, CITY, STATE, ZIP CODE 25350 ROCKSIDE ROAD BEDFORD HEIGHTS, OH 44146		
(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 231	<p>Continued From page 4</p> <p>respiratory stimulant medication with the same expiration date of 11/2018.</p> <p>2. Observation of the nurses' medication preparation area of the facility revealed the presence of a plastic basket of 10 milliliter syringes. Closer inspection revealed there were three syringes filled with an unidentified clear liquid. The syringes contained a label containing the date, time and initials of the preparer but failed to contain the name of the medication or medications contained in the syringes.</p> <p>Interview with Staff B on 04/30/19 at 10:05 AM confirmed these findings. Staff B verbalized that medication carts were checked monthly by staff for outdated medication and verbalized disappointment they hadn't removed the expired ammonia stimulants since after November, 2018. Staff B verbalized the expectation of facility nursing staff was that all pre-filled syringes used for procedures should be labeled with the name of the contents, date, time and initials of the preparer and further verbalized we need to discard them we don't know what's in them..</p>	C 231		

State Medical Board of Ohio
Report of RU-486 Event

Required pursuant to R.C. 2919.123.

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

08

Month

09

Day

2019

Year

2. Name of medical practice or facility at which RU-486 was provided:

Preterm

3. Address of medical practice or facility at which RU-486 was provided:

12000 Shaker Blvd. Cleveland 44120

4. Date post RU-486 complication began:

5. Event(s) (Please check all that apply):

☒ Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion

☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486

Mitchell Reider

8. b. Physician's signature

MR

Date

11/22/19

M.D. / D.O.



Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 37th Floor

Columbus, OH 43215-6127

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for Life
MEDICAL BOARD

NOV 25 2019

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2519.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u>	<u>19</u>	<u>2019</u>
Month Day Year			
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>11/02/19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>4</u> Hours _____ Days			
7. Remarks:			

8. a. Name of physician who provided RU-486: Mitchell Reider
8. b. Physician's signature: [Signature] Date: 11/22/19



Send completed forms to:
State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

Americans
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for Life**
MEDICAL BOARD

NOV 25 2019

State Medical Board of Ohio Report of RU-486 Event

Required pursuant to R.C. 2915.123

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

10 19 2019
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

Preterm

3. Address of medical practice or facility at which RU-486 was provided:

12000 Shaker Blvd Cleveland 44120

4. Date post RU-486 complication began:

11.2.2019

5. Event(s) (Please check all that apply):

☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486:

Mitchell Reider

8. b. Physician's signature

MR

(M.D.) D.O.

Date 11/22/19



Send completed forms to:

State Medical Board of Ohio
Legal Department
30 E. Broad St., 8th Floor
Columbus, OH 43215-6127

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MEDICAL BOARD

NOV 25 2019

State Medical Board of Ohio
Report of RU-486 Event

Required pursuant to R.C. 2919.123

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

10 05 19
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

Pretorm

3. Address of medical practice or facility at which RU-486 was provided:

12000 Shaker Blvd. Cleveland 44120

4. Date post RU-486 complication began:

11.2.19

5. Event(s) (Please check all that apply):

☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify):

6. Duration of event: 4 Hours Days

7. Remarks:

8. a. Name of physician who provided RU-486

Mitchell Reider

8. b. Physician's signature

MR

Date 11/22/19

M.D. D.O.



Send completed forms to:

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Legal Department
30 E. Broad St., 8th Floor
Columbus, OH 43215-6107

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MEDICAL BOARD
for Life
NOV 25 2019

State Medical Board of Ohio Report of RU-486 Event

Required pursuant to R.C. 2919.123

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

09 20 2019
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

Preterm

3. Address of medical practice or facility at which RU-486 was provided:

12000 Shaker Blvd. Cleveland 44120

4. Date post RU-486 complication began:

10/12/19

5. Event(s) (Please check all that apply):

☒ Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion

☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event:

4

Hours

Days

7. Remarks:

8. a. Name of physician who provided RU-486

Mitchell Reider

8. b. Physician's signature

MR

Date

11/22/19

M.D./D.O.



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Legal Department

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NOV 25 2019

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	9	10	2019
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Capital Care Toledo			
3. Address of medical practice or facility at which RU-486 was provided: 1160 W. Sylvania Toledo, OH 43612			
4. Date post RU-486 complication began: 9/14/19			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>N/A</u> Hours <u>N/A</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Dr. David Burkons</u>			
8. b. Physician's signature <u>[Signature]</u> M.D/D.O. _____ Date <u>9/14/19</u>			

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Columbus, OH 43215-6127



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MEDICAL BOARD OF OHIO

OCT 1 2019

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	08	27	19
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Capital Care of Toledo			
3. Address of medical practice or facility at which RU-486 was provided: Capital Care of Toledo 1160 W. Sylvania Ave Toledo OH 43612			
4. Date post RU-486 complication began: 10/01/19			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>N/A</u> Hours _____ Days			
7. Remarks: pt reported to clinic for sono four weeks post med ab, sono confirms pregnancy returned. pt to other clinic for surgical flap care.			
8. a. Name of physician who provided RU-486 <u>David Burkons M.D.</u>			
8. b. Physician's signature _____ M.D./D.O. _____ Date <u>10/1/19</u>			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127



AMERICANS
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for Life
MEDICAL BOARD
OCT 19

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	09	24	2019
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Capital Care of Toledo			
3. Address of medical practice or facility at which RU-486 was provided: 1160 W. Sylvania Ave Toledo OH 43612			
4. Date post RU-486 complication began: 10/01/19			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days <u>N/A</u>			
7. Remarks: Pt reported to clinic for standard F/U sonogram, sonogram shows pregnancy retained.			
8. a. Name of physician who provided RU-486 <u>David Burkons MD</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____ Date <u>10/1/19</u>			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127



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MEDICAL BOARD

OCT 11 2019

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

7/24/19

Month

Day

Year

2. Name of medical practice or facility at which RU-486 was provided:

3. Address of medical practice or facility at which RU-486 was provided:

4. Date post RU-486 complication began:

There was a failed Med Ab

5. Event(s) (Please check all that apply):

☐ Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion

☐ Severe bleeding

☐ Other serious event (specify)

Failed Med Ab

6. Duration of event: _____ Hours _____ Days

7. Remarks:

It was attempted several times to do a preg test and came up for #/h. One of which showed

8. a. Name of physician who provided RU-486

D. M. Burrows

8. b. Physician's signature

[Signature]

M.D. / D.O.

Date

10/7/16

Send completed forms to:

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Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD
OCT 10 2019

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>8</u>	<u>10</u>	<u>2019</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd.</u>			
4. Date post RU-486 complication began: <u>9.10.2019</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>4</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486			
8. b. Physician's signature _____ M.D. / D.O. _____ Date <u>10/2/19</u>			

Send completed forms to: State Medical Board of Ohio
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Columbus, OH 43215-6127

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MEDICAL BOARD

OCT 08 2019

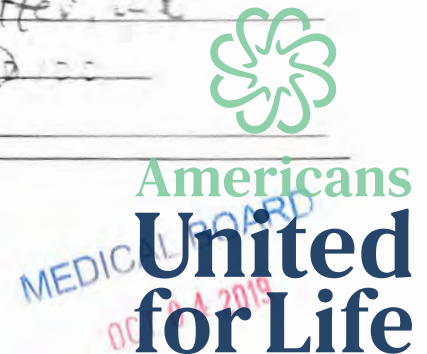
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	9	19	19
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: THE founder's Women's Health Ctr.			
3. Address of medical practice or facility at which RU-486 was provided: 1243 E. Broad St. Columbus, OH 43205			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours 14 Days			
7. Remarks: Patient was incomplete abortion and was referred to The Women's Medical Center in Dayton, OH for surgical abortion.			
8. a. Name of physician who provided RU-486 Karl I. Schaeffer, M.D.			
8. b. Physician's signature Karl I. Schaeffer M.D.			
Date 11-3-19			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>09</u>	<u>19</u>	<u>2019</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>The Founder's Women's Health Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E. Broad St. Columbus, OH 43205</u>			
4. Date post RU-486 complication began: <u>10/02/19</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed abortion</u>			
6. Duration of event: _____ Hours <u>14</u> Days			
7. Remarks: <u>Patient had failed abortion and was sent to The Women's Health Center in Dayton, Ohio for surgical abortion.</u>			
8. a. Name of physician who provided RU-486 <u>Karl Schaeffer, MD</u>			
8. b. Physician's signature <u>Karl Schaeffer</u> <u>MD/DO</u>			
Date <u>10-2-19</u>			

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OCT 04 2019

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>9</u> Month	<u>12</u> Day	<u>2019</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>The founder's Women's Health Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E. Broad Street</u> <u>Columbus, OH 43205</u>			
4. Date post RU-486 complication began: <u>9-24-19 is when clinic was consulted</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed abortion</u>			
6. Duration of event: _____ Hours <u>12</u> Days			
7. Remarks: <u>Patient had failed abortion. Discussed with patient need for surgical abortion. Patient left clinic without arrangements.</u>			
8. a. Name of physician who provided RU-486 <u>Karl I. Schaeffer, MD</u>			
8. b. Physician's signature <u>Karl D. Schaeffer</u> (M.D./D.O.) Date <u>9-25-19</u>			

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MEDICAL BOARD
SEP 25 2019

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	8	7	19
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: 8/8/19			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>failed ab</u>			
6. Duration of event: <u>7</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Roslyn Kade</u>			
8. b. Physician's signature <u>R. Kade MD</u> <u>MD/DO</u> Date _____			

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State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	8	5	19
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: 8/13/19			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: Roslyn Kade			
8. b. Physician's signature: <i>R. Kade MD</i> MD / D.O.			
Date: _____			



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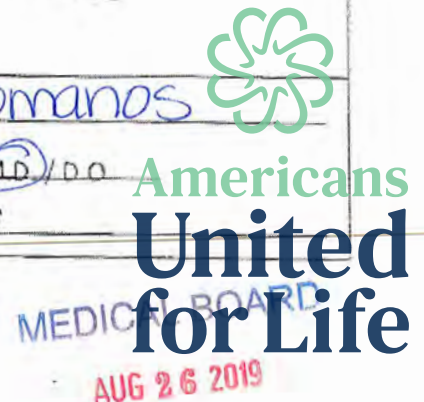
State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	08	01	19
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: 8/13/19			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion (failed) <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks: uncomplicated dilation and suction			
8. a. Name of physician who provided RU-486 Catherine Romanos			
8. b. Physician's signature  M.D./D.O. 8/15/19			

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>July</u>	<u>15</u>	<u>2019</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: <u>8/6/19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: <u>uncomplicated suction.</u>			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature <u>[Signature]</u> MD/DO <u>8/16/19</u>			

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>07</u>	<u>19</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: <u>08/05/19</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: <u>uncomplicated dilation and suction.</u>			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature _____ Date <u>8/16/19</u> MB/D.O.			

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>6</u>	<u>28</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>6/30/19 error 7/2/19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion / <u>Failed</u> <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Prasad</u>			
8. b. Physician's signature <u>[Signature]</u> <u>M.D./D.O.</u>			
Date <u>7/19/19</u>			

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	May	30	2019
Month Day Year			
2. Name of medical practice or facility at which RU-486 was provided: Your Choice Healthcare of Columbus			
3. Address of medical practice or facility at which RU-486 was provided: 6721 Karl Rd. Columbus, Ohio 43229			
4. Date post RU-486 complication began: 6-27-19			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks: D+C @ Northeast Ohio Womens Center			
8. a. Name of physician who provided RU-486: Lucy Ann Nunnally MD			
8. b. Physician's signature: <i>L.A. Nunnally MD</i> (M.D./D.O.)			
Date: 7-15-19			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>6</u>	<u>27</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>7/19/19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion / <u>Failed</u> <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>2</u> Days			
7. Remarks: <u>Completed surgically</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Beasly</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u> Date <u>7/19/19</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>6</u>	<u>6</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>6/27/19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion/ <u>failed</u> <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Completed surgically</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Pensale</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u> Date <u>7/19/19</u>			

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State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>6</u>	<u>25</u>	<u>2019</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>The Foundros Women's Health Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E. Broad Street</u> <u>Columbus, Ohio 43205</u>			
4. Date post RU-486 complication began: <u>7-9-19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>14</u> Days			
7. Remarks: <u>Patient sent to Women's Med Center in Dayton, Ohio for a D+C. for retained tissue in the uterus.</u>			
8. a. Name of physician who provided RU-486 <u>Karl J. Schaeffer, MD</u>			
8. b. Physician's signature <u>Karl J. Schaeffer</u> (M.D./D.O.) Date <u>7-10-19</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

5 15 19
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

Preterm

3. Address of medical practice or facility at which RU-486 was provided:

12000 Shaker Blvd

4. Date post RU-486 complication began:

5-29-19

5. Event(s) (Please check all that apply):

☒ Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion

☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: 4 Hours 0 Days

7. Remarks:

8. a. Name of physician who provided RU-486

8. b. Physician's signature

Date

MR

6/22/19

MD / D.O.



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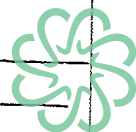
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

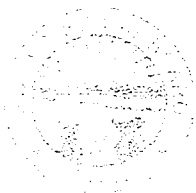
1. Date RU-486 was provided:	<u>5</u>	<u>25</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed medical abortion</u>			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Completed surgically without incident</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Kaley</u>			
8. b. Physician's signature <u>Kaley</u> <u>MD/DO</u>			
Date <u>6/20/19</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>5</u> <u>25</u> <u>19</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>2314 Auburn Ave. Cincinnati, OH 45219</u>
4. Date post RU-486 complication began:	<u>6/12/19</u>
5. Event(s) (Please check all that apply):	<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>NA</u> Hours _____ Days
7. Remarks:	<u>excess blood loss w/ medication abortion, no treatment needed other than iron supplement</u>
8. a. Name of physician who provided RU-486	<u>Dr. Kalsj</u>
8. b. Physician's signature	<u>[Signature]</u> <u>MD/DO</u>
	Date <u>6/26/19</u>

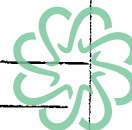
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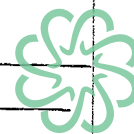
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>5</u>	<u>28</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>6/11/19</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>NA</u> Hours _____ Days _____			
7. Remarks: <u>excess blood loss w/ medication abortion, no treatment needed other than iron supplement.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Kerschbaum</u>			
8. b. Physician's signature _____ M.D. / D.O. _____ Date _____			

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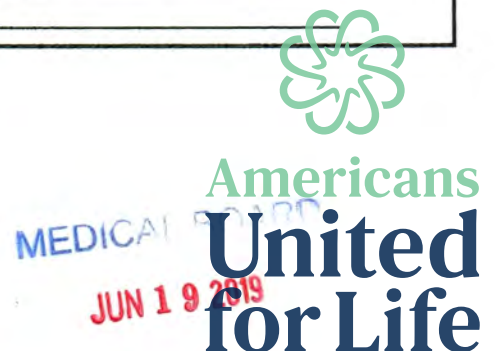
State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>05</u> <u>22</u> <u>19</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>The founder's Women's Health Ctr.</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>1243 E. Broad St</u> <u>Columbus, OH 43205</u>
4. Date post RU-486 complication began:	<u>6-6-19</u>
5. Event(s) (Please check all that apply):	<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed RU-486</u>
6. Duration of event:	<input type="checkbox"/> Hours <u>16</u> Days
7. Remarks:	<u>Patient had failure of medical abortion and was sent to Women's Medical Center in Dayton, Ohio for a D+C.</u>
8. a. Name of physician who provided RU-486	<u>Karl I. Schaeffer, MD</u>
8. b. Physician's signature	<u>Karl I. Schaeffer</u> (M.D./D.O.) Date <u>6-17-19</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>April</u>	<u>11</u>	<u>2019</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: <u>5/14/19</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed M&B</u>			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: <u>Uncomplicated Dilatation and Suction</u>			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u> Date <u>5/20/19</u>			

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>May</u>	<u>03</u>	<u>2019</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: <u>5/17/19</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>retained clot</u>			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: <u>uncomplicated suction</u>			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u> Date <u>5/20/19</u>			

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JUN 17 2019

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

MEMA-00123

1. Date RU-486 was provided:	<u>5</u> Month <u>20</u> Day <u>19</u> Year
2. Name of medical practice or facility at which RU-486 was provided:	
3. Address of medical practice or facility at which RU-486 was provided: NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223	
4. Date post RU-486 complication began: <u>4/1/19</u>	
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____	
6. Duration of event: <u>4</u> Hours _____ Days	
7. Remarks: <u>Had suction D & C 5 cervical</u>	
8. a. Name of physician who provided RU-486	<u>Christine Stott, M.D.</u>
8. b. Physician's signature	<u>[Signature]</u> M.D. / D.O.
Date: <u>6/1/19</u>	

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JUN 03 2019

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	April	23	2019
Month Day Year			
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: 5/9/19			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) failed molar			
6. Duration of event: 1 Hours Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 Roslyn Kerde, MD			
8. b. Physician's signature R. Kerde MD/DO			
Date 5/9/19			

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MAY 20 2019



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State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	03	26	2019
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Capital Care Network			
3. Address of medical practice or facility at which RU-486 was provided: 1160 W. Sylvania Ave Toledo, OH 43612			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 0 Hours 1 Days			
7. Remarks: Incomplete medical ABORTION. D&C completed w/ no complications.			
8. a. Name of physician who provided RU-486: D.M. Bucken, MD			
8. b. Physician's signature: [Signature] M.D./D.O. _____			
Date: 4/17/19			

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MAY 13 2019



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>3</u>	<u>1</u>	<u>2019</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland, Oh 44120</u>			
4. Date post RU-486 complication began: <u>3.22.19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>3</u> Hours _____ Days			
7. Remarks: 			
8. a. Name of physician who provided RU-486: <u>MR M. Reider</u>			
8. b. Physician's signature: _____ M.D. / D.O. _____ Date: <u>5.18.19</u>			

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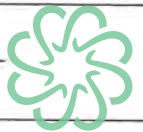
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MAY 13 2019

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>3</u>	<u>26</u>	<u>2019</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland, OH 44120</u>			
4. Date post RU-486 complication began: <u>3.26.19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>4</u> Hours _____ Days			
7. Remarks: 			
8. a. Name of physician who provided RU-486: <u>M. Reider</u>			
8. b. Physician's signature: <u>MR</u> M.D. / D.O. _____ Date: <u>5.8.19</u>			



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>4</u>	<u>16</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Founders Women's Health Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 East Broad Street</u> <u>Columbus, Ohio 43205</u>			
4. Date post RU-486 complication began: <u>5-2-19</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed Mifeprex/Misoprostol abortion</u>			
6. Duration of event: _____ Hours <u>14</u> Days			
7. Remarks: <u>Patient sent to Women's Medical Center in Dayton, Ohio</u> <u>on 5/3/19 for surgical abortion</u>			
8. a. Name of physician who provided RU-486 <u>Karl I. Schaeffer, MD</u>			
8. b. Physician's signature <u>Karl I. Schaeffer</u> <u>(M.D./D.O.)</u> Date <u>5-2-19</u>			

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MAY 08 2019



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>April</u>	<u>1</u>	<u>2019</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: <u>4/22/19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: <u>dilation and suction</u>			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature _____ Date <u>4/22/19</u>			



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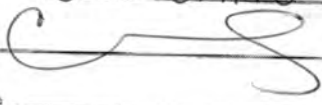
APR 29 2019



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	February	22	2019
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: 2/27/19			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks: tissue removed from OS. suction uncomplicated.			
8. a. Name of physician who provided RU-486 Catherine Romanos			
8. b. Physician's signature  M.D./D.O. 4/16/19			
Date _____			

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MEDICAL BOARD

APR 25 2019



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	March	18	2019
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: 3/19/19			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks: tissue removed thru cervical as uncomplicated suction			
8. a. Name of physician who provided RU-486 Catherine Romanos			
8. b. Physician's signature _____			
Date _____ MD/DO 4/16/19			

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APR 25 2019



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 3 1 19
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cincinnati, OH 45219

4. Date post RU-486 complication began:
3/14/19

5. Event(s) (Please check all that apply):
☐ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized
☐ Patient received a transfusion ☐ Severe bleeding
☒ Other serious event (specify) ongoing pregnancy / failed medical ab

6. Duration of event: 2 ^{of treatment} Hours _____ Days

7. Remarks:
Completed Surgically

8. a. Name of physician who provided RU-486 Dr. Koby
8. b. Physician's signature [Signature] M.D./D.O.
Date _____

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MEDICAL BOARD OF OHIO
APR 23 2019

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.122B)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>02</u>	<u>22</u>	<u>2019</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd Cleveland, Oh 44120</u>			
4. Date post RU-486 complication began: <u>03/19/19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>4</u> Hours _____ Days			
7. Remarks: 			
8. a. Name of physician who provided RU-486: <u>Mitchell Reider, MD</u>			
8. b. Physician's signature: <u>MR</u> M.D./D.O. <u>3/22/19</u>			
Date: _____			

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MEDICAL BOARD
APR 01 2019

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>2</u>	<u>27</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Preterm</u>			
4. Date post RU-486 complication began: <u>3/23/19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>4</u> Hours _____ Days			
7. Remarks: 			
8. a. Name of physician who provided RU-486: <u>Mitchell Reider, MD</u>			
8. b. Physician's signature: <u>MR</u> <u>MD/DO</u>			
Date: <u>3/27/19</u>			



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APR 01 2019

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>2</u>	<u>27</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland Oh 44120</u>			
4. Date post RU-486 complication began: <u>3/23/19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>4</u> Hours _____ Days			
7. Remarks: 			
8. a. Name of physician who provided RU-486: <u>Mitchell Reider, MD</u>			
8. b. Physician's signature: <u>MR</u> <u>MD/DD</u> Date: <u>3/27/19</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>March</u>	<u>7</u>	<u>2019</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: <u>3/12/19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: <u>uncomplicated dilation & suction.</u>			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature _____ Date <u>3/21/19</u> <u>MD/DO</u>			

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APR 01 2019



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State Medical Board of Ohio Report of RU-486 Event

Required pursuant to R.C. 2919.123

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

02/20/2019
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

Preterm

3. Address of medical practice or facility at which RU-486 was provided:

12000 Shaker Blvd. Cleveland, Oh 44120

4. Date post RU-486 complication began:

03/08/2019

5. Event(s) (Please check all that apply):

☒ Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion

☐ Severe bleeding

☐ Other serious event (specify) _____

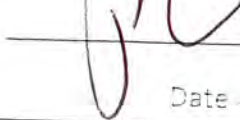
6. Duration of event: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486

Mitchell Reider, MD

8. b. Physician's signature



Date

03/20/19

(M.D.) / (D.O.)



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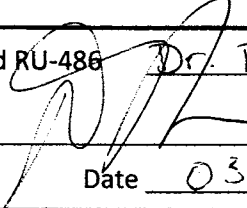
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MAR 21 2019

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	February 19 2019 Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	Capital Care Network
3. Address of medical practice or facility at which RU-486 was provided:	1160 W. Sylvania Ave. Toledo, OH 43612
4. Date post RU-486 complication began:	February 26, 2019
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	0 Hours 2 Days
7. Remarks:	Failed medical abortion, D&C completed with no complications.
8. a. Name of physician who provided RU-486	Dr. David Burkens MD.
8. b. Physician's signature	 M.D./D.O. Date 03 / 01 / 2019

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WAAA0831

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: Feb 10 2014
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

3. Address of medical practice or facility at which RU-486 was provided:

NORTHEAST OHIO WOMENS CENTER
LLC

4. Date post RU-486 complication began:

2127 STATE RD
CUYAHOGA FALLS, OH 44223

5. Event(s) (Please check all that apply):

☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized
was thru pregnancy. One passed on descent
☐ Patient received a transfusion ☐ Severe bleeding
☐ Other serious event (specify) _____

6. Duration of event: 6 Hours _____ Days

7. Remarks: *Pt had twin. One passed on descent
Due to C.S. difficulty*

8. a. Name of physician who provided RU-486

8. b. Physician's signature

Date

D M Burkens, MD
[Signature]
3/7/14

M.D. / D.O.



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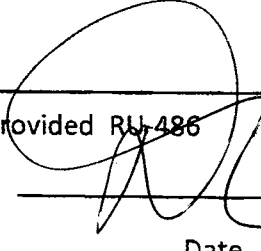
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R0060505

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	2 11 14 Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	
3. Address of medical practice or facility at which RU-486 was provided: NORTHEAST OHIO WOMEN'S CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44226	
4. Date post RU-486 complication began: 3/6/14	
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____	
6. Duration of event: 4 Hours _____ Days	
7. Remarks: Had a.c.s difficulty	
8. a. Name of physician who provided RU-486: D. Burkett	
8. b. Physician's signature:  M.D./D.O.	
Date: 3/11/14	

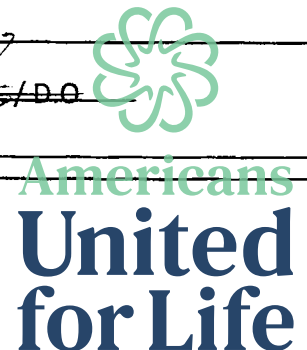
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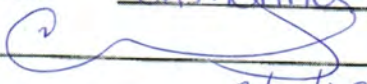




State Medical Board of Ohio Report of RU-486 Event

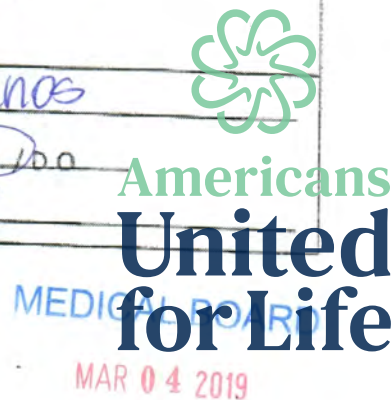
(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>January</u> <u>21</u> <u>2019</u>
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	Women's Med Dayton
3. Address of medical practice or facility at which RU-486 was provided:	1401 E Stroop Rd Dayton, Ohio 45429
4. Date post RU-486 complication began:	2/14/19
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	Uncomplicated dilation and suction
8. a. Name of physician who provided RU-486	Catherine Romanos
8. b. Physician's signature	
	Date <u>2/14/19</u> <u>M.D./D.O.</u>

Send completed forms to:

State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127





State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486


1. Date RU-486 was provided:	<u>February</u> <u>07</u> , <u>2019</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	Women's Med Dayton
3. Address of medical practice or facility at which RU-486 was provided:	1401 E Stroop Rd Dayton, Ohio 45429
4. Date post RU-486 complication began:	<u>02/21/19</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>2</u> <u>4</u> Hours <u>0</u> Days
7. Remarks:	<u>uncomplicated dilation: suction</u>
8. a. Name of physician who provided RU-486	<u>Catherine Romanos, MD</u>
8. b. Physician's signature	<u>[Signature]</u> <u>MD/DO</u>
	Date <u>2/21/19</u>

Send completed forms to:

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Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

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MAR 04 2019


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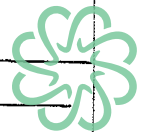
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>1</u>	<u>17</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>D+C done</u>			
8. a. Name of physician who provided RU-486 <u>Dr. [Signature]</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. Date <u>2/14/19</u>			

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Columbus, OH 43215-6127



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>1</u>	<u>30</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>2/13/19</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed medication abortion</u>			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Completed Surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. [Signature]</u>			
8. b. Physician's signature <u>[Signature]</u> M.D. / D.O. _____			
Date <u>2/14/19</u>			

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Columbus, OH 43215-6127



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>1</u>	<u>29</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>2/12/19</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed medical abortion</u>			
6. Duration of event: <u>2</u> Hours <u> </u> Days			
7. Remarks: <u>Completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. [Signature]</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MB / D.O.</u>			
Date <u>2/12/19</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>2</u>	<u>12</u>	<u>2019</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>The Founder's Women's Health Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 East Broad Street</u> <u>Columbus, Ohio 43205</u>			
4. Date post RU-486 complication began: <u>2-18-19</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed of Mifeprax</u>			
6. Duration of event: _____ Hours <u>6</u> Days			
7. Remarks: <u>Patient sent to Women's Med Center in Dayton, Ohio</u> <u>for surgical abortion</u>			
8. a. Name of physician who provided RU-486 <u>Karl I Schaeffer, MD</u>			
8. b. Physician's signature <u>Karl I. Schaeffer</u> <u>(M.D./D.O.)</u>			
Date <u>2-19-19</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>January</u>	<u>25</u>	<u>2019</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: <u>1/31/2019</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>failed medication abortion</u>			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: <u>uncomplicated dilation and suction</u>			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>1/31/19</u>			

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Columbus, OH 43215-6127

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>01</u> <u>24</u> <u>2019</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Founder's Women's Health Center</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>1243 E Broad Street</u> <u>Columbus, Ohio 43205</u>
4. Date post RU-486 complication began:	<u>2-5-19</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	____ Hours <u>14</u> Days
7. Remarks:	<u>Patient has retained tissue and was sent to Women's Med Center in Dayton, Ohio for surgical procedure.</u>
8. a. Name of physician who provided RU-486	<u>Karl D. Schaeffer, MD</u>
8. b. Physician's signature	<u>Karl D. Schaeffer</u> (M.D./D.O.) Date <u>2-14-19</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>1</u>	<u>8</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>1/23/19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>D+C performed</u>			
8. a. Name of physician who provided RU-486 <u>Dr. K. Johnson</u>			
8. b. Physician's signature <u>[Signature]</u> MD/DO _____ Date <u>2/7/19</u>			

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30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127





State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
January	09	2019
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton		
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429		
4. Date post RU-486 complication began: 1/22/19		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input checked="" type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: _____ Hours / _____ Days		
7. Remarks:		
8. a. Name of physician who provided RU-486: Roslyn Kade		
8. b. Physician's signature: <i>R. Kade</i> MD / DO		
Date: 1/20/19		

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Legal Department
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Columbus, OH 43215-6127

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JAN 31 2019



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>01</u>	<u>17</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>The founder's Women's Health Ctr.</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E. Broad St. Columbus, OH 43205</u>			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <u>fetal demise</u> <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>14</u> Days			
7. Remarks: <u>Patient had a Fetal Demise & retained products in the uterus. Patient was sent to Women's Med Center in Dayton, Ohio for a surgical abortion.</u>			
8. a. Name of physician who provided RU-486 <u>Karl I. Schaeffer, MD</u>			
8. b. Physician's signature <u>Karl I. Schaeffer</u> <u>M.D./D.O.</u> Date <u>1-31-19</u>			

Send completed forms to:

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Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127



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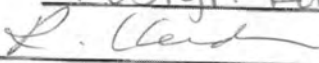
FEB 04 2019



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	January	8	2019
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: 1/17/19			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 Roslyn Kade M.D.			
8. b. Physician's signature  (MD)/D.O.			
Date 1/22/19			

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Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127



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JAN 25 2019



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>January</u> <u>11</u> <u>2019</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	Women's Med Dayton
3. Address of medical practice or facility at which RU-486 was provided:	1401 E Stroop Rd Dayton, Ohio 45429
4. Date post RU-486 complication began:	
5. Event(s) (Please check all that apply):	<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>failed medical abortion</u>
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	<u>uncomplicated Dilation and Suction.</u>
8. a. Name of physician who provided RU-486	<u>Catherine Romanos</u>
8. b. Physician's signature	<u>[Signature]</u> M.D./D.O.
Date	<u>1/16/19</u>

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>JAN.</u>	<u>03</u>	<u>2019</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>founder's Women's Health Ctr.</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E. Broad St.</u>			
4. Date post RU-486 complication began: <u>JAN. 4th or 5th 2019</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion (Medical) <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>13</u> Days			
7. Remarks: <u>fetal demise - pt. referred to The Women's Med Ctr. in Dayton, OH for D&C - appt. on 1-21-19</u>			
8. a. Name of physician who provided RU-486 <u>Karl Schaeffer, MD</u>			
8. b. Physician's signature <u>Karl Schaeffer</u> <u>(M.D.)</u> Date <u>1-17-19</u>			

Send completed forms to:

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Columbus, OH 43215-6127



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>2</u>	<u>14</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>2/26/19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> ^{hr} ^{time} Hours _____ Days			
7. Remarks: <u>D+C done in office</u>			
8. a. Name of physician who provided RU-486 <u>M. Pasch</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>3/22/19</u>			

Send completed forms to:

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Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

2019 MAR 29 AM 10:26
STATE MEDICAL BOARD OF OHIO



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Post Abortion Care Report For Complications

Ohio Department of Health

(Required Pursuant to O.A.C. 3701-47-03)

To be completed by the physician providing post-abortion care

State Use Only

1. Facility where post-abortion care was provided: Planned Parenthood SW Ohio			
2. Street or Post Number 2314 Auburn Ave.	City Cincinnati	State OH	Zip 45219

3. Date of Abortion: Month Day Year 2 / 15 / 19		4. Weeks of Gestation: 10	
5A. Facility where Abortion was performed: Planned Parenthood SW Ohio			
5B. Address of Facility: 2314 Auburn Ave.	Street or Post Number	City Cincinnati	State OH Zip 45219
6. Date Post Abortion Care Begin: Month Day Year 2 / 21 / 19		7. Patient Number 01010101242533	
8. Complication (s) (Please check all that apply): <input checked="" type="checkbox"/> Hemorrhage <input type="checkbox"/> Anesthetic <input type="checkbox"/> Hematometra <input type="checkbox"/> Perforation of Uterus <input type="checkbox"/> Failure of Amniotic Fluid Ex <input type="checkbox"/> RH Incompatibility <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Failed Abortion <input type="checkbox"/> Infection <input type="checkbox"/> Incomplete Abortion <input type="checkbox"/> Death <input checked="" type="checkbox"/> Other (Specify) <u>endometritis</u>			
9. Duration of treatment: (Indicate number of hours or days) <div style="display: flex; justify-content: space-between;"> Hours ⑦ 14 hours Days </div>			

10. Remarks pt. tx empirically with antibiotics due to pain but pain could have been residual from recent heavy bleeding that resolved on its own.	
11A. Physician's Name providing care (Type or print) <u>Dr. Lin</u>	11.B Physicians Signature: <u>[Signature]</u> M.D. D.O. Date: <u>3/14/19</u>

Send Completed Forms to: Ohio Department of Health

Confidential Reports A
PO Box 118

Columbus, Ohio 43216



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>2</u>	<u>14</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>3/11/19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> <u>treatment time</u> Hours Days			
7. Remarks: <u>Completed surgically</u>			
8. a. Name of physician who provided RU-486 <u>M. Bonide</u>			
8. b. Physician's signature <u>[Signature]</u> (M.D./D.O.) Date <u>3/13/19</u>			

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127



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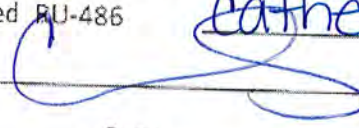
STATE MEDICAL BOARD
OF OHIO
MAR 29 2019 10:26

APR 10 2019

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	February 28 2019
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	Women's Med Dayton
3. Address of medical practice or facility at which RU-486 was provided:	1401 E Stroop Rd Dayton, Ohio 45429
4. Date post RU-486 complication began:	4/5/19
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	1 Hours _____ Days
7. Remarks:	suction - uncomplicated.
8. a. Name of physician who provided RU-486	Catherine Romanos MD
8. b. Physician's signature	
	Date 4/5/19 (MD) / D.O.

Send completed forms to: State Medical Board of Ohio
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30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>8</u>	<u>28</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>9/12/19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Completed surgically w/o incident.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Kelson</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>9/18/19</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>9</u>	<u>12</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>9/26/19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Failed med Ab - completed surgically w/o issue</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Benzek</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>10/25/19</u>			

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State Medical Board of Ohio Report of RU-486 Event

Required pursuant to R.C. 2919.223

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

10 25 2019
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

Preterm

3. Address of medical practice or facility at which RU-486 was provided:

12000 Shaker Blvd. Cleveland, Oh 44120

4. Date post RU-486 complication began:

11.23.19

5. Event(s) (Please check all that apply):

☒ Incomplete abortion

☐ Adverse reaction to RU-486 ☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486:

MR Mitchell Reider

8. b. Physician's signature

Date

11/30/2019

MD D.D.



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State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u> <u>22</u> <u>19</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>The founder's Women's Health Center</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>1243 E. Broad St. Col's, OH 43205</u>
4. Date post RU-486 complication began:	<u>11-6-19</u>
5. Event(s) (Please check all that apply):	<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed abortion</u>
6. Duration of event:	____ Hours <u>14</u> Days
7. Remarks:	<u>Patient sent for D+C on 11/12/19 to Warren's Med Center in Dayton, Ohio.</u>
8. a. Name of physician who provided RU-486	<u>Karl Schaeffer, MD</u>
8. b. Physician's signature	<u>Karl Schaeffer</u> <u>M.D./D.O.</u>
	Date <u>11-7-19</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

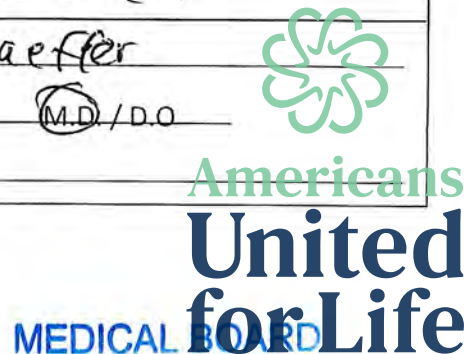
1. Date RU-486 was provided:	<u>10</u> <u>31</u> <u>19</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	THE Founder's Women's Health Ctr.
3. Address of medical practice or facility at which RU-486 was provided:	1243 E. Broad St. Cel's, OH 43205
4. Date post RU-486 complication began:	11-1-19
5. Event(s) (Please check all that apply):	<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed abortion</u>
6. Duration of event:	____ Hours <u>14</u> Days
7. Remarks:	Patient took misoprostol incorrectly and failed the abortion. She was sent to Women's Med Center in Dayton, Ohio for a D&C.
8. a. Name of physician who provided RU-486	<u>Karl Schaeffer</u>
8. b. Physician's signature	<u>Karl Schaeffer</u> <u>M.D.</u> / D.O.
	Date <u>11-14-19</u>

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NOV 18 2019

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u>	<u>18</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: <u>11/12/19</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>failed abortion</u>			
6. Duration of event: _____ Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>ROSALYN KAPR</u>			
8. b. Physician's signature <u>R. Kapr</u> M.D. / D.O.			
Date <u>11/12/19</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u>	<u>24</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>11/9/19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>completed surgically</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Pensato</u>			
8. b. Physician's signature _____ M.D./D.O. _____ Date <u>11/22/19</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>6</u>	<u>14</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>7/5/19</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion / <u>failed</u> <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Completed surgically</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Borschay</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. Date <u>7/19/19</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
<u>10</u> Month	<u>17</u> Day	<u>18</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>		
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>		
4. Date post RU-486 complication began: <u>11/17/19</u>		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed M.</u>		
6. Duration of event: _____ Hours <u>2</u> Days <u>treatment time</u>		
7. Remarks: <u>Completed surgically.</u>		
8. a. Name of physician who provided RU-486 <u>Dr. Kirby</u>		
8. b. Physician's signature <u>Kirby</u> (MD/DO) _____ Date <u>2/15/19</u>		

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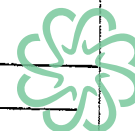
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u>	<u>31</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed med Ab</u>			
6. Duration of event: _____ Hours <u>2</u> ^{hr} <u>15</u> Days			
7. Remarks: <u>Completed surgically</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Gier</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>2/14/19</u>			

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State Medical Board of Ohio Report of RU-486 Event

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>12</u>	<u>27</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>1/12/19</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed med AB</u>			
6. Duration of event: <u>2</u> ^{for treatment} Hours _____ Days			
7. Remarks: <u>Completed surgically</u>			
8. a. Name of physician who provided RU-486 <u>Shawn Line</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____			
Date <u>1/16/19</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

November 10 2018
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

Preterm

3. Address of medical practice or facility at which RU-486 was provided:

12000 Shaker Blvd. Cleveland, OH 44120

4. Date post RU-486 complication began:

5. Event(s) (Please check all that apply):

☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: 6 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486

MR Mitchell Reider, MD

8. b. Physician's signature

MR

MD / DO

Date 1/23/2019



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>12</u>	<u>14</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>failed medication abortion</u>			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: <u>uncomplicated dilation and suction</u>			
8. a. Name of physician who provided RU-486 <u>Catherine Remanos, MD</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>1/16/19</u>			

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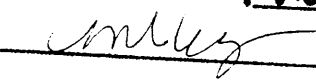


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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
August	31	2018
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: East Columbus Health Center		
3. Address of medical practice or facility at which RU-486 was provided: 3255 East Main St. Columbus, OH 43213		
4. Date post RU-486 complication began: 9-14-18		
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: _____ Hours 14 Days		
7. Remarks:		
8. a. Name of physician who provided RU-486 Michelle Kley		
8. b. Physician's signature  Date 11/30/18		
<div style="text-align: right;">MD / D.O. </div>		

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

August 15 2018
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

East Columbus Health Center

3. Address of medical practice or facility at which RU-486 was provided:

3255 East Main Street

4. Date post RU-486 complication began:

9/4/18

5. Event(s) (Please check all that apply):



☒ Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: _____ Hours 19 Days

7. Remarks:

8. a. Name of physician who provided RU-486

Anne-Marie Sinay

8. b. Physician's signature

M.D./D.O.

Date

11-29-18

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

June 29 2018
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

East Columbus Health Center

3. Address of medical practice or facility at which RU-486 was provided:

3255 East Main Street Columbus, Ohio 43213

4. Date post RU-486 complication began:

7/6/18

5. Event(s) (Please check all that apply):

☐ Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) Failed Medical Abortion

6. Duration of event: _____ Hours 7 Days

7. Remarks:

8. a. Name of physician who provided RU-486

Michelle Lsley,

8. b. Physician's signature

Michelle Lsley

(M.D./D.O.)

Date

11/30/18

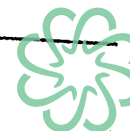
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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: June 21 2018
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
East Columbus Health Center

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main Street Columbus, OH 43213

4. Date post RU-486 complication began: 7/2/2018

5. Event(s) (Please check all that apply):

☐ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) Failed Medical Abortion

6. Duration of event: _____ Hours 11 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Michelle Tsley

8. b. Physician's signature [Signature] (M.D./D.O.)

Date 11/30/18

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

May

18

2018

Month

Day

Year

2. Name of medical practice or facility at which RU-486 was provided:

East Columbus Surgical Center

3. Address of medical practice or facility at which RU-486 was provided:

3255 East Main Street Columbus, Ohio 43213

4. Date post RU-486 complication began:

5-29-18

5. Event(s) (Please check all that apply):

☐ Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☒ Other serious event (specify) Failed Medical Abortion

6. Duration of event: ~~2~~ Hours 11 Days

7. Remarks:

Failed Medical Abortion, treated w/ Aspiration

8. a. Name of physician who provided RU-486

Michelle Isley

8. b. Physician's signature

[Signature]

MD/DO

Date

5/31/18

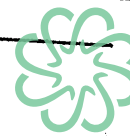
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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>3</u>	<u>16</u>	<u>2018</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>East Columbus Health Center</u>			

3. Address of medical practice or facility at which RU-486 was provided: <u>3255 East Main Street Columbus OH 43213</u>
--

4. Date post RU-486 complication began: <u>3/23/2018</u>
--

5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
--

6. Duration of event: _____ Hours <u>7</u> Days

7. Remarks: <u>INCOMPLETE MEDICAL ABORTION, AND TREATED W/ASPIRATION</u>

8. a. Name of physician who provided RU-486 <u>Iskey, Michelle</u>
8. b. Physician's signature <u>[Signature]</u> <u>(M.D.) / D.O.</u>
Date <u>11/30/18</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u> Month	<u>19</u> Day	<u>2018</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Capital Core Network of Toledo</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1160 W Sylvania Ave.</u> <u>Toledo, OH 43612</u>			
4. Date post RU-486 complication began: <u>11-19-18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>3</u> Hours _____ Days			
7. Remarks: <div style="text-align: right;"><u>COH 0922</u></div>			
8. a. Name of physician who provided RU-486: <u>Dr. David Burkous</u>			
8. b. Physician's signature: <u>[Signature]</u> (M.D./D.O.) Date: <u>11/30/18</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u>	<u>30</u>	<u>2018</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Founder's Women's Health Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E. Broad Street Columbus, Ohio 43205</u>			
4. Date post RU-486 complication began: <u>11/14/18</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed abortion</u>			
6. Duration of event: _____ Hours <u>15</u> Days			
7. Remarks: <u>Patient was sent to Women's Med Center on 11/15/18 for a surgical abortion in Dayton, Ohio</u>			
8. a. Name of physician who provided RU-486 <u>Karl Schaeffer, MD</u>			
8. b. Physician's signature <u>Karl J. Schaeffer, MD</u> <u>MD/DO</u> Date <u>11-29-18</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
MAY	29	2018
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: EAST COLUMBUS HEALTH CENTER		
3. Address of medical practice or facility at which RU-486 was provided: 3255 EAST MAIN STREET COLUMBUS, OH 43213		
4. Date post RU-486 complication began: 6/7/18		
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: _____ Hours <u>9</u> Days		
7. Remarks: INCOMPLETE MEDICAL ABORTION, TREATED W/ ASPIRATION		
8. a. Name of physician who provided RU-486: KATHERINE RIVLIN		
8. b. Physician's signature: <u>[Signature]</u> M.D./D.O.		
Date: 11/20/18		

Send completed forms to:

State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127



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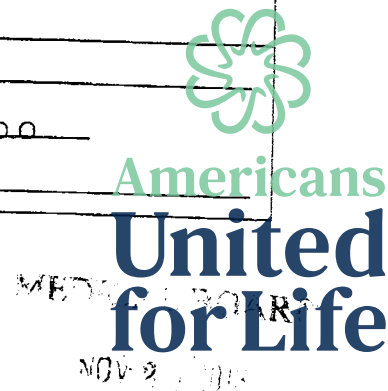
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
10	4	18
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood		
3. Address of medical practice or facility at which RU-486 was provided: 2314 Auburn Ave. Cincinnati, OH 45219		
4. Date post RU-486 complication began: 10/17/18		
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion possible <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: _____ Hours 1 Days		
7. Remarks: treated w/ medication		
8. a. Name of physician who provided RU-486 Dr. K. [Signature]		
8. b. Physician's signature [Signature] M.D./D.O. Date 11/14/18		

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>11</u>	<u>1</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>11/7/18</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: 			
8. a. Name of physician who provided RU-486 <u>Dr. Kalsky</u>			
8. b. Physician's signature <u>[Signature]</u> (MD/DO) Date <u>11/15/18</u>			

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State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	9	20	2018
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: The Founder's Women's Health Center			
3. Address of medical practice or facility at which RU-486 was provided: 1243 E. Broad Street Columbus, Ohio 43205			
4. Date post RU-486 complication began: 10-4-18			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) Failed Abortion, fetal demise			
6. Duration of event: _____ Hours 15 Days			
7. Remarks: Patient had failed abortion and was sent to The Women's Med Center in Dayton, Ohio for surgical abortion on 10/23/18			
8. a. Name of physician who provided RU-486 Karl I. Schaeffer, MD			
8. b. Physician's signature Karl I. Schaeffer M.D./D.O. Date 11-14-18			

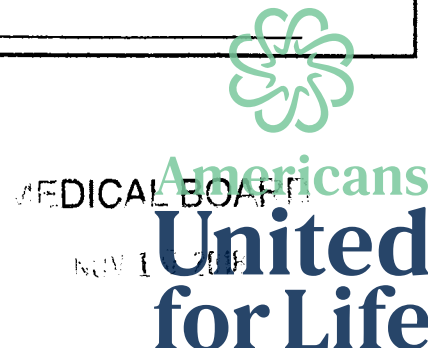
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State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>09</u>	<u>20</u>	<u>2018</u>
Month Day Year			
2. Name of medical practice or facility at which RU-486 was provided: <u>The Founders Women's Health Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E Broad Street Columbus, Ohio 43205</u>			
4. Date post RU-486 complication began: <u>10-8-18</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed Abortion</u>			
6. Duration of event: _____ Hours <u>26</u> Days			
7. Remarks: <u>Patient was sent to Women's Med Center in Dayton, Ohio on 10/24/18 for surgical abortion.</u>			
8. a. Name of physician who provided RU-486 <u>Karl I. Schaeffer, MD</u>			
8. b. Physician's signature <u>Karl I. Schaeffer</u> M.D./D.O. Date <u>11-14-18</u>			

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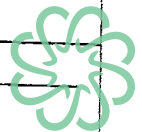
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
10	25	18
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood		
3. Address of medical practice or facility at which RU-486 was provided: 2314 Auburn Ave. Cincinnati, OH 45219		
4. Date post RU-486 complication began:		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed med Ab</u>		
6. Duration of event: <u>2</u> Hours _____ Days		
7. Remarks: <u>Completed Surgically</u>		
8. a. Name of physician who provided RU-486 <u>Dr. Kalsky</u>		
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____ Date <u>11/18</u>		

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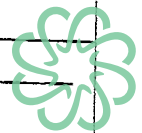
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>9</u>	<u>26</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>10/10/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion (<u>failed</u>) <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Gier</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u> Date <u>10/16/18</u>			

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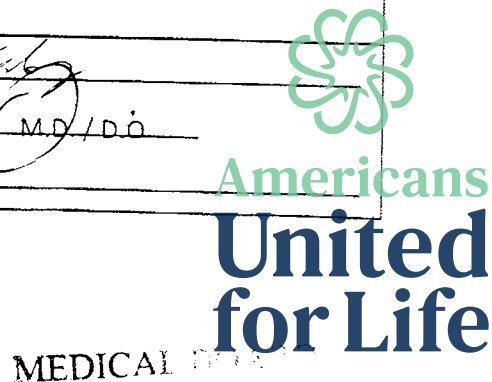
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>8</u>	<u>2</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood Southwest Ohio Region</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave.</u>			
4. Date post RU-486 complication began: <u>8/16/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <u>possible</u> <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>30</u> Days (<u>pt. monitored over this time</u>)			
7. Remarks: <u>Resolved w/ medical management</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Kelly</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date _____			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>8</u>	<u>16</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>9/5/18</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days <u>N/A</u>			
7. Remarks: <u>Significant decrease in the thrombocytopenia process, pt. stable & no treatment needed.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Giv</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u> Date <u>9/25/18</u>			

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State Medical Board of Ohio Report of RU-486 Event

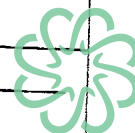
(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>8</u>	<u>22</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>9/14/18</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed medication abortion</u>			
6. Duration of event: <u>2</u> Hours <u> </u> Days			
7. Remarks: <u>Completed surgically w/o incident.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. [Signature]</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. <u> </u>			
Date <u>9/18/18</u>			

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State Medical Board of Ohio Report of RU-486 Event

Required pursuant to R.C. 2919.123

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>8</u>	<u>15</u>	<u>2018</u>
Month Day Year			
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland, OH 44120</u>			
4. Date post RU-486 complication began: <u>9/8/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>4</u> Hours _____ Days			
7. Remarks:			

8. a. Name of physician who provided RU-486: Mitch Reider, MD
8. b. Physician's signature: [Signature] Date: 9.21.18



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SEP 26 2018

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	08	01	2018
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Capital Care Network of Toledo			
3. Address of medical practice or facility at which RU-486 was provided: 1160 W. SYLVANIA AVE. Toledo, OH 43612			
4. Date post RU-486 complication began: 08/27/2018			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>1</u> Days			
7. Remarks: Incomplete med. AB. SX d+c performed. No further issues			
8. a. Name of physician who provided RU-486 <u>Dr. David Burkons</u>			
8. b. Physician's signature <u>[Signature]</u> (M.D./D.O.) _____ Date <u>08/31/18</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	8	18	2018
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Preterm			
3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd. Cleveland, OH 44120			
4. Date post RU-486 complication began: 9/1/18			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 2 Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: Mitch Reider, MD			
8. b. Physician's signature:  M.D./D.O. 			
Date: 9/12/18			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	8	15	2018
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Preterm			
3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd. Cleveland, OH 44120			
4. Date post RU-486 complication began: 9/5/18			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 3 Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: Mitch Reider, MD			
8. b. Physician's signature:  M.D./D.O. 			
Date: 9/12/18			

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SEP 17 2018

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>08</u>	<u>14</u>	<u>2018</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland, OH 44120</u>			
4. Date post RU-486 complication began: <u>8/29/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>4</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Monique Koutsos, MD</u>			
8. b. Physician's signature <u>[Signature]</u> MD / DO _____ Date <u>9/4/18</u>			



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>8</u> Month	<u>11</u> Day	<u>18</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Northeast Ohio Women's Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2127 State St</u> <u>Cuyahoga Falls OH 44323</u>			
4. Date post RU-486 complication began: <u>8/16/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> <u>Failure</u> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: <u>pt had severe P.R. on 8/16</u> <u>with difficulty completing</u>			
8. a. Name of physician who provided RU-486 <u>David Burkman</u>			
8. b. Physician's signature _____ MD/DO _____ Date <u>8/27/18</u>			

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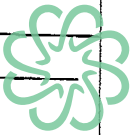
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>6</u>	<u>6</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>6/2/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion possible <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours <u>plus follow up monitoring.</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Dr. Kerby</u>			
8. b. Physician's signature <u>[Signature]</u> (M.D./D.O.) Date <u>8/29/18</u>			

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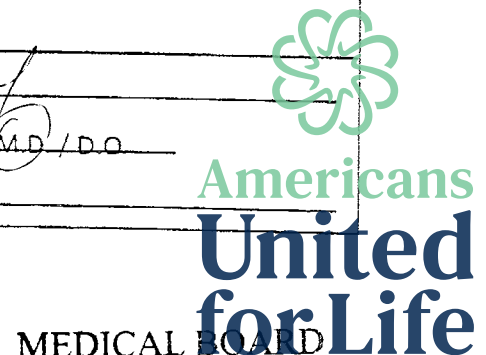
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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>8</u>	<u>8</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>8/22/18</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed medication abortion</u>			
6. Duration of event: <u>2</u> Hours <u> </u> Days			
7. Remarks: <u>Completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>S. Kalsy</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>8/29/18</u>			

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State Medical Board of Ohio Report of RU-486 Event

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>8</u>	<u>15</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>8/17/18</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>3</u> Hours _____ Days			
7. Remarks: 			
8. a. Name of physician who provided RU-486: <u>Dr. Lin</u>			
8. b. Physician's signature: _____ MD/DO _____ Date: <u>8/28/18</u>			

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MEDICAL BOARD

AUG 31 2018



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	06	12	2018
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Capital Care Network Toledo			
3. Address of medical practice or facility at which RU-486 was provided: 1160 W. Sylvan Ave. Toledo, OH 43612			
4. Date post RU-486 complication began: 08-13-18			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized			
<input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding			
<input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>1</u> Days			
7. Remarks: Incomplete medical abortion			
8. a. Name of physician who provided RU-486: Dr. Lucy Ann Nunnally			
8. b. Physician's signature: <u>L.A. Nunnally MD</u>			
Date: <u>8/25/18</u> (M.D./D.O.)			

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AUG 29 2018

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	08	08	18
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Capital Care Network Toledo			
3. Address of medical practice or facility at which RU-486 was provided: 1160 W. Sylvania Ave Toledo, OH 43612			
4. Date post RU-486 complication began: 08-15-18			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>failed medical abortion</u>			
6. Duration of event: _____ Hours <u>1</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Dr. David Burkons</u>			
8. b. Physician's signature <u>[Signature]</u> <u>8/17/18</u> (M.D./D.O.)			

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AUG 29 2018



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	July	19	2018
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: 8/8/18			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: Joyce Horn			
8. b. Physician's signature: <i>Joyce Horn</i> M.D. / D.O. Date: 8/8/18			

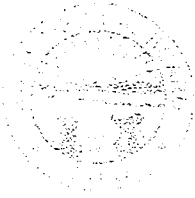
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AUG 14 2018



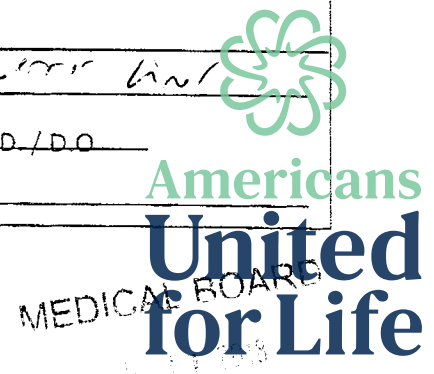
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>7</u>	<u>11</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>7/18/18</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>ongoing pregnancy</u>			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>surgical abortion done</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Katsy...</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. Date <u>7/18/18</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>7</u>	<u>12</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood South West Ohio</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>7/16/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input checked="" type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>1</u> Days			
7. Remarks: 			
8. a. Name of physician who provided RU-486 <u>Dr. Lint</u>			
8. b. Physician's signature _____ M.D. / D.O. _____ Date <u>7/25/18</u>			

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JUL 31 2018

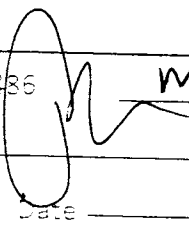
State Medical Board of Ohio Report of RU-486 Event

Required pursuant to R.C. 2919.123

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	06	13	2018
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Preterm Cleveland			
3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd Cleveland, OH 44120			
4. Date post RU-486 complication began: 7/11/18			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 3 Hours _____ Days			

7. Remarks:

8. a. Name of physician who provided RU-486: Mitch Reider, MD
8. b. Physician's signature: 
Date: 7/25/18



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MEDICAL DEFENSE

JUL 31

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

04

20

2018

Month

Day

Year

2. Name of medical practice or facility at which RU-486 was provided:

Preterm

3. Address of medical practice or facility at which RU-486 was provided:

12000 Shaker Blvd Cleveland, OH 44120

4. Date post RU-486 complication began:

6/30/18

5. Event(s) (Please check all that apply):



Incomplete abortion



Adverse reaction to RU-486



Patient hospitalized



Patient received a transfusion



Severe bleeding



Other serious event (specify)

6. Duration of event:

3

Hours

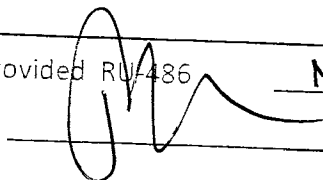
Days

7. Remarks:

8. a. Name of physician who provided RU-486

Mitch Reider, MD

8. b. Physician's signature



Date

7/25/18

MD / DO



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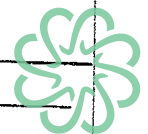
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>4</u>	<u>19</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>6/7/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>4 total treatment time</u> Hours _____ Days _____			
7. Remarks: <u>completed surgically</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Kalsky</u>			
8. b. Physician's signature <u>[Signature]</u> <u>M.D./D.O.</u> Date <u>7/18/18</u>			

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MEDICAL BOARD

JUL 23 2018

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>05</u>	<u>05</u>	<u>2018</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Pre term</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland, OH 44120</u>			
4. Date post RU-486 complication began: <u>6/23/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>4</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Mitch Reider, MD</u>			
8. b. Physician's signature <u>[Signature]</u> MD/DO <u>6/23/18</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

Month

Day

Year

2. Name of medical practice or facility at which RU-486 was provided:

3. Address of medical practice or facility at which RU-486 was provided:

NORTHEAST OHIO WOMENS CENTER

LLC

2127 STATE RD

CUYAHOGA FALLS, OH 44223

4. Date post RU-486 complication began:

5. Event(s) (Please check all that apply):

☒ Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks:

PT had stable low level HCG
Did Suction D.C. on 4/28/18. With small
ant of bleeding

8. a. Name of physician who provided RU-486

Jennifer Wilson, MD

8. b. Physician's signature

Date

4/25/18

MD / DO

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JUL 02 2018

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>05</u>	<u>29</u>	<u>2018</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd Cleveland, OH 44120</u>			
4. Date post RU-486 complication began: <u>6/4/2018</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input checked="" type="checkbox"/> Patient hospitalized <input checked="" type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>2</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Monique Katsuki, MD</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u> Date <u>6/18/18</u>			



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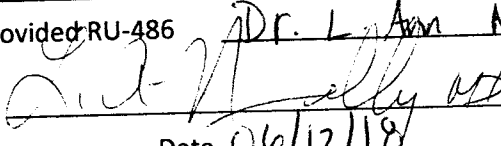
MEDICAL BOARD

JUN 26 2018

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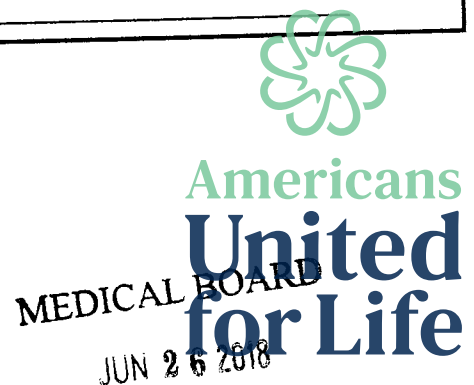
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	05	07	18
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Capital Care Network of Toledo			
3. Address of medical practice or facility at which RU-486 was provided: 1160 W. Sylvania Ave. Toledo, OH 43612			
4. Date post RU-486 complication began: 06/12/18			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 2 Hours _____ Days			
7. Remarks: Incomplete Med. AB. D+C completed. & complications NOA 0927			
8. a. Name of physician who provided RU-486: Dr. L. Ann Nunnally			
8. b. Physician's signature:  (M.D./D.O.) Date: 06/12/18			

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State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
5/31/18	May	31 2018
2. Name of medical practice or facility at which RU-486 was provided:		
Founders Women's Health Center		
3. Address of medical practice or facility at which RU-486 was provided:		
1243 E. Broad St. Columbus, Ohio 432		
4. Date post RU-486 complication began:		
6/16/18		
5. Event(s) (Please check all that apply):		
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding	
<input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: 0.1 Hours _____ Days		
7. Remarks:		
8. a. Name of physician who provided RU-486: Harky Blank MD		
8. b. Physician's signature: [Signature] M.D./D.O. _____		
Date: 6/16/18		

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>May</u> <u>21</u> <u>2018</u>
2. Name of medical practice or facility at which RU-486 was provided:	<u>Founder's Women's Health Center</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>1243 E. Broad St. Columbus, Ohio 43205</u>
4. Date post RU-486 complication began:	<u>6-18-18</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>0.1</u> Hours _____ Days
7. Remarks:	
8. a. Name of physician who provided RU-486	<u>Harley Blank MD</u>
8. b. Physician's signature	<u>ASL</u> (M.D./D.O.)
Date	<u>6-18-18</u>

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

Month

Day

Year

2. Name of medical practice or facility at which RU-486 was provided:

Planned Parenthood East Surgical

3. Address of medical practice or facility at which RU-486 was provided:

3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began:

6/4/18

5. Event(s) (Please check all that apply):

☐ Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☒ Other serious event (specify) failed MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486

Michelle Isley

8. b. Physician's signature

[Signature]

M.D./D.O.

Date

6/14/18

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

Month

Day

Year

2. Name of medical practice or facility at which RU-486 was provided:

Planned Parenthood East

3. Address of medical practice or facility at which RU-486 was provided:

3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began:

5/7/18

5. Event(s) (Please check all that apply):

☐ Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion

☐ Severe bleeding

☒ Other serious event (specify) Failed MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486

Michelle Isley

8. b. Physician's signature

[Signature]

M.D./D.O.

Date

6/14/18

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>05</u>	<u>15</u>	<u>2018</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland, OH 44120</u>			
4. Date post RU-486 complication began: <u>6/5/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>3</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Monique Katsuki, MD</u>			
8. b. Physician's signature <u>[Signature]</u> M.D. / D.O. <u>MD</u>			
Date <u>6/12/18</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>11/04</u>	<u>11</u>	<u>2006</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: <u>05/15/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>7</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: <u>Dr. [Signature]</u>			
8. b. Physician's signature: <u>[Signature]</u> (M.D./D.O.)			
Date: <u>5/15/18</u>			

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MAY 21 2018



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	05	10	2018
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Capital Care Network Toledo			
3. Address of medical practice or facility at which RU-486 was provided: 1160 W. Sylvania Ave Toledo OH 43612			
4. Date post RU-486 complication began: 05/23/2018			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed Medical Abortion</u>			
6. Duration of event: _____ Hours <u>2</u> Days			
7. Remarks: <u>Surgical Abortion completed on 05/25/2018.</u> GUK0730			
8. a. Name of physician who provided RU-486 <u>Dr. Lucy Ann Nunnally</u>			
8. b. Physician's signature <u>[Signature]</u> (M.D./D.O.) Date <u>5/25/18</u>			

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JUN 11 2018

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>04</u> Month	<u>27</u> Day	<u>2018</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Capital Care Network of Toledo</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1160 W. Sylvania Ave.</u>			
4. Date post RU-486 complication began: <u>06-02-18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>5</u> Hours _____ Days			
7. Remarks: <u>Incomplete med ab. pt requests d/c.</u> <u>D/c completed. No complications</u> <div style="text-align: right;"><u>WIK0819</u></div>			
8. a. Name of physician who provided RU-486 _____			
8. b. Physician's signature <u>L. A. Mally MD</u> (M.D./D.O. _____) Date <u>06/02/18</u>			

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MEDICAL BOARD

JUN 11 2018

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>5 - 7 - 18</u>
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Founder's Women's Health Center</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>1243 E. Broad St Columbus, Ohio 43205</u>
4. Date post RU-486 complication began:	<u>6-6-18</u>
5. Event(s) (Please check all that apply):	
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding
<input type="checkbox"/> Other serious event (specify)	_____
6. Duration of event:	<u>0.1</u> Hours _____ Days
7. Remarks:	<u>9mm vacurette D+C</u>
8. a. Name of physician who provided RU-486	<u>Harvey Blank MD</u>
8. b. Physician's signature	<u>[Signature]</u> M.D./D.O.
	Date <u>6-6-18</u>

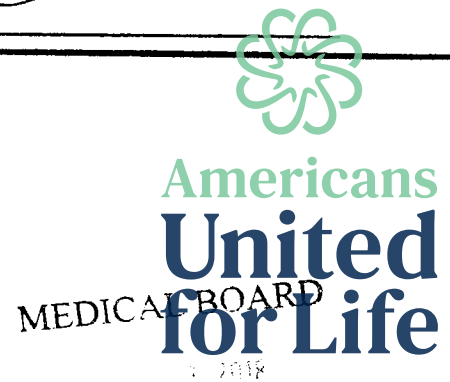
Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127





State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>4</u>	<u>28</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>5/9/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>3</u> Hours _____ Days			
7. Remarks: <u>completed surgically</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Kirby</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date _____			

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MAY 21 2018



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>4</u>	<u>11</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>4/25/18</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>1</u> Days			
7. Remarks: <u>pt. stable, started on ivor</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Lial</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____ Date <u>5/1/18</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>4</u>	<u>5</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>4/11/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>4</u> ^{hrs} Hours _____ Days			
7. Remarks: <u>trial of medicine but needed D+C which was done with success.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. [Signature]</u>			
8. b. Physician's signature <u>[Signature]</u> M.D. / D.O. _____ Date <u>5/16/18</u>			



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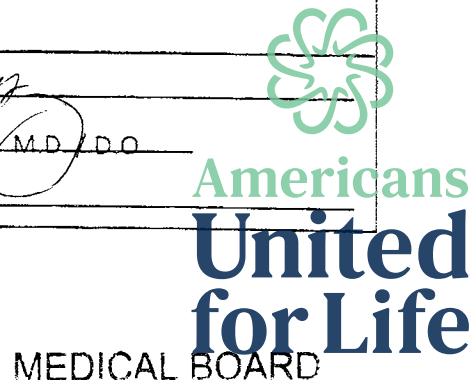
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>3</u>	<u>26</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>4/5/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>resolved w/ 2nd dose of misoprostol</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Kirby</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>5/16/18</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
April	24	2018
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East		
3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus OH 43213		
4. Date post RU-486 complication began: May 3, 2018		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed MAB</u>		
6. Duration of event: _____ Hours _____ Days		
7. Remarks: Failed MAB. Uncomplicated D&C done		
8. a. Name of physician who provided RU-486 <u>Kathy Rivlin</u>		
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____		
Date <u>5/8/18</u>		

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: April 19 2018
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood East Surgery

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began:
4/24/18

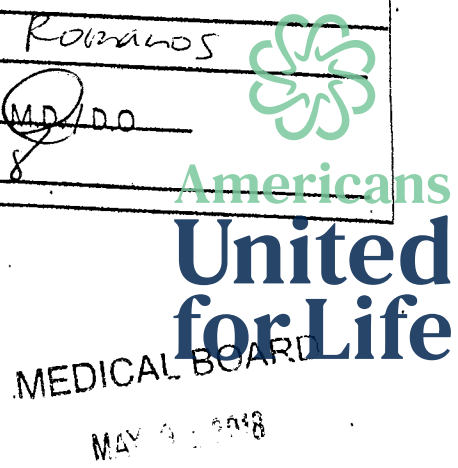
5. Event(s) (Please check all that apply):
☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized
☐ Patient received a transfusion ☐ Severe bleeding
☐ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks:
Uncomplicated D+C

8. a. Name of physician who provided RU-486 Catherine Romanos
8. b. Physician's signature [Signature] MD/DO
Date 5/3/18

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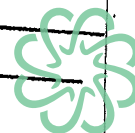
(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
April	2	2018
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgery		
3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus OH 43213		
4. Date post RU-486 complication began: 4/6/18		
5. Event(s) (Please check all that apply):		
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding	
<input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: _____ Hours _____ Days		
7. Remarks: Uncomplicated D+E		
8. a. Name of physician who provided RU-486 Celia McClurey		
8. b. Physician's signature 		
Date 4/30/18		

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MAY 03 2018



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
March	22	2018
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgery		
3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus OH 43213		
4. Date post RU-486 complication began: 4/5/18		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>failed abortion</u>		
6. Duration of event: _____ Hours _____ Days		
7. Remarks: <u>uncomplicated suction</u>		
8. a. Name of physician who provided RU-486 Catherine Romanos		
8. b. Physician's signature <u>[Signature]</u> MD/DO		
Date <u>4/19/18</u>		

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	
Month <u>3</u>	Day <u>28</u> Year <u>18</u>
2. Name of medical practice or facility at which RU-486 was provided: <u>Founders Women's Health Center</u>	
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E. Broad St., Columbus OH 43205</u>	
4. Date post RU-486 complication began: <u>4/11/18</u>	
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____	
6. Duration of event: <u>0.1</u> Hours _____ Days	
7. Remarks: <u>Gestational sac visualized on U/S 4/11/18.</u> <u>Managed w/ D&C. Pt tolerated well.</u>	
8. a. Name of physician who provided RU-486 <u>Abigail Lowther, MD</u>	
8. b. Physician's signature <u>[Signature]</u> (M.D./D.O.) _____ Date <u>4/18/18</u>	

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>3</u>	<u>22</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>4/5/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Completed surgically</u>			
8. a. Name of physician who provided RU-486: <u>B. L...</u>			
8. b. Physician's signature: <u>[Signature]</u> M.D./D.O. _____			
Date: <u>4/17/18</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
3	15	18
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood		
3. Address of medical practice or facility at which RU-486 was provided: 2314 Auburn Ave. Cincinnati, OH 45219		
4. Date post RU-486 complication began: ~ 4/3/18 (notified by pt. on 4/15)		
5. Event(s) (Please check all that apply):		
<input type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input checked="" type="checkbox"/> Severe bleeding	
<input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: _____ Hours <u>2</u> Days		
7. Remarks: informed by pt. @ Thu appt. that she had been seen elsewhere and had a blood transfusion.		
8. a. Name of physician who provided RU-486 <u>J. Kelly</u>		
8. b. Physician's signature <u>[Signature]</u> M.D. / D.O. _____		
Date <u>4/18/18</u>		

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>2</u> Month <u>24</u> Day <u>18</u> Year
2. Name of medical practice or facility at which RU-486 was provided:	NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223
3. Address of medical practice or facility at which RU-486 was provided:	NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223
4. Date post RU-486 complication began:	<u>4/13/18</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	_____ Hours <u>2</u> Days
7. Remarks:	<i>It took single aspirator rather than being given a 2nd dose of Misop. Done 5 days later & normal discharge</i>
8. a. Name of physician who provided RU-486	<u>J. M. Watson, MD</u>
8. b. Physician's signature	<u>[Signature]</u> MD / D.O.
Date	<u>7/17/18</u>

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MEDICAL BOARD
APR 17 2018

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>3</u> Month <u>31</u> Day <u>18</u> Year
2. Name of medical practice or facility at which RU-486 was provided:	NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223
3. Address of medical practice or facility at which RU-486 was provided:	NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223
4. Date post RU-486 complication began:	<u>4/14/18</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>2</u> Hours _____ Days
7. Remarks:	<u>mostly int is small amt of vldt</u> <u>Simple Suction Aspiration done & difficult</u>
8. a. Name of physician who provided RU-486	<u>L. Anna Marmally</u>
8. b. Physician's signature	<u>[Signature]</u> M.D. / D.O.
Date	<u>4/14/18</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	02 Month	29 Day	18 Year	
2. Name of medical practice or facility at which RU-486 was provided: Capital Care Network Toledo				
3. Address of medical practice or facility at which RU-486 was provided: 1100 W. Sylvan Ave Toledo, OH 43612				
4. Date post RU-486 complication began: 3/9/19				
5. Event(s) (Please check all that apply):				
<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____				
6. Duration of event: _____ Hours <u>1</u> Days				
7. Remarks: p/in for suction after incomplete RU-486 complications (D+C)				
8. a. Name of physician who provided RU-486 <u>Dr. David Burkens</u> MAA1224				
8. b. Physician's signature <u>[Signature]</u> (M.D/D.O _____) Date <u>03/09/18</u>				

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>01</u>	<u>26</u>	<u>2018</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Capital Care Network Toledo</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1160 W. Sylvan Ave.</u> <u>Toledo, OH 43612</u>			
4. Date post RU-486 complication began: <u>02/20/2018</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>4</u> Hours <u>0</u> Days			
7. Remarks: <u>Incomplete med. AB. D&C completed. No complications.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. L. Ann Nunnally</u>			
8. b. Physician's signature <u>L. Ann Nunnally MD</u> <u>M.D./D.O.</u> Date <u>02/20/2018</u>			

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APR 13 2018



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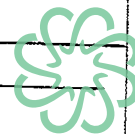
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>3</u>	<u>28</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>4/3/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>1</u> Days <u>treatment ~ 1 hr.</u>			
7. Remarks: 			
8. a. Name of physician who provided RU-486 <u>Dr. Kober</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>4/4/18</u>			

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MEDICAL BOARD
APR 12 2018

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>March</u> <u>19</u> <u>2018</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Founder's Women's Health Center</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>1243 E. Broad St. Columbus, Ohio 43205</u>
4. Date post RU-486 complication began:	<u>4-2-18</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>01</u> Hours _____ Days
7. Remarks:	
8. a. Name of physician who provided RU-486	<u>Harley Blank MD</u>
8. b. Physician's signature	<u>[Signature]</u> (M.D./D.O.)
	Date <u>4/2/18</u>

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Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>03</u>	<u>02</u>	<u>2018</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Founders Womens Health Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E BROAD ST Columbus Ohio 43205</u>			
4. Date post RU-486 complication began: <u>03-16-18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>20+1</u> Hours <u>0</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Harley Blank MD</u>			
8. b. Physician's signature <u>ABL</u> <u>M.D./D.O.</u> Date <u>3-16-18</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>MARCH</u> Month	<u>13</u> Day	<u>2018</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Founder's Women's Health Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E Broad St, Columbus OH 43205</u>			
4. Date post RU-486 complication began: <u>March 30, 2018</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2.5</u> Hours _____ Days			
7. Remarks: <u>Incomplete medication abortion. Guided by ultrasound</u> <u>DmC performed, no complications. Pt tolerated well.</u>			
8. a. Name of physician who provided RU-486 <u>Karl Schaeffer, MD</u>			
8. b. Physician's signature <u>Karl Schaeffer</u> M.D./D.O. _____ Date <u>3-30-18</u>			

Send completed forms to:

State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127



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MEDICAL BOARD

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 3 14 2018
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Preterm

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd. Cleveland, OH 44120

4. Date post RU-486 complication began:
3/31/2018

5. Event(s) (Please check all that apply):
☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized
☐ Patient received a transfusion ☐ Severe bleeding
☐ Other serious event (specify) _____

6. Duration of event: 3 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Natalie Hinchcliffe, DO
8. b. Physician's signature [Signature] M.D. (D.O.)
Date 4/4/18



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>MARCH</u> Month	<u>13</u> Day	<u>2018</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Founder's Women's Health Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E Broad St, Columbus OH 43205</u>			
4. Date post RU-486 complication began: <u>March 30, 2018</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2.5</u> Hours _____ Days			
7. Remarks: <u>Incomplete medication abortion. Guided by ultrasound. DmC performed, no complications. Pt tolerated well.</u>			
8. a. Name of physician who provided RU-486 <u>Karl Schaeffer, MD</u>			
8. b. Physician's signature <u>Karl Schaeffer</u> M.D./D.O. Date <u>3-30-18</u>			

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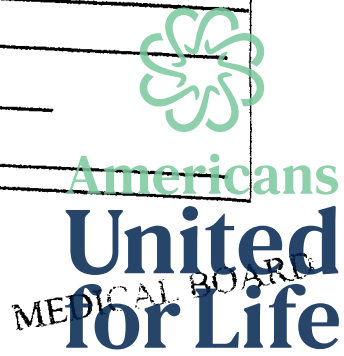
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
Feb	21	2018
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgery		
3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus OH 43212		
4. Date post RU-486 complication began: 2/28 - 2nd dose miso given		
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____ 3/8 - suction done		
6. Duration of event: _____ Hours _____ Days		
7. Remarks:		
8. a. Name of physician who provided RU-486: Sinay		
8. b. Physician's signature: _____ M.D./D.O. _____ Date: 3-28-18		

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>January</u> <u>29</u> <u>2018</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood East Surgery</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>3255 E. Main St.</u> <u>Columbus OH 43213</u>
4. Date post RU-486 complication began:	<u>3/21/18</u>
5. Event(s) (Please check all that apply):	<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>failed MAB</u>
6. Duration of event: _____ Hours _____ Days	
7. Remarks:	<u>uncomplicated D-E</u>
8. a. Name of physician who provided RU-486	<u>Catherine Romanos</u>
8. b. Physician's signature	<u>[Signature]</u> MD/DO Date <u>3/29/18</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>1</u> / <u>29</u> / <u>18</u>
Month Day Year	
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>
4. Date post RU-486 complication began:	<u>2/1/18</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	<u>Med ab procedure initiated per FDA regimen on 1/29/18. Pt. clo no results from medication - was given 2nd dose of misoprostol on 2/1/18. Flu ultrasound on 2/6/18 showed failed procedure. Surgical aspiration was done on 2/6/18; pt did well post op.</u>
8. a. Name of physician who provided RU-486	<u>Timothy Kress, MD</u>
8. b. Physician's signature	<u>Timothy S Kress MD/DO</u>
Date	<u>3/16/18</u>

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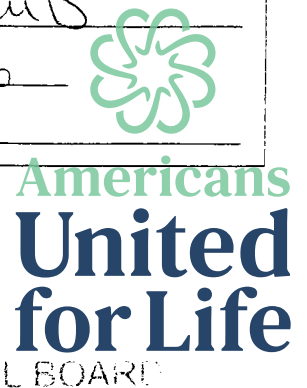
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>02</u>	<u>13</u>	<u>2018</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland, OH 44120</u>			
4. Date post RU-486 complication began: <u>3/10/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>3</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Monique Katsuki, MD</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____ Date <u>3/20/18</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>2</u>	<u>24</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>3/7/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <u>failed</u> <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Completed surgically</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Kating</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD / D.O.</u> Date <u>3/14/18</u>			

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MAR 20 2018



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
Feb	19	2018
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgery		
3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus OH 43213		
4. Date post RU-486 complication began: 2/28/18		
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: _____ Hours _____ Days		
7. Remarks: Uncomplicated suction		
8. a. Name of physician who provided RU-486 Catherine Romanos		
8. b. Physician's signature [Signature] MD/D.O. Date 3/8/18		

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>2</u>	<u>9</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Northeast Ohio Women Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2127 State Rd</u> <u>Cumtoga Falls, Ohio 44223</u>			
4. Date post RU-486 complication began: <u>3/5/18</u>			
5. Event(s) (Please check all that apply): <u>Failed</u> <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed medical</u>			
6. Duration of event: _____ Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>J. Ann Nunnally MD</u>			
8. b. Physician's signature <u>[Signature]</u> MD/DO <u>[Signature]</u> Date <u>3/5/18</u>			

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State Medical Board of Ohio Report of RU-486 Event


(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
Month	Day	Year
1	30	18
2. Name of medical practice or facility at which RU-486 was provided: <i>Planned Parenthood East Surgery</i>		
3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus OH 43213		
4. Date post RU-486 complication began: <i>2/8/18</i>		
5. Event(s) (Please check all that apply):		
<input type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding	
<input checked="" type="checkbox"/> Other serious event (specify) <i>failed MAB</i>		
6. Duration of event: _____ Hours _____ Days		
7. Remarks: <i>no further action</i>		
8. a. Name of physician who provided RU-486 <i>Catherine Romanos</i>		
8. b. Physician's signature _____ M.D./D.O. _____		
Date _____		

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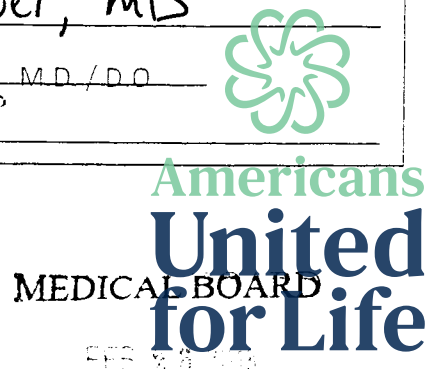
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>01</u>	<u>26</u>	<u>2018</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland, OH 44120</u>			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Mitch Reider, MD</u>			
8. b. Physician's signature <u>[Signature]</u> <u>2/21/18</u> MD/DO			

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State Medical Board of Ohio Report of RU-486 Event

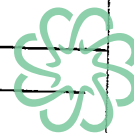
(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>1</u>	<u>24</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>2/14/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: 			
8. a. Name of physician who provided RU-486 <u>A. Kuby</u>			
8. b. Physician's signature <u>Maly</u> <u>(M.D./D.O.)</u> Date <u>2/21/18</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>1</u>	<u>30th</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>1/23/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <u>possible</u> <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>7</u> Days			
7. Remarks: <u>Resolved w/ medication</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Lin</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____ Date <u>2/20/18</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
<u>1</u> Month	<u>5</u> Day	<u>18</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>		
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>		
4. Date post RU-486 complication began: <u>1/19/18</u>		
5. Event(s) (Please check all that apply):		
<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized		
<input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding		
<input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: _____ Hours <u>6</u> Days		
7. Remarks:		
8. a. Name of physician who provided RU-486 <u>Dr. Kuntz</u>		
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____		
Date <u>1/19/2018</u>		

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>01</u>	<u>05</u>	<u>2018</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland, OH 44120</u>			
4. Date post RU-486 complication began: <u>1/27/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>3</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Mitch Reider, MD</u>			
8. b. Physician's signature _____ MD / DO _____ Date <u>2.9.18</u>			

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MEDICAL BOARD

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

Month

Day

Year

2. Name of medical practice or facility at which RU-486 was provided:

Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:

25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began:

1/25/18

5. Event(s) (Please check all that apply):



Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: Med ab. procedure initiated per FDA regimen on 1/20/18. Follow up ultrasound on 1/25/18 showed uterine debris. Surgical aspiration was done on 1/26/18; pt did well post op.

8. a. Name of physician who provided RU-486

Timothy Kress, MD

8. b. Physician's signature

Timothy Kress MD/DO

Date

2/7/18

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>12</u>	<u>20</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Greater Ohio</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>			
4. Date post RU-486 complication began: <u>1/4/18</u>			
5. Event(s): (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: <u>Med ab. procedure initiated per FDA regimen on 12/20/17. Followup bldk on 1/4/18 indicated an incomplete abortion. Pt was given repeat dose of misoprostol on 1/4/18. Results of bldk on 1/9/18 indicated incomplete process. Pt refuses to return for further treatment.</u>			
8. a. Name of physician who provided RU-486: <u>Timothy Kress, MD</u>			
8. b. Physician's signature: <u>Timothy Kress</u> <u>MD/DO</u> Date: <u>2/7/18</u>			

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Columbus, OH 43215-6127

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>1</u>	<u>8</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Greater Ohio</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>			
4. Date post RU-486 complication began: <u>1/25/18</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: <u>Med ab procedure initiated per FDA regimen on 1/8/18. Follow up ultrasound on 1/25/18 showed "uterine debris". Surgical aspiration was done on 1/29/18; pt did well post-op.</u>			
8. a. Name of physician who provided RU-486: <u>Timothy Kress, MD</u>			
8. b. Physician's signature: <u>Timothy Kress</u> MD/DO			
Date: <u>2/7/18</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>1</u> / <u>8</u> / <u>18</u>
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>
4. Date post RU-486 complication began:	<u>1/25/18</u>
5. Event(s): (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours _____ Days
7. Remarks:	<u>Med. ab procedure was initiated per FDA regimen on 1/8/18. Follow up ultrasound on 1/25/18 showed a continuing pregnancy. Surgical procedure was done on 1/30/18; pt. did well post-op.</u>
8. a. Name of physician who provided RU-486	<u>Timothy Kress</u>
8. b. Physician's signature	<u>Timothy Kress</u> M.D./D.O.
	Date <u>2/7/18</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u>	<u>16</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Greater Ohio</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>			
4. Date post RU-486 complication began: <u>12/9/17</u>			
5. Event(s): (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: <u>Med ab procedure initiated per FDA regimen on 10/16/17. Pt. did not keep flu appt, but went to ER on 12/9 for bleeding & cramping; was referred to PPGOH for treatment. Pt. had flu ultrasound at PPGOH on 12/27 which showed "uterine debris" & had surgical aspiration on 1/10/18 and did well post-op.</u>			
8. a. Name of physician who provided RU-486 <u>Timothy Kress, MD</u>			
8. b. Physician's signature <u>[Signature]</u> (MD/DO)			
Date <u>2/7/18</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
Jan	22	2018
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgery Center		
3. Address of medical practice at which RU-486 was provided: 3255 E. Main St. Columbus OH 43213		
4. Date post RU-486 complication began: 1/26		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>failed NAR</u>		
6. Duration of event: <u>2</u> Hours <u>0</u> Days		
7. Remarks: uncomplicated Dilation: suction		
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>		
8. b. Physician's signature <u>[Signature]</u>		
Date <u>2/7/18</u>		

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
<u>10</u> Month	<u>17</u> Day	<u>17</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>		
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>		
4. Date post RU-486 complication began: <u>11/10/17</u>		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>ongoing pregnancy</u>		
6. Duration of event: <u>3</u> Hours <u> </u> Days		
7. Remarks: <u>Completed surgically</u>		
8. a. Name of physician who provided RU-486 <u>A. Pickel</u>		
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. <u>11/16/18</u> Date		

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

12 / 16 / 17
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:

25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began:

12/22/17

5. Event(s) (Please check all that apply):

☒ Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion

☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: 1 Hours 2 Days

7. Remarks: Med ab procedure was initiated on 12/16/17 per FDA regimen. Flt ultrasound on 12/22/17 showed remaining uterine debris. Pt chose to have 2nd dose of misoprostol, but returned on 12/28/17 due to continued pain + heavy bleeding. Surgical aspiration was performed; pt did well post-op.

8. a. Name of physician who provided RU-486

Dr. A. Petrakovets

8. b. Physician's signature

M.D./D.O.

Date

1/20/18

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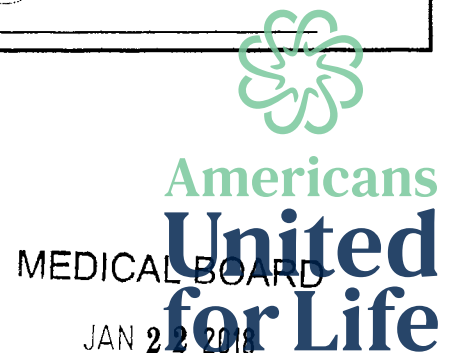
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>11</u> <u>29</u> <u>2017</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Capital Care Network Toledo</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>1160 W Sylvania Ave Toledo, OH 43612</u>
4. Date post RU-486 complication began:	<u>11/6/18</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	____ Hours <u>1</u> Days
7. Remarks:	<u>DZC on 11/6/18 no further complication</u>
8. a. Name of physician who provided RU-486	<u>L. Ann Nannally</u>
8. b. Physician's signature	<u>L. A. Nannally</u> M.D./D.O. _____ Date <u>1/9/18</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	12	9	17
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd. Bedford Heights, Ohio 44146			
4. Date post RU-486 complication began: 12/29/17			
5. Event(s): (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify):			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: Med ab procedure was initiated on 12/9/17 per FDA regimen. Pt returned for flu ultrasound on 12/29/17 and uterine debris was noted. Surgical aspiration was performed at that time; pt did well post op.			
8. a. Name of physician who provided RU-486: Dr. T. Kress MD			
8. b. Physician's signature: <u>T. Kress</u> (M.D./D.O.)			
Date: 1/5/18			

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Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	11	17	17
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <div style="text-align: center;">Capital Care Network Toledo</div>			
3. Address of medical practice or facility at which RU-486 was provided: <div style="text-align: center;">1160 W. Sylvan Ave Toledo OH 43612</div>			
4. Date post RU-486 complication began: <div style="text-align: center;">12/19/17</div>			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized			
<input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding			
<input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>3</u> Days			
7. Remarks: <div style="text-align: center;">DZC on 12/22/17 no further complications</div>			
8. a. Name of physician who provided RU-486 <u>L. Ann Nonnally</u>			
8. b. Physician's signature <u>[Signature]</u> M.D. <u>(M.D./D.O.)</u>			
Date <u>12/22/17</u>			

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JAN 17 2018



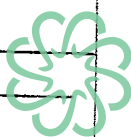
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
<u>12</u> Month	<u>2</u> Day	<u>17</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>		
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>		
4. Date post RU-486 complication began: <u>12/21/17</u>		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: <u>2</u> Hours _____ Days		
7. Remarks: 		
8. a. Name of physician who provided RU-486 <u>Dr. Lu-</u>		
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____ Date <u>12/26/17</u>		

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

10 / 21 / 17
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:

25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began:

11/10/17

5. Event(s) (Please check all that apply):

☒ Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: Med. ab process was initiated on 10/21/17, following FDA criteria. Follow-up ultrasound on 11/10 showed continuing pregnancy. Surgical ab was done on 11/16/17 and pt. dis. well post-op.

8. a. Name of physician who provided RU-486

8. b. Physician's signature

Date

12/5/17

MD/DO

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>11</u>	<u>20</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood East Surgery Ctr.</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>3255 E. Main St.</u> <u>Columbus OH 43213</u>			
4. Date post RU-486 complication began: <u>11/30/17</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>failed MAB</u>			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: <u>uncomplicated D+C</u>			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____			
Date <u>12/15/17</u>			

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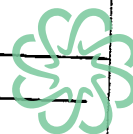


State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
11 Month	15 Day	17 Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood		
3. Address of medical practice or facility at which RU-486 was provided: 2314 Auburn Ave. Cincinnati, OH 45219		
4. Date post RU-486 complication began: 11/29/17		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>on going pregnancy</u>		
6. Duration of event: <u>1</u> Hours <u> </u> Days		
7. Remarks: Completed surgically.		
8. a. Name of physician who provided RU-486 <u>Dr. Fink</u>		
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. <u> </u>		
Date <u>12/11/17</u>		



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
10 Month	19 Day	17 Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood		
3. Address of medical practice or facility at which RU-486 was provided: 2314 Auburn Ave. Cincinnati, OH 45219		
4. Date post RU-486 complication began: 12/1/17		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>continued pregnancy.</u>		
6. Duration of event: _____ Hours <u>2</u> Days		
7. Remarks: pt. had termination completed surgically.		
8. a. Name of physician who provided RU-486 <u>D. L. W.</u>		
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. Date <u>12/6/17</u>		

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DEC 15 2017

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>11</u> Month	<u>25</u> Day	<u>17</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Founder's Women's Health Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E. Broad St. Columbus, Ohio 43205</u>			
4. Date post RU-486 complication began: <u>12.9.17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours _____ Days			
7. Remarks: <u>Moderate tissue</u>			
8. a. Name of physician who provided RU-486 <u>Harley Blank MD</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. <u>MD</u>			
Date <u>12.9.17</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u>	<u>28</u>	<u>2017</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd Cleveland OH 44120</u>			
4. Date post RU-486 complication began: <u>11/17/2017</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Justin Lappen, MD</u>			
8. b. Physician's signature <u>[Signature]</u> M.D. / D.O. Date <u>12/2/17</u>			

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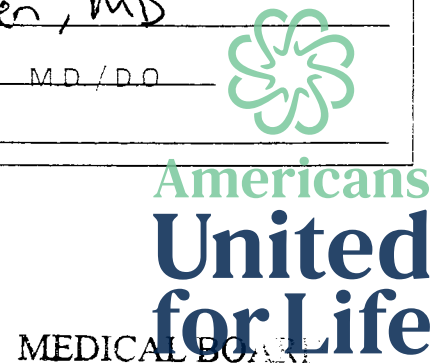
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u>	<u>28</u>	<u>2017</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Pre-term</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland, OH 44120</u>			
4. Date post RU-486 complication began: <u>11/11/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>3</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Justin Lappen, MD</u>			
8. b. Physician's signature <u>[Signature]</u> M.D. / D.O. <u>12/2/17</u>			
Date			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u>	<u>27</u>	<u>2017</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd Cleveland, Ohio 44120</u>			
4. Date post RU-486 complication began: <u>11/29/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>3</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Mitchell Reider, MD</u>			
8. b. Physician's signature <u>[Signature]</u> Date <u>12/1/17</u> MD/DO _____			



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To be completed by the physician who provided RU-486

1. Date RU-486 was provided: Oct 16 2017
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood East Surgery Center

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began:
11/22/17

5. Event(s) (Please check all that apply):
☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized
☐ Patient received a transfusion ☐ Severe bleeding
☐ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks:
uncomplicated D+C

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____
Date 11/28/17

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
Nov	9	2017
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgery		
3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus OH 43213		
4. Date post RU-486 complication began: 11/17/17		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed M&B</u>		
6. Duration of event: _____ Hours _____ Days		
7. Remarks: uncomplicated suction		
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>		
8. b. Physician's signature _____ M.D./D.O. _____ Date <u>11/20/17</u>		

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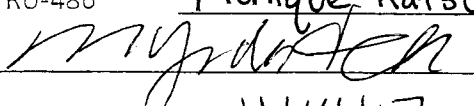
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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u>	<u>10</u>	<u>2017</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland, Ohio 44120</u>			
4. Date post RU-486 complication began: <u>11/14/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>3</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Monique Katsuki, MD</u>			
8. b. Physician's signature <u></u> <u>MD/DO</u>			
Date <u>11/14/17</u>			



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

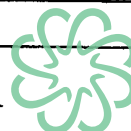
1. Date RU-486 was provided:	<u>October</u>	<u>21</u>	<u>2017</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>North east Ohio Women's Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2127 State St</u> <u>Cuyahoga Falls, Ohio 44223</u>			
4. Date post RU-486 complication began: <u>11/16/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Failed incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>a suction D & C was performed 11/16/17</u> <u>without difficulty</u>			
8. a. Name of physician who provided RU-486 <u>Jennifer Watson</u>			
8. b. Physician's signature <u>J. Watson</u> MD/DO _____ Date <u>11/18/17</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>9</u> / <u>13</u> / <u>17</u>
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Rd. Bedford Heights, OH 44116</u>
4. Date post RU-486 complication began:	<u>10/3/17</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	<u>Med abortion procedure started 9/13/17 per FDA protocol. Follow up bloodwork on 10/3/17 indicated an incomplete abortion and ultrasound showed a continuing pregnancy. Surgical abortion was performed on 10/31/17, pt did well post op.</u>
8. a. Name of physician who provided RU-486	<u>TIMOTHY KREBS, MD</u>
8. b. Physician's signature	<u>Timothy Krebs</u> <u>MD/DO</u>
	Date <u>11/10/2017</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>9</u> / <u>8</u> / <u>17</u>
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>
4. Date post RU-486 complication began:	<u>10/14/17</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	<u>pt had ab procedure started 9/8/17 per FDA protocol. Pt returned for follow-up on 10/14/17 at which time ultrasound showed a continuing pregnancy. Surgical abortion was performed on 10/14/17; pt did well post-op.</u>
8. a. Name of physician who provided RU-486	<u>TIMOTHY KRESS, M.D.</u>
8. b. Physician's signature	<u>Timothy Kress</u> <u>MD/DO</u>
	Date <u>11/10/2017</u>



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>8</u> / <u>2</u> / <u>17</u>
	Month / Day / Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>
4. Date post RU-486 complication began:	<u>10/3/17</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	<u>Vmed ab procedure started 8/2/17 per FDA protocol. Pt. returned for follow up on 10/3/17 at which time ultrasound showed a continuing pregnancy. Surgical abortion was performed on 10/14/17; pt did well post-op.</u>
8. a. Name of physician who provided RU-486	<u>TIMOTHY KRESS, MD</u>
8. b. Physician's signature	<u>Timothy Kress</u> MD/DO
	Date <u>11/10/2017</u>



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486.


1. Date RU-486 was provided:	9	27	17
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd. Bedford Heights, Ohio 44146			
4. Date post RU-486 complication began: 10/11/17			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: Med ab procedure started on 9/27/17 per FDR protocol. Follow up ultrasound on 10/11/17 showed incomplete debris. Surgical exploration was done on 10/11/17, pt did well post op.			
8. a. Name of physician who provided RU-486 TIMOTHY KRESS, MD			
8. b. Physician's signature <u>Timothy Kress</u> MD/D.O. Date 11/10/2017			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>09</u>	<u>21</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: The Founder's Women's Health Center 1243 East Broad Street Columbus, Ohio 43205			
3. Address of medical practice or facility at which RU-486 was provided: <u>See above</u>			
4. Date post RU-486 complication began: <u>9-25-17</u> , <u>10-12-17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>41</u> Hours <u>0</u> Days			
7. Remarks: <u>Multiple pregnancy, failed medical Suction aspiration treatment.</u>			
8. a. Name of physician who provided RU-486 <u>DR. Blank MD</u>			
8. b. Physician's signature <u>[Signature]</u> (M.D./D.O.) Date <u>11-11-17</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	
10	18 17
Month	Day Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgery	
3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus OH 43213	
4. Date post RU-486 complication began: 10/25/17	
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____	
6. Duration of event: _____ Hours _____ Days	
7. Remarks: uncomplicated D.C.	
8. a. Name of physician who provided RU-486 Catherine Romanos	
8. b. Physician's signature _____ Date 11/2/17	

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Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	09	01	2016
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: The Founder's Women's Health Center			
3. Address of medical practice or facility at which RU-486 was provided: 1243 E Broad St Col Oh 43205			
4. Date post RU-486 complication began: 9-15-16			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>< 1</u> Hours <input checked="" type="checkbox"/> Days			
7. Remarks: Pregnancy still Intact			
8. a. Name of physician who provided RU-486 <u>Karl Schaeffer MD</u>			
8. b. Physician's signature <u>Karl Schaeffer, MD</u> (M.D./D.O.) Date <u>10-31-17</u>			

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NOV 03 2017

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>08</u>	<u>04</u>	<u>2016</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: The Founder's Women's Health Center 1243 East Broad Street Columbus, Ohio 43205 (614) 251-1800			
3. Address of medical practice or facility at which RU-486 was provided: <u>See above</u>			
4. Date post RU-486 complication began: <u>08-26-16</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>41</u> Hours <u>0</u> Days			
7. Remarks: <u>D+C procedure, POC sent to Pathologist.</u> <u>Diagnosis: necrotic villi + decidua. Constant & nonviable pregnancy</u>			
8. a. Name of physician who provided RU-486 <u>Karl Schaeffer MD</u>			
8. b. Physician's signature <u>Karl Schaeffer</u> <u>M.D./D.O.</u> Date <u>03/17</u>			

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NOV 8 2017

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>08</u> Month	<u>18</u> Day	<u>2014</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>THE FOUNDER'S Women's Health Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E BROAD ST COLUM OH 43205</u>			
4. Date post RU-486 complication began: <u>9-01-14</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>DEBRIS IN UTERUS</u>			
6. Duration of event: <u><1</u> Hours <u>0</u> Days			
7. Remarks: <u>Uterine Contents suctioned D+C</u> <u>Sent to Pathology Lab. Diagnosis = Necrotic villi + Necrotic Decidua</u> <u>consistent w nonviable pregnancy</u>			
8. a. Name of physician who provided RU-486 <u>Karl Schaeffer MD</u>			
8. b. Physician's signature <u>Karl Schaeffer, MD</u> (M.D.) D.O. Date <u>10-31-17</u>			

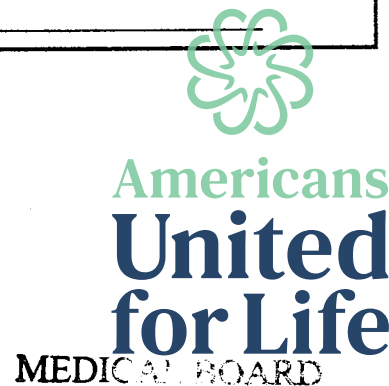
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NOV 03 2017

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>11</u>	<u>10</u>	<u>2014</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>The Founder's Womens Health Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E Broad St. Col OH 43205</u>			
4. Date post RU-486 complication began: <u>11-28-2016</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Retained POC D+C</u>			
6. Duration of event: <u>21</u> Hours <input checked="" type="checkbox"/> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Karl Schaeffer MD</u>			
8. b. Physician's signature <u>Karl Schaeffer, MD</u> <u>MD/D.O.</u> Date <u>10-30-17</u>			

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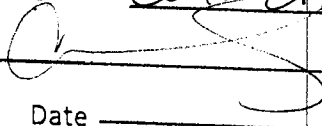
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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

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NOV 03 2017

1. Date RU-486 was provided:		
10	11	17
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgery		
3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus OH 43213		
4. Date post RU-486 complication began: 10/31/17		
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: _____ Hours _____ Days		
7. Remarks: uncomplicated DC		
8. a. Name of physician who provided RU-486 Catherine Romanos		
8. b. Physician's signature  Date 10/31/17		



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: OCT 18 2017
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood East Surgery

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St. Columbus, OH 43213

4. Date post RU-486 complication began:
10/23/17

5. Event(s) (Please check all that apply):
☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized
☐ Patient received a transfusion ☐ Severe bleeding
☐ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks:
Uncomplicated DC

8. a. Name of physician who provided RU-486 Catharine Romanos

8. b. Physician's signature [Signature] MD/DO
Date 12/25/17

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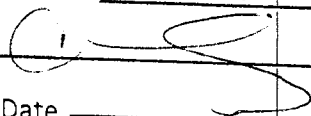
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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	Sept	25	2017
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	Planned Parenthood East Surgery		
3. Address of medical practice or facility at which RU-486 was provided:	3255 E Main St. Columbus, OH 43215		
4. Date post RU-486 complication began:	10/3/17		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: _____ Hours _____ Days			
7. Remarks:	Incomplete abortion D.C.		
8. a. Name of physician who provided RU-486	Catherine Romanos		
8. b. Physician's signature			
	Date _____ (M.D./D.O.) 10/16/17		

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>09</u>	<u>22</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Clev. 44120</u>			
4. Date post RU-486 complication began: <u>10/06/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: <u>Mitchell Reider, M.D.</u>			
8. b. Physician's signature: <u>[Signature]</u> <u>10/20/17</u> <u>MD/DO</u>			
Date			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 9 / 8 / 17
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 9/19/17

5. Event(s) (Please check all that apply):

☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: 1 Hours Days

7. Remarks: Medication ab procedure started on 9/8/17. Follow-up bloodwork + ultrasound showed continuing pregnancy. Surgical aspiration completed on 9/23/17; pt did well post-op.

8. a. Name of physician who provided RU-486 Timothy Kress, MD

8. b. Physician's signature Timothy S. Kress (M.D./D.O.)

Date 10/6/17



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OCT 20 2017



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
<u>Oct.</u> Month	<u>9</u> Day	<u>2017</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood East Surgery</u>		
3. Address of medical practice or facility at which RU-486 was provided: <u>3255 E Main St. Columbus, OH 43213</u>		
4. Date post RU-486 complication began: <u>10/13/17</u>		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>failed M&B</u>		
6. Duration of event: _____ Hours _____ Days		
7. Remarks:		
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>		
8. b. Physician's signature _____		<u>M.D./D.O.</u> <u>10/14/17</u>



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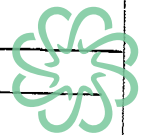
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>9</u>	<u>20</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>10/04/17</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed medical Abortion</u>			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Completed surgically w/o issue</u>			
8. a. Name of physician who provided RU-486 <u>D. Lind</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>10/5/17</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	
9	15 17
Month	Day Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgery	
3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus, OH 43213	
4. Date post RU-486 complication began: 9/25/17 at follow up	
5. Event(s) (Please check all that apply):	
<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized	
<input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding	
<input checked="" type="checkbox"/> Other serious event (specify) failed MAB	
6. Duration of event: _____ Hours _____ Days	
7. Remarks:	
8. a. Name of physician who provided RU-486 Michelle Isley	
8. b. Physician's signature [Signature] M.D./D.O.	
Date 10/6/17	

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OCT 11 2017



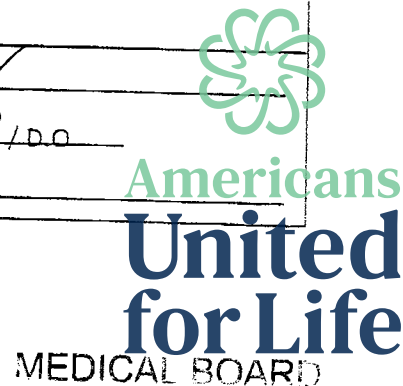
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>9</u>	<u>21</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>failed med Ab</u>			
6. Duration of event: <u>1</u> Hours <u>12/3/17</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>J. Lin</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>12/3/17</u>			

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Columbus, OH 43215-6127



OCT 06 2017



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	8	9	17
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd. Bedford Heights, Ohio 44146			
4. Date post RU-486 complication began: 8/15/17			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks: Medication abortion procedure was initiated per FDA regimen on 8/14/17. Follow-up visit on 8/15/17, ultrasound revealed a continuing pregnancy. Surgical abortion was done on 8/17/17 and the pt. did well post op.			
8. a. Name of physician who provided RU-486 _____			
8. b. Physician's signature _____ Date _____			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
09	18	17
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgery		
3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus, OH 43213		
4. Date post RU-486 complication began: 9/22/17		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>failed Medication abortion</u>		
6. Duration of event: _____ Hours _____ Days		
7. Remarks: uncomplicated suction		
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>		
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. <u>9/25/17</u>		
Date _____		

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Prescribed: 5/- SEP 28 2017



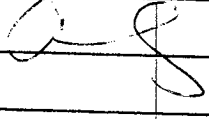
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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
9	21	17
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgery		
3. Address of medical practice or facility at which RU-486 was provided: 3255 E Main St. Columbus, OH 43213		
4. Date post RU-486 complication began: 9/25/17		
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: _____ Hours _____ Days		
7. Remarks: uncomplicated D&C		
8. a. Name of physician who provided RU-486 Catherine Romanos		
8. b. Physician's signature  Date 9/27/17		

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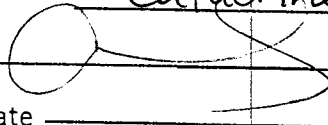
SEP 28 2017



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	8	28	17
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgery Ctr.			
3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus, OH 43213			
4. Date post RU-486 complication began: 9/7/17			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: uncomplicated suction procedure			
8. a. Name of physician who provided RU-486 Catherine Romanas			
8. b. Physician's signature  Date 9/21/17			



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>08</u>	<u>14</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>09/12/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>4</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Mitchell Reider, M.D.</u>			
8. b. Physician's signature _____ M.D. / D.O. _____ Date <u>9/14/17</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)


To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>7</u>	<u>10</u>	<u>2017</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Northeast Ohio Women's Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2127 State Rd Cuyahoga Falls Ohio 44223</u>			
4. Date post RU-486 complication began: <u>7/27/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: <u>post med AB patient had a remaining gestational sac w/ no fetal pole developed or remaining. patient had DEC on 7/27/17 to complete her process.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. DAVID Burkens</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>9/2/17</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>7</u>	<u>13</u>	<u>2017</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Northeast Ohio Women's Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2127 State Rd Cuyahoga Falls 44223</u>			
4. Date post RU-486 complication began: <u>8/12/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: <u>pt. had (+) ptu post Medication Abortion. She had heavy bleeding and on ultrasound there was remaining tissue but pregnancy was resolved. pt had a DEC on 8/22/17</u>			
8. a. Name of physician who provided RU-486 <u>Dr. L.A. Nunnally</u>			
8. b. Physician's signature <u>[Signature]</u> MD/DO _____ Date <u>9/7/17</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>7</u> / <u>19</u> / <u>17</u> Month / Day / Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>
4. Date post RU-486 complication began:	<u>8/2/17</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	<u>Medication abortion procedure was initiated per FDA regimen on 7/19/17. At follow-up visit on 8/1/17 ultrasound revealed continued pregnancy. Surgical abortion was performed the same day and pt. did well post-op.</u>
8. a. Name of physician who provided RU-486	<u>Timothy Kress, MD</u>
8. b. Physician's signature	<u>Timothy Kress</u> MD/DO
Date	<u>9/1/17</u>

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SEP 15 2017


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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

Month 8 Day 1 Year 17

2. Name of medical practice or facility at which RU-486 was provided:

Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:

25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began:

8/15/17

5. Event(s) (Please check all that apply):

☒ Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: 1 Hours Days

7. Remarks: Medication abortion procedure was initiated per FDA regimen on 8/1/17. At follow-up visit on 8/15/17, ultrasound revealed a continuing pregnancy. Surgical abortion was done the same day and pt. did well post-op.

8. a. Name of physician who provided RU-486

Timothy Kress, MD

8. b. Physician's signature

Timothy Kress MD/DO

Date 9/1/17

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 8 / 15 / 17
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 8/24/17

5. Event(s) (Please check all that apply):

☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: 1 Hours Days

7. Remarks: Medication abortion procedure was initiated per FDA regimen on 8/15/17. At follow-up visit on 8/24/17, ultrasound showed absence of gestational sac, but incomplete abortion. Surgical aspiration was done on 8/24/17 and pt. did well post op.

8. a. Name of physician who provided RU-486 Timothy Kress, MD

8. b. Physician's signature Timothy Kress MD/DO

Date 9/1/17

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SEP 15 2017



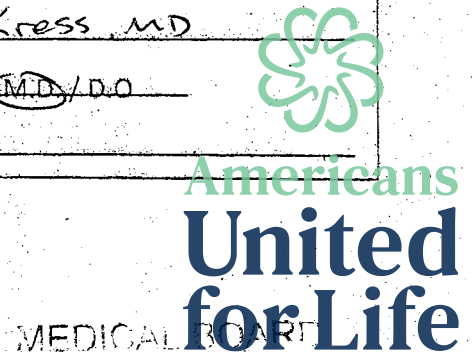
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	8	1	17
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd. Bedford Heights, Ohio 44146			
4. Date post RU-486 complication began: 8/18/17			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours: _____ Days			
7. Remarks: Med abortion procedure was initiated per FDA regimen on 8/1/17. Bloodwork on 8/18/17 and ultrasound on 8/22/17 revealed an incomplete abortion. Pt chose to repeat the medication regimen on 8/22/17; ultrasound on 8/29/17 showed abortion was complete.			
8. a. Name of physician who provided RU-486: Timothy Kress, MD			
8. b. Physician's signature: <u>Timothy Kress</u> (MD/DO) Date: 9/1/17			

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SEP 15 2017

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>08</u>	<u>15</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Monique Katsuki, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>9/18/17</u>			



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State Medical Board of Ohio Report of RU-486 Event

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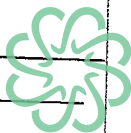
To be completed by the physician who provided RU-486

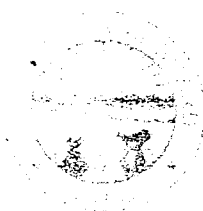
1. Date RU-486 was provided:	<u>8</u>	<u>4</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>8/18/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>D&C performed</u>			
8. a. Name of physician who provided RU-486 <u>Dr. G. Schlang</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. Date <u>8/18/17</u>			

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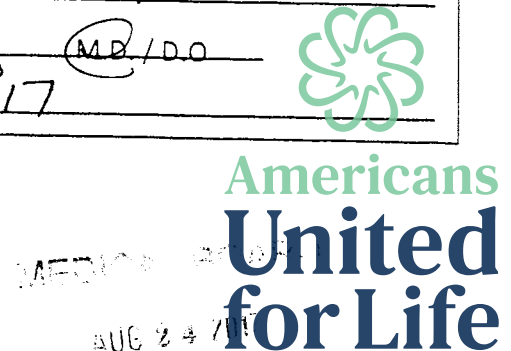
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	8	16	17
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgical			
3. Address of medical practice or facility at which RU-486 was provided: 3255 E Main St. Columbus, OH 43213			
4. Date post RU-486 complication began: 8/21/17			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed MAB</u>			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: Dilation and suction - uncomplicated.			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>8/22/17</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486


1. Date RU-486 was provided:	<u>7</u> / <u>13</u> / <u>17</u> Month / Day / Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>
4. Date post RU-486 complication began:	<u>7/17/17</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	<u>Med abortion process initiated per FDA regimen on 7/13/17. Second dose of misoprostol was given on 7/17/17 due to lack of results from first dose. Follow-up ultrasound on 7/19/17 showed ongoing pregnancy. Surgical aspiration was performed and pt did well post-op.</u>
8. a. Name of physician who provided RU-486	<u>TIMOTHY KRESS, MD</u>
8. b. Physician's signature	<u>Timothy Kress</u> (M.D./D.O.)
Date	<u>8/15/17</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>7</u>	<u>12</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Greater Ohio</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>			
4. Date post RU-486 complication began: <u>7/19/17</u>			
5. Event(s): (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: <u>Med abortion process was initiated per FDA regimen on 7/12/17. Follow up ultrasound on 7/19/17. Showed an ongoing pregnancy. Surgical aspiration was done on 7/20/17, pt did well post-op.</u>			
8. a. Name of physician who provided RU-486: <u>Timothy Kress, MD</u>			
8. b. Physician's signature: <u>Timothy Kress</u> <u>MD/DO</u> Date: <u>8/15/17</u>			

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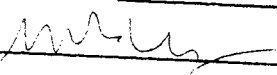
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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
7	28	17
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgical		
3. Address of medical practice or facility at which RU-486 was provided: 3255 E main St. Columbus, OH 43213		
4. Date post RU-486 complication began: 8/9/17		
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: 2 Hours _____ Days		
7. Remarks:		
8. a. Name of physician who provided RU-486 Michelle Isley		
8. b. Physician's signature  Date 8/11/17		
M.D./D.O. _____		

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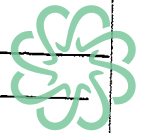
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>6</u>	<u>16</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>7/27/17</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Resolved w/ D+C.</u>			
8. a. Name of physician who provided RU-486: <u>Dr. Lin</u>			
8. b. Physician's signature: <u>[Signature]</u> M.D./D.O. _____ Date: <u>8/3/17</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>07</u>	<u>07</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>07/21/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Mitchell Reider, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>8/2/17</u>			

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MEDICAL ABORTION
AUG 07 2017



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>5</u> / <u>11</u> / <u>17</u>
	Month / Day / Year
2. Name of medical practice or facility at which RU-486 was provided:	Planned Parenthood of Greater Ohio
3. Address of medical practice or facility at which RU-486 was provided:	25350 Rockside Rd. Bedford Heights, Ohio 44146
4. Date post RU-486 complication began:	5/25/17
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	Med. ab. was initiated per FDA regimen on 5/11/17. Follow-up exam indicated an incomplete abortion - persistent gestational sac. Surgical aspiration was done on 6/16/17; Pt did well post-op.
8. a. Name of physician who provided RU-486	<u>TIMOTHY KRESS, MD</u>
8. b. Physician's signature	<u>Timothy Kress</u> (M.D./D.O.)
	Date <u>7/19/17</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 6 / 10 / 17
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 6/22/17

5. Event(s) (Please check all that apply):

☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: 1 Hours Days

7. Remarks: Med abortion initiated per FDA regimen on 6/10/17. Follow-up bloodwork and ultrasound indicated a failed abortion. Surgical aspiration was done on 6/22/17; pt. did well post-op

8. a. Name of physician who provided RU-486 TIMOTHY CROSS, MD

8. b. Physician's signature Timothy Cross MD/DO

Date 7/19/17

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>6</u> / <u>16</u> / <u>17</u>
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	Planned Parenthood of Greater Ohio
3. Address of medical practice or facility at which RU-486 was provided:	25350 Rockside Rd. Bedford Heights, Ohio 44146
4. Date post RU-486 complication began:	6/27/17
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	Med abortion initiated per FDA regimen on 6/16/17. Follow-up ultrasound showed a continuing pregnancy. Surgical aspiration was done on 6/27/17; pt did well post-op.
8. a. Name of physician who provided RU-486	TIMOTHY KRESS, MD
8. b. Physician's signature	<u>Timothy Kress</u> (MD/DO)
Date	7/19/17

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>5</u>	<u>9</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Greater Ohio</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>			
4. Date post RU-486 complication began: <u>6/27/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: <u>Med abortion was initiated per FDA regimen on 5/9/17. Pt. returned for follow-up ultrasound on 6/27/17 - continuing pregnancy was confirmed. Surgical abortion was performed on 6/28/17; pt did well post-op.</u>			
8. a. Name of physician who provided RU-486: <u>TIMOTHY KRESS, MD</u>			
8. b. Physician's signature: <u>Timothy Kress</u> (MD/DO) 			
Date: <u>7/19/17</u>			

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	5	16	17
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd. Bedford Heights, Ohio 44146			
4. Date post RU-486 complication began: 6/2/17			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks: Met abortion was initiated per FDA regimen on 5/16/17. Follow-up bloodwork indicated a failed abortion. Surgical aspiration was done on 6/7/17; pt. did well post-op.			
8. a. Name of physician who provided RU-486: TIMOTHY KRESS, MD			
8. b. Physician's signature: <u>Timothy Kress</u> (M.D./D.O.)			
Date: 7/19/17			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 5 / 24 / 17
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:

25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began:

6/17/17

5. Event(s) (Please check all that apply):

☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: med. abortion was initiated per FDA regimen on 5/24/17. Follow-up ultrasound showed a continuing pregnancy. Surgical abortion was done on 6/2/17; pt did well post-op

8. a. Name of physician who provided RU-486 Timothy Kress MD

8. b. Physician's signature Timothy Kress (M.D./D.O.)

Date 7/19/17

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>4</u>	<u>5</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>6/27/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>completed w/ D&C</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Gerschlager</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>7.7.2017</u>			

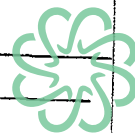
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JUL 19 2017

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>06</u>	<u>17</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>7/6/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u> </u> / <u> </u> Hours <u> </u> Days			
7. Remarks: 			
8. a. Name of physician who provided RU-486 <u>Mitchell Reider, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> MD/DO <u> </u> Date <u>7/12/17</u>			

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JUL 17 2017



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	
July Month	3 2017 Day Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East	
3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus, OH 43213	
4. Date post RU-486 complication began: 7/10/17	
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____	
6. Duration of event: _____ Hours _____ Days	
7. Remarks:	
8. a. Name of physician who provided RU-486 Catherine Romanas	
8. b. Physician's signature _____ Date 7/12/17	

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JUL 13 2017



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
10	23	17
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: East Planned Parenthood		
3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus, OH 43213		
4. Date post RU-486 complication began: 7/3/17		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed MAB</u>		
6. Duration of event: _____ Hours _____ Days		
7. Remarks: Suction on 7/3/17 at MAB Follow up appt		
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>		
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>		
Date <u>7/5/17</u>		

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State Medical Board of Ohio Report of RU-486 Event

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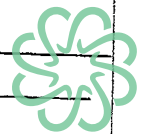
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>5</u>	<u>31</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>6/1/17</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input checked="" type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>2</u> Days			
7. Remarks: 			
8. a. Name of physician who provided RU-486 <u>Dr. Karsch</u>			
8. b. Physician's signature <u>Punya Karsah</u> M.D./D.O. Date <u>6/30/2017</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	
June	13 26 2017
Month	Day Year
2. Name of medical practice or facility at which RU-486 was provided:	
Planned Parenthood East	
3. Address of medical practice or facility at which RU-486 was provided:	
3255 E. Main St. Columbus OH 43213	
4. Date post RU-486 complication began:	
June 26, 2017	
5. Event(s) (Please check all that apply):	
<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized	
<input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding	
<input type="checkbox"/> Other serious event (specify) _____	
6. Duration of event: _____ Hours _____ Days	
7. Remarks:	
6/26 - Surgical AB after incomplete Med AB	
8. a. Name of physician who provided RU-486	
Catherine Ramanes	
8. b. Physician's signature	
Date 6/27/17	

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MEDICAL BOARD

JUN 28 2017





State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
June	7	2017
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East		
3. Address of medical practice or facility at which RU-486 was provided: 3255 E Main St. Columbus, OH 43213		
4. Date post RU-486 complication began: 6/21/17 at MAB follow up		
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> failed <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: _____ Hours _____ Days		
7. Remarks: Surgical AB after medical AB on 6/22/17		
8. a. Name of physician who provided RU-486 Catherine Romanos		
8. b. Physician's signature Date 6/27/17 MD/DO		

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>3</u>	<u>22</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Greater Ohio</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>			
4. Date post RU-486 complication began: <u>5/19/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: <u>Med abortion process started on 3/22/17. Pt did not have followup bloodwork as instructed. Ultrasound on 5/19/17 showed continued pregnancy. Surgical abortion was done on 5/19/17 and pt. did well post-op.</u>			
8. a. Name of physician who provided RU-486 <u>Timothy S. Kress, MD</u>			
8. b. Physician's signature <u>Timothy S. Kress MD/DO</u> Date <u>6/16/17</u>			

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JUN 22 2017



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 5 / 5 / 17
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 5/18/17

5. Event(s) (Please check all that apply):
☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized
☐ Patient received a transfusion ☐ Severe bleeding
☐ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: med abortion procedure started on 5/5/17.
Followup ultrasound showed continued pregnancy.
surgical abortion done 5/19/17 and pt. did well post-op

8. a. Name of physician who provided RU-486 Timothy S. Kress MD

8. b. Physician's signature Timothy S. Kress MD/DO

Date 6/16/17

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JUN 22 2017



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>4</u> / <u>27</u> / <u>17</u>
	Month / Day / Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>
4. Date post RU-486 complication began:	<u>5/12/17</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	<u>med abortion procedure started on 4/27/17. Follow up ultrasound showed continued pregnancy. Surgical abortion done on 5/12/17 and pt. did well post-op.</u>
8. a. Name of physician who provided RU-486	<u>TIMOTHY S. KRESS, MD</u>
8. b. Physician's signature	<u>Timothy S. Kress MD/DO</u>
Date	<u>6/15/17</u>

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State Medical Board of Ohio Report of RU-486 Event

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>5</u> / <u>12</u> / <u>17</u>
	Month / Day / Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>
4. Date post RU-486 complication began:	<u>5/26/17</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	<u>Med. abortion process began 5/12/17. Followup ultrasound showed continued pregnancy. Surgical abortion done 5/31/17 and pt. did well post op.</u>
8. a. Name of physician who provided RU-486	<u>TIMOTHY S. KRESS MD</u>
8. b. Physician's signature	<u>Timothy S. Kress MD/DO</u>
	Date <u>6/15/17</u>

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MEDICAL REPORT

JUN 22 2017



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 4 / 14 / 17
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:

25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began:

5/2/17

5. Event(s) (Please check all that apply):

☒ Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks: Med abortion process started on 4/14/17. Follow up bloodwork showed incomplete abortion. Aspiration done at PP604 on 5/3/17 and pt. did well post op.

8. a. Name of physician who provided RU-486 TIMOTHY S. KRESS, MD

8. b. Physician's signature

Timothy S. Kress MD/DO

Date 6/15/17

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>5</u> / <u>16</u> / <u>17</u>
	Month / Day / Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Greater Ohio</u>	
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>	
4. Date post RU-486 complication began: <u>5/25/17</u>	
5. Event(s): (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____	
6. Duration of event: <u>1</u> Hours <u> </u> Days	
7. Remarks: <u>Med. abortion process began 5/16/17. Followup bloodwork showed incomplete abortion. Aspiration done at PPFOH on 5/25/17 and pt did well post op.</u>	
8. a. Name of physician who provided RU-486 <u>TIMOTHY S. KRESS, MD</u>	
8. b. Physician's signature <u>Timothy S. Kress</u> <u>MD/DO</u> Date <u>6/15/17</u>	

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JUN 22 2017



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

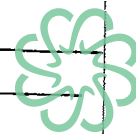
1. Date RU-486 was provided:	<u>5</u>	<u>26</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>6/8/17</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>ongoing pregnancy</u>			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>completed surgically without issue</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Lin</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____			
Date <u>6/14/17</u>			

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JUN 19 2017



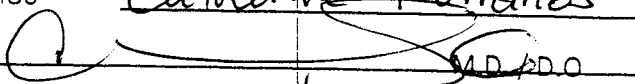
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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
June	1	2017
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: East Surgery Ctr. Planned Parenthood		
3. Address of medical practice or facility at which RU-486 was provided: 3255 E. main st. Columbus, OH 43213		
4. Date post RU-486 complication began: 6/9/17		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) Hematometra		
6. Duration of event: _____ Hours _____ Days		
7. Remarks: Patient had aspiration on 6/9/17		
8. a. Name of physician who provided RU-486 Catherine Romanas		
8. b. Physician's signature  M.D./D.O.		
Date 6/14/17		

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JUN 19 2017



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>March 22 2017</u> 3/22/17 Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Northeast Ohio Women's Center</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>21249 State Rd</u> <u>Cuyahoga Falls, Ohio 44223</u>
4. Date post RU-486 complication began:	<u>4/28/17</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>3</u> Hours _____ Days
7. Remarks:	<u>It had D&C without complications</u>
8. a. Name of physician who provided RU-486	<u>L. Ann Nunna/ly</u>
8. b. Physician's signature	<u>[Signature]</u> MD / D.O.
Date	<u>5/24/17</u>

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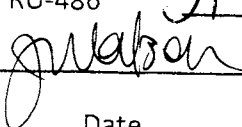
MEDICAL BOARD

MAY 22 2017

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	3/	March	16	2017
Month Day Year				
2. Name of medical practice or facility at which RU-486 was provided:	Northeast Ohio Women's Center			
3. Address of medical practice or facility at which RU-486 was provided:	2107 State Rd Cuyahoga Falls Ohio 44003			
4. Date post RU-486 complication began:	4/15/17			
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event:	3	Hours	_____	Days
7. Remarks:	PT had D+E without complications			
8. a. Name of physician who provided RU-486	J. M. Watson, M.D.			
8. b. Physician's signature	 M.D. / D.O.			
	Date 5/18/17			

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MAY 20 2017



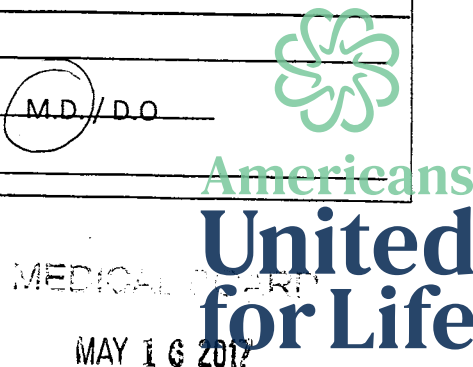
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>04</u>	<u>13</u>	<u>2017</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>3255 E. main St, Columbus OH 43213</u>			
4. Date post RU-486 complication began: <u>4/28/17</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed Abortion</u>			
6. Duration of event: _____ Hours <u>15</u> Days			
7. Remarks: 			
8. a. Name of physician who provided RU-486 <u>Dr. Lowther</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. <u>[Signature]</u> Date <u>5/11/17</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486


1. Date RU-486 was provided:	<u>2</u> / <u>28</u> / <u>2017</u>
	Month / Day / Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>
4. Date post RU-486 complication began:	<u>4/19/17</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	<u>Med. ab. per FDA regimen on 2/28/17. Pt returned for post-abortion follow up on 4/19/17. Bldwork showed <80% drop in Hgb. Ultrasound on 4/25/17 showed continued pregnancy. D+E was performed on 4/26/17. Pt did well post-op.</u>
8. a. Name of physician who provided RU-486	<u>Timothy S. Kress, MD</u>
8. b. Physician's signature	<u>Timothy S. Kress</u> M.D./D.O.
	Date <u>5/9/17</u>

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MAY 15 2017



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>3</u> Month	<u>3</u> Day	<u>2017</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Greater Ohio</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>			
4. Date post RU-486 complication began: <u>4/12/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event: (specify) _____			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: <u>Med. ab. per FDA regimen on 3/3/17. Pt did not return for scheduled followup in 2wks - returned on 4/12/17 for post-ab ultrasound. Results showed continued pregnancy. D+E performed on 4/13/17. Pt did well post-op.</u>			
8. a. Name of physician who provided RU-486 <u>Timothy S. Kress, MD</u>			
8. b. Physician's signature <u>Timothy S. Kress</u> <u>MD/DO</u> Date <u>5/19/17</u>			

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MAY 15 2017

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	3	31	2017
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd. Bedford Heights, Ohio 44146			
4. Date post RU-486 complication began: 4/6/17			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>hematoma</u>			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: Medication abortion per FDA regimen on 3/31/17. Pt. reported heavy bleeding and cramping intermittently on 4/5/17. Aspiration was performed on 4/6/17. Pt did well post op.			
8. a. Name of physician who provided RU-486 <u>Timothy S. Kress, MD</u>			
8. b. Physician's signature <u>Timothy S. Kress, MD</u> <u>MD/DO</u>			
Date <u>5/8/17</u>			

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MAY 15 2017

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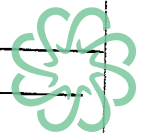
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>4</u>	<u>28</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>5/5/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
MEDICAL BOARD MAY 12 2017			
6. Duration of event: _____ Hours <u>4</u> Days			
7. Remarks: <u>pt. returned for D+C as she could not stay on day this was diagnosed.</u>			
8. a. Name of physician who provided RU-486 <u>D. Lin</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>5/9/17</u>			

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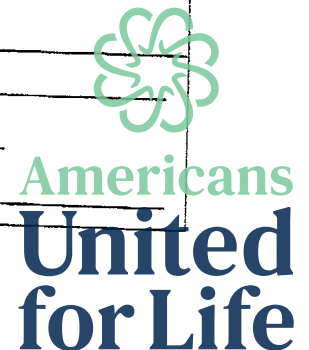
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>3</u>	<u>29</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>4/18/17</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			MEDICAL BOARD MAY 12 2017
7. Remarks: 			
8. a. Name of physician who provided RU-486 <u>Dr. Kelly</u>			
8. b. Physician's signature <u>[Signature]</u> (MD/DO) Date <u>5/9/17</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: April 29 2017
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood East Surgery Center

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St. Columbus, OH 43217

4. Date post RU-486 complication began:
5/1/17

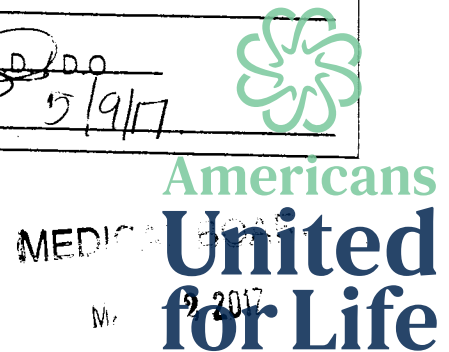
5. Event(s) (Please check all that apply): **MEDICAL**
☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized **MAY 12 2017**
☐ Patient received a transfusion ☐ Severe bleeding
☐ Other serious event (specify) _____

6. Duration of event: N/A Hours _____ Days

7. Remarks:
Incomplete MAB, D&C performed 5/9/17

8. a. Name of physician who provided RU-486 Romanos
8. b. Physician's signature [Signature] **MD/DO**
Date 5/9/17


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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>04</u>	<u>12</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Mohammed Razaee, M.D.</u>			
8. b. Physician's signature <u>M. Razaee</u> M.D./D.O. 			
Date <u>5/6/17</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>2</u>	<u>28</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Greater Ohio</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>			
4. Date post RU-486 complication began: <u>3/17/17</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Hematometra</u>			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: <u>Medication abortion started on 2/28/17. Pt reported increased bleeding and cramping two weeks later. Suction procedure was done on 3/17/17 for Hematometra. Pt did well post-op.</u>			
8. a. Name of physician who provided RU-486 <u>Timothy S. Kress, MD</u>			
8. b. Physician's signature <u>Timothy S. Kress MD</u>			
Date <u>4/14/17</u>			

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APR 20 2017



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>March</u> <u>11</u> <u>2017</u>
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>
4. Date post RU-486 complication began:	<u>3/16/17</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	<u>Persistent gestational sac noted on ultrasound at MAB follow-up visit on 3/16/17. Suction procedure done and pt. did well post-op.</u>
8. a. Name of physician who provided RU-486	<u>Timothy S. Kress, MD</u>
8. b. Physician's signature	<u>Timothy S. Kress MD/DO</u>
	Date <u>4/14/17</u>

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APR 20 2017



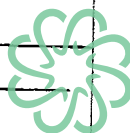
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>3</u>	<u>11</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>D+C done without incident</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Giv</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>4/5/17</u>			

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APR 14 2017



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	03	30	2017
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood east surgical center			
3. Address of medical practice or facility at which RU-486 was provided: 3235 East main St, Columbus OH, 43213			
4. Date post RU-486 complication began: 4/3/17			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours 5 Days			
7. Remarks: D+C performed, uncomplicated.			
8. a. Name of physician who provided RU-486: Catherine Romanos			
8. b. Physician's signature: _____ Date: 4/4/17			

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APR 07 2017



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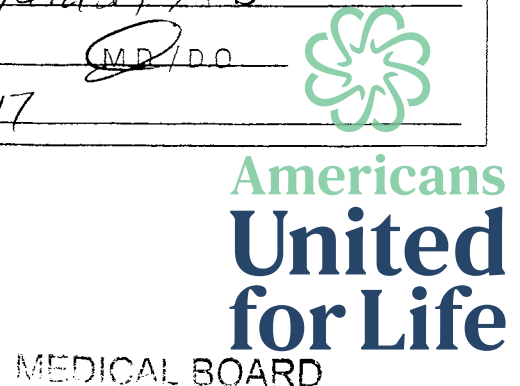
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>02</u>	<u>24</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>3/24/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Mitchell Rider, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u> Date <u>3/31/17</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>02</u>	<u>14</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleve 44120</u>			
4. Date post RU-486 complication began: <u>03/15/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Monique Katsuki, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>3/28/17</u>			



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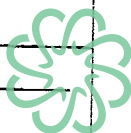
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>2</u>	<u>28</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>3/14/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>D+C performed without incident.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Fickel</u>			
8. b. Physician's signature <u>[Signature]</u> <u>3/21/17</u> <u>M.D.</u> <u>D.O.</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>03</u>	<u>07</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>03/18/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Monique Katsuki, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>M.D./D.O.</u> Date <u>3/21/17</u>			

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MEDICAL BOARD

MAR 24 2017

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>2</u>	<u>25</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>3/11/17</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed Abortion</u>			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Completed Surgically without incident.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Kaly</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____			
Date <u>3/16/17</u>			

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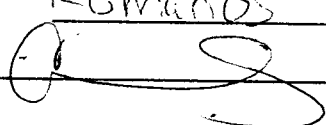
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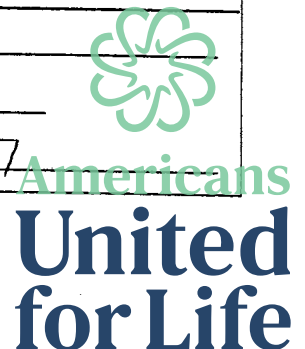
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	2	23	17
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood			
3. Address of medical practice or facility at which RU-486 was provided: 3255 East Main St Columbus OH			
4. Date post RU-486 complication began: 3/2/17			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion			
<input type="checkbox"/> Adverse reaction to RU-486			
<input type="checkbox"/> Patient hospitalized			
<input type="checkbox"/> Patient received a transfusion			
<input type="checkbox"/> Severe bleeding			
<input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours 7 Days			
7. Remarks: med AB incomplete MISO repeat dosing.			
8. a. Name of physician who provided RU-486: ROMANOS			
8. b. Physician's signature: 			
Date: 3/7/17			

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MAR 17 2017




State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>02</u>	<u>24</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Proterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>3/10/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: <u>Mitchell Reider, M.D.</u>			
8. b. Physician's signature: <u>[Signature]</u> M.D. / D.O. _____			
Date: <u>3/11/17</u>			

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MAR 15 2017



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>1</u> / <u>13</u> / <u>2017</u>
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>
4. Date post RU-486 complication began:	<u>2/3/17</u>
5. Event(s) (Please check all that apply):	
<input type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding
<input checked="" type="checkbox"/> Other serious event (specify)	<u>hematometra</u>
6. Duration of event:	<u>1</u> Hours <u>5</u> Days
7. Remarks:	<u>Pt. had medication abortion on 1/13/17. Flw bloodwork confirmed complete abortion. Subsequently, patient complained of increased bleeding and aspiration performed on 2/8/17. Pt. is well post-op.</u>
8. a. Name of physician who provided RU-486	<u>T. Kress</u>
8. b. Physician's signature	<u>Thomas S. Kress MD/DO</u>
	Date <u>3/3/17</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>02</u>	<u>01</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Proterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>02/22/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Mitchell Reider, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>3/25/17</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>1</u>	<u>19</u>	<u>2017</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood - East Surgical</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>3255 East Main St., Columbus, Ohio 43213</u>			
4. Date post RU-486 complication began: <u>1/30/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>11</u> Days			
7. Remarks: <u>Incomplete MAB requiring D&C</u>			
8. a. Name of physician who provided RU-486: <u>Catherine Romanos</u>			
8. b. Physician's signature: <u>[Signature]</u> <u>MD/D.O.</u> Date: <u>2/21/17</u>			



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MEDICAL BOARD

FEB 22 2017



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	01	09	2017
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgical			
3. Address of medical practice or facility at which RU-486 was provided: 3255 East Main St., Columbus, Ohio 43213			
4. Date post RU-486 complication began: 1/23/17			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours 14 Days			
7. Remarks: D+C after Incomplete Medication Abortion			
8. a. Name of physician who provided RU-486: Catherine Romanos			
8. b. Physician's signature: _____ M.D./D.O. _____ Date: 1/20/17			

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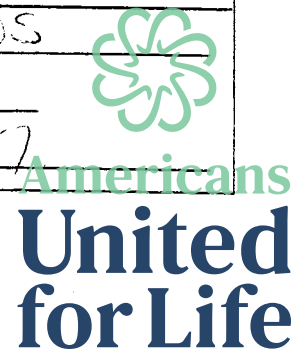
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>01</u>	<u>17</u>	<u>2017</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood East surgical</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>3255 East Main St., Columbus, Ohio 43213</u>			
4. Date post RU-486 complication began: <u>01/24/17</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed Medication Abortion</u>			
6. Duration of event: _____ Hours <u>8</u> Days			
7. Remarks: <u>D+C after failed medication abortion</u>			
8. a. Name of physician who provided RU-486: <u>Catherine Romanos</u>			
8. b. Physician's signature: _____ (Signature) _____ (MD/DO) Date: _____ <u>1/30/17</u>			

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FEB 01 2017





State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>12</u> / <u>14</u> / <u>16</u>
	Month / Day / Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Rd. Bedford Heights, Ohio 44146</u>
4. Date post RU-486 complication began:	<u>12-22-16</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	<u>Pt underwent FDA protocol medication abortion regimen. At follow up ultrasound visit, a continuing IUP was detected. Pt was aspirated at that visit and has been doing well since then.</u>
8. a. Name of physician who provided RU-486	<u>TIMOTHY KROSS MD</u>
8. b. Physician's signature	<u>Timothy Kross MD/DO</u>
Date	<u>11/27/17</u>

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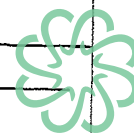
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JAN 27 2017

1. Date RU-486 was provided:	<u>1</u>	<u>3</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>1/10/17</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>infection</u>			
6. Duration of event: _____ Hours <u>14</u> Days			
7. Remarks: <u>responded well to antibiotics</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Pickel</u>			
8. b. Physician's signature _____ (M.D./D.O.) Date _____			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>11</u>	<u>29</u>	<u>2016</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood East Surgical</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>3255 East Main St., Columbus, Ohio 43213</u>			
4. Date post RU-486 complication began: <u>1/3/17</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed Medication Abortion</u>			
6. Duration of event: _____ Hours <u>45</u> Days			
7. Remarks: <u>Failed Medication Abortion with D&C procedure</u>			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature _____ M.D./D.O. _____ Date <u>1/17/17</u>			

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 12 6 2016
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood East Columbus Surgical

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St, Columbus, OH 43213

4. Date post RU-486 complication began: 1/5/17

5. Event(s) (Please check all that apply):
☐ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized
☐ Patient received a transfusion ☐ Severe bleeding
☒ Other serious event (specify) Failed Medication Abortion

6. Duration of event: _____ Hours 35 Days

7. Remarks: Failed Medication Abortion with D&C procedure

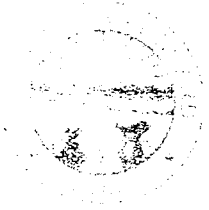
8. a. Name of physician who provided RU-486 Catherine Romanos
8. b. Physician's signature [Signature] MD/DO
Date 1/17/17

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State Medical Board of Ohio Report of RU-486 Event

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>December</u> <u>15</u> <u>2016</u>
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood - East Surgical</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>3255 East Main St., Columbus, OHIO 43213</u>
4. Date post RU-486 complication began:	<u>12/22/16</u>
5. Event(s) (Please check all that apply):	
<input type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding
<input checked="" type="checkbox"/> Other serious event (specify)	<u>Failed Medication Abortion</u>
6. Duration of event:	Hours <u>15</u> Days
7. Remarks:	<u>failed medication abortion resolved with DIC - uncomplicated</u>
8. a. Name of physician who provided RU-486	<u>Catherine Romanos</u>
8. b. Physician's signature	<u>[Signature]</u> MD/DO
	Date <u>1/9/17</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>11 / 9 / 16</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Rd, Bedford Heights, Ohio 44146</u>
4. Date post RU-486 complication began:	<u>11 / 11 / 16</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	_____ Hours _____ Days
7. Remarks:	<u>Surgical aspiration performed with no further complications. Pt. did well post-op.</u>
8. a. Name of physician who provided RU-486	<u>Timothy Kress MD</u>
8. b. Physician's signature	<u>Timothy S. Kress MD/DO</u>
Date	<u>12/23/16</u>

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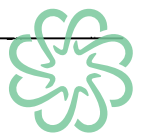
State Medical Board of Ohio Report of RU-486 Event

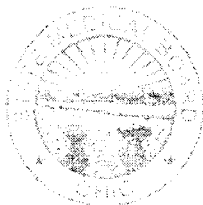
(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u> / <u>27</u> / <u>16</u>
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Raxside Road</u> <u>Bedford Heights, OH 44146</u>
4. Date post RU-486 complication began:	<u>11</u> / <u>11</u> / <u>16</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	_____ Hours _____ Days
7. Remarks:	<u>Surgical aspiration was done with no further complications. Pt did well post op.</u>
8. a. Name of physician who provided RU-486	<u>Timothy Kress MD</u>
8. b. Physician's signature	<u>Timothy S. Kress MD/D.O.</u>
	Date <u>12/28/16</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
<u>Oct</u> Month	<u>14</u> Day	<u>2016</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Greater Ohio</u>		
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 Rockside Road</u> <u>Bedford Heights, OH 44146</u>		
4. Date post RU-486 complication began: <u>11/10/16</u>		
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: _____ Hours _____ Days		
7. Remarks: <u>Pt. treated with surgical aspiration with no further complications. Pt did well post-op.</u>		
8. a. Name of physician who provided RU-486 <u>Timothy Kress, MD</u>		
8. b. Physician's signature <u>Timothy S. Kress, MD/DO</u>		
Date <u>12/23/16</u>		

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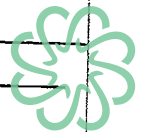
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>12</u>	<u>15</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>1/3/17</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Completed w/ D&C without issue</u>			
8. a. Name of physician who provided RU-486 <u>Sharon Line</u>			
8. b. Physician's signature _____ MD/DO _____ Date <u>1/4/17</u>			

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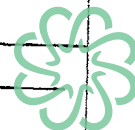
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
12 Month	15 Day	16 Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood		
3. Address of medical practice or facility at which RU-486 was provided: 2314 Auburn Ave. Cincinnati, OH 45219		
4. Date post RU-486 complication began: 1/3/17		
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: 2 Hours _____ Days		
7. Remarks: Doc done without issue		
8. a. Name of physician who provided RU-486: Dr. Lin		
8. b. Physician's signature: _____ M.D./D.O.		
Date: 1/4/17		

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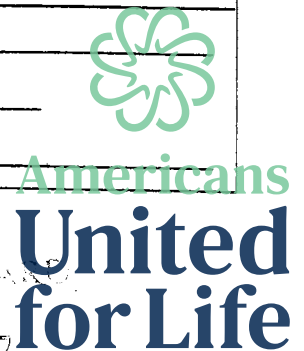
(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>2</u>	<u>6</u>	<u>2017</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood - East Surgical</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>3255 East Main St., Columbus, Ohio 43213</u>			
4. Date post RU-486 complication began: <u>2/14/17</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed Medication Abortion</u>			
6. Duration of event: _____ Hours <u>8</u> Days			
7. Remarks: <u>Failed Medication Abortion requiring surgical D+C</u>			
8. a. Name of physician who provided RU-486 <u>Romane</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD./D.O.</u>			
Date <u>2/21/17</u>			

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FEB 22 2017





State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
<u>12</u> Month	<u>13</u> Day	<u>16</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood - East surgical</u>		
3. Address of medical practice or facility at which RU-486 was provided: <u>3255 East Main St</u> <u>Columbus, OH 43213</u>		
4. Date post RU-486 complication began: <u>12/21/16</u>		
5. Event(s) (Please check all that apply):		
<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized		
<input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding		
<input checked="" type="checkbox"/> Other serious event (specify) <u>Failed Medication Abortion</u>		
6. Duration of event: _____ Hours <u>9</u> Days		
7. Remarks: <u>D.C. performed uncomplicated</u>		
8. a. Name of physician who provided RU-486 <u>Catherine Romanas</u>		
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____		
Date <u>12/29/16</u>		



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>November</u>	<u>17</u>	<u>2016</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood - East Surgical</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>3255 East Main St</u> <u>Columbus, OH 43213</u>			
4. Date post RU-486 complication began: <u>12/15/16</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed Medication Abortion</u>			
6. Duration of event: _____ Hours <u>33</u> Days			
7. Remarks: <u>DC performed - uncomplicated</u>			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature _____ MD/DO _____ Date <u>12/29/16</u>			



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>12</u>	<u>2</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>12/8/16</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>3</u> Hours _____ Days			
7. Remarks: <u>Completed Surgically</u>			
8. a. Name of physician who provided RU-486 <u>D. Kelly</u>			
8. b. Physician's signature <u>[Signature]</u> <u>(M.D./D.O.)</u>			
Date _____			

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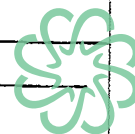
Legal Department

30 E. Broad St., 3rd Floor

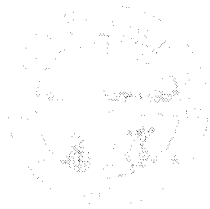
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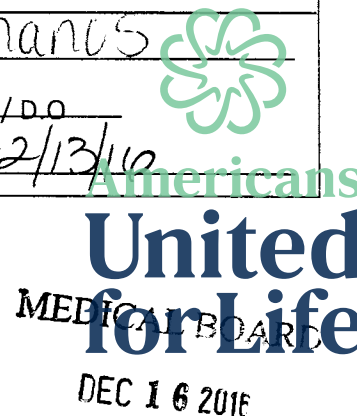
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>November 22 2016</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood East Surgical</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>3255 East Main St Columbus, Ohio 43213</u>
4. Date post RU-486 complication began:	<u>12/6/16</u>
5. Event(s) (Please check all that apply):	<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed Abortion</u>
6. Duration of event:	Hours <u>12</u> Days <u>1</u>
7. Remarks:	<u>FDA medication abortion @ 9w3d failed. DIC for ongoing IUP on 12/13/16.</u>
8. a. Name of physician who provided RU-486	<u>Catherine Romanos</u>
8. b. Physician's signature	<u>[Signature]</u> M.D./D.O. Date <u>12/13/16</u>

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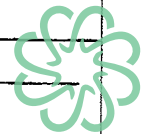
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>11</u>	<u>22</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>12/3/16</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>D-C done without incident</u>			
8. a. Name of physician who provided RU-486 <u>Theresa K. [Signature]</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. Date <u>12/3/16</u>			

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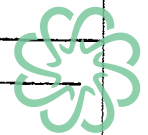


State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u>	<u>25</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>11/4/16</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed Medical or Abortion</u>			
6. Duration of event: <u>3</u> Hours _____ Days			
7. Remarks: <u>Completed successfully without issue</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Pickett</u>			
8. b. Physician's signature <u>[Signature]</u> (M.D./D.O.) Date <u>12/6/16</u>			



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u>	<u>4</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave, Cinc, 45219</u>			
4. Date post RU-486 complication began: <u>10/22/16</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed medication Abt. c.</u>			
6. Duration of event: <u>2</u> Hours _____ Days <u>when it returned to physical completion</u>			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Dr. Pickle</u>			
8. b. Physician's signature <u>[Signature]</u> <u>M.D./D.O.</u> Date <u>12/6/16</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>November</u>	<u>3</u>	<u>2016</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>3255 East Main Street</u> <u>Columbus, OHIO 43213</u>			
4. Date post RU-486 complication began: <u>11/10/16</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>19</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u> Date <u>11/22/16</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

10

28

2016

Month

Day

Year

2. Name of medical practice or facility at which RU-486 was provided:

Planned Parenthood East Suriname

3. Address of medical practice or facility at which RU-486 was provided:

3255 E. Main St Columbus OH 43213

4. Date post RU-486 complication began:

11/8/16

5. Event(s) (Please check all that apply):

☐ Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding



Other serious event (specify)

Failed Medication Abortion

6. Duration of event: _____ Hours 11 Days

7. Remarks:

8. a. Name of physician who provided RU-486

Michelle Isley

8. b. Physician's signature

Michelle Isley

M.D./D.O.

Date

11/18/16



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>Oct</u> <u>5</u> <u>2016</u>
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Road</u> <u>Bedford Heights OH 44146</u>
4. Date post RU-486 complication began:	<u>10/21/16</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	<u>Medication abortion per FDA regimen on 10/5/16.</u> <u>Pt diagnosed with on-going pregnancy and treated</u> <u>with aspiration on 10/21/16. Pt did very well</u> <u>post op.</u>
8. a. Name of physician who provided RU-486	<u>Timothy Kress, MD</u>
8. b. Physician's signature	<u>Timothy Kress MD/DO</u>
	Date <u>11/10/16</u>



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	Sept 15 2016 Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	Planned Parenthood of Greater Ohio
3. Address of medical practice or facility at which RU-486 was provided:	25350 Rockside Road Bedford Heights OH 44146
4. Date post RU-486 complication began:	9/29/16
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	____ Hours 14 Days
7. Remarks:	Medication abortion per FDA regimen on 9/15/16 Pt. diagnosed with ongoing pregnancy and treated with aspiration on 10/13/16. Pt. did very well post-op.
8. a. Name of physician who provided RU-486	Timothy Kress, MD
8. b. Physician's signature	Timothy Kress MD/DO
	Date 11/10/16



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>Oct</u> <u>7</u> <u>2016</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Road</u> <u>Bedford Heights OH 44146</u>
4. Date post RU-486 complication began:	<u>10/18/16</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	_____ Hours <u>3</u> Days
7. Remarks:	<u>Patient did very well post aspiration.</u>
8. a. Name of physician who provided RU-486	<u>Timothy Kress, MD</u>
8. b. Physician's signature	<u>Timothy Kress</u> <u>MD/DO</u>
	Date <u>11/10/16</u>



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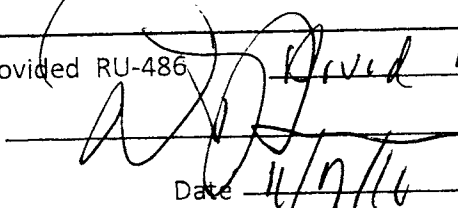
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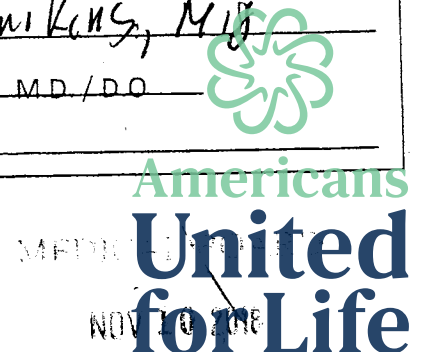
(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	10	6	2014
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223		
3. Address of medical practice or facility at which RU-486 was provided:	NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223		
4. Date post RU-486 complication began:	10/30/16		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event:	1 Hours _____ Days		
7. Remarks:	P had D&C at our facility on 10/31/16 without complication.		
8. a. Name of physician who provided RU-486	David M. Burkens, MD		
8. b. Physician's signature	 MD / DO		
	Date 11/7/16		

Send completed forms to:

State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127






State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u>	<u>4</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood Southwest Ohio</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave.</u>			
4. Date post RU-486 complication began: <u>10/16/16</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>3</u> Hours _____ Days			
7. Remarks: <u>Completed surgically without issue</u>			
8. a. Name of physician who provided RU-486 <u>Dr. P. Kelly</u>			
8. b. Physician's signature <u>[Signature]</u> <u>10/25/16</u> <u>(M.D./D.O.)</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	Sept	8	2016
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road Bedford Heights OH 44146			
4. Date post RU-486 complication began: 9/21/16			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks: Medication abortion per FDA regimen on 9/8/16 Pt diagnosed with on-going pregnancy + treated with aspiration on 9/21/16. Pt did very well post op.			
8. a. Name of physician who provided RU-486: Timothy Kress, MD			
8. b. Physician's signature: <u>Timothy Kress</u> (MD) / D.O. Date: 10/21/16			



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OCT 31 2016



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: Aug 19 2016
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Road
Bedford Heights OH 44146

4. Date post RU-486 complication began: 9/2/16

5. Event(s) (Please check all that apply):

☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: Patient did very well post aspiration.

8. a. Name of physician who provided RU-486 Timothy Kress, MD

8. b. Physician's signature Timothy S. Kress MD/DO

Date 10/21/16



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OCT 31 2016



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	
September 27	2016
Month	Day Year
2. Name of medical practice or facility at which RU-486 was provided:	
Planned Parenthood	
3. Address of medical practice or facility at which RU-486 was provided:	
3255 E. Main St Columbus OH 43213	
4. Date post RU-486 complication began:	
10/5/16	
5. Event(s) (Please check all that apply):	
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding
<input type="checkbox"/> Other serious event (specify) _____	
6. Duration of event: _____ Hours _____ Days	
7. Remarks:	
Incomplete MIB required Suction procedure	
8. a. Name of physician who provided RU-486	
Lisa Kider MD © Catherine Romanos	
8. b. Physician's signature	
CS	
Date 10/12/16	
MD/D.O.	

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>8</u>	<u>11</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood South West Ohio</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>9/11/16</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Fetal Abortion completed Surgically.</u>			
6. Duration of event: _____ Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>D. Kelly</u>			
8. b. Physician's signature <u>[Signature]</u> MD/DO _____			
Date <u>10/4/16</u>			

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OCT 11 2016



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 9 / 9 / 16
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

Planned Parenthood Southwest Ohio

3. Address of medical practice or facility at which RU-486 was provided:

2314 Auburn Ave, Cincinnati, OH 45219

4. Date post RU-486 complication began:

9/15/16

5. Event(s) (Please check all that apply):

☐ Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☒ Patient received a transfusion

☒ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: 2 Hours _____ Days (plus time in ER for transfusion)

7. Remarks:

8. a. Name of physician who provided RU-486

Dr. Kalsy

8. b. Physician's signature

[Signature]

M.D./D.O.

Date

10/4/16

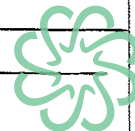
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(Required pursuant to R.C. 2919.123)

SEP 23 2016

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>8</u>	<u>16</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood Southeast Ohio Region</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave., Cincinnati OH 45219</u>			
4. Date post RU-486 complication began: <u>9/30/16</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>0</u> Hours _____ Days			
7. Remarks: <u>Doc done without issue.</u>			
8. a. Name of physician who provided RU-486 <u>Sarah Pickett</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____			
Date <u>9/20/16</u>			

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>07</u>	<u>06</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>08/17/16</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: 			
8. a. Name of physician who provided RU-486 <u>Mohammed Rezaee, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u> Date <u>8/31/16</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>07</u>	<u>30</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Artem</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>08/13/16</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Mitchell Leider, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> Date <u>8/20/16</u> <u>(M.D.)</u> (D.O.)			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>MAY</u> Month	<u>27</u> Day	<u>2016</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Greater Ohio</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 Rockside Road</u> <u>Bedford Heights OH 44146</u>			
4. Date post RU-486 complication began: <u>6/16/16</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>19</u> Days			
7. Remarks: <u>Aspiration for on-going pregnancy</u> <u>following medication abortion</u>			
8. a. Name of physician who provided RU-486 <u>Timothy S. Kress, MD</u>			
8. b. Physician's signature <u>Timothy S. Kress MD</u> Date <u>9/15/16</u>			



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>Aug</u> <u>26</u> <u>2016</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Road</u> <u>Bedford Heights OH 44146</u>
4. Date post RU-486 complication began:	<u>8/31/16</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	_____ Hours <u>5</u> Days
7. Remarks:	<u>Aspiration for non-viable gestation following medication abortion.</u>
8. a. Name of physician who provided RU-486	<u>Timothy S Kress, MD</u>
8. b. Physician's signature	<u>Timothy S Kress</u> <u>MD/DO</u>
	Date <u>9/15/16</u>

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Columbus, OH 43215-6127

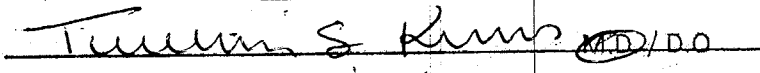
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SEP 19 2016



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>Aug</u> / <u>17</u> / <u>2016</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Road</u> <u>Bedford Heights OH 44146</u>
4. Date post RU-486 complication began:	<u>8/26/16</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	_____ Hours <u>9</u> Days
7. Remarks:	<u>Aspiration for slowly declining hCG levels following medication abortion.</u>
8. a. Name of physician who provided RU-486	<u>Timothy S. Kress, MD</u>
8. b. Physician's signature	<u>Timothy S. Kress, MD</u> 
	Date <u>9/15/16</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	
8 Month	5 2016 Day Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio	
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road Bedford Heights OH 44146	
4. Date post RU-486 complication began: 8/17/16	
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____	
6. Duration of event: 1 Hours _____ Days	
7. Remarks: Aspiration for on-going pregnancy following medication abortion.	
8. a. Name of physician who provided RU-486: Timothy S. Kress, MD	
8. b. Physician's signature: <u>Timothy S. Kress</u> <u>MD/DO</u> Date: 9/15/16	



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SEP 19 2016



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>8</u> / <u>19</u> / <u>2016</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Road</u> <u>Bedford Heights OH 44146</u>
4. Date post RU-486 complication began:	<u>8/24/16</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	_____ Hours <u>5</u> Days
7. Remarks:	<u>Aspiration for on-going pregnancy following medication abortion</u>
8. a. Name of physician who provided RU-486	<u>Timothy S. Kress, MD</u>
8. b. Physician's signature	<u>Timothy S. Kress</u> <u>MD/DO</u>
	Date <u>9/15/16</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>7</u> / <u>21</u> / <u>2016</u>
	Month / Day / Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood of Greater Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>25350 Rockside Road</u> <u>Bedford Heights OH 44146</u>
4. Date post RU-486 complication began:	<u>8/11/16</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	_____ Hours <u>10</u> Days
7. Remarks:	<u>Aspiration for non-viable gestation</u> <u>following medication abortion.</u>
8. a. Name of physician who provided RU-486	<u>Timothy S. Kress, MD</u>
8. b. Physician's signature	<u>Timothy Kress</u> (MD/DO)
	Date <u>9/15/16</u>

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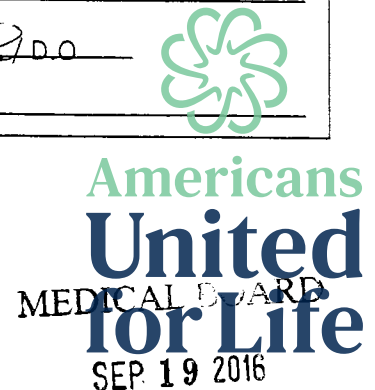
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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>08</u>	<u>24</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>3255 E. Main St. Columbus OH 43213</u>			
4. Date post RU-486 complication began: <u>9/6/16</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: <u>failed medication abortion completed surgical</u>			
8. a. Name of physician who provided RU-486 <u>Lisa Keder</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/D.O.</u> Date <u>9/14/2016</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
August Month	16 Day	2016 Year
2. Name of medical practice or facility at which RU-486 was provided: PPG OH		
3. Address of medical practice or facility at which RU-486 was provided: 3255 W Main St. Columbus, OH 43213		MEDICAL BOARD AUG 29 2016
4. Date post RU-486 complication began: 8/24/2016		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed medical abortion</u>		
6. Duration of event: <u>2</u> Hours _____ Days		
7. Remarks: Surgical completion of abortion		
8. a. Name of physician who provided RU-486 <u>C. Romanos</u>		
8. b. Physician's signature <u>[Signature]</u> M.D. / D.O. _____ Date <u>8/24/2016</u>		

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>06</u>	<u>25</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood Southwest Ohio Region</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave.</u> <u>Gahmngt. OH 45219</u>			
4. Date post RU-486 complication began: <u>7/9/16</u>			
5. Event(s) (Please check all that apply):			
<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized			
<input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding			
<input checked="" type="checkbox"/> Other serious event (specify) <u>Failed Ab, completed with surgery</u>			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Sharon Limer</u>			
8. b. Physician's signature <u>[Signature]</u> M.D. / D.O. <u> </u>			
Date <u>7/2/16</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: July 05, 2016
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

YPGH

3. Address of medical practice or facility at which RU-486 was provided:

3255 East Main St. Columbus, OH 43213

4. Date post RU-486 complication began:

07/14/2016

5. Event(s) (Please check all that apply):

☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks: Failed medical abortion completed surgically

8. a. Name of physician who provided RU-486 Romanos

8. b. Physician's signature [Signature]

M.D. / D.O. _____

Date 7/15/2016

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JUL 18 2016

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>06</u>	<u>17</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>07/05/16</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486: <u>Mitchell Reider, M.D.</u>			
8. b. Physician's signature: _____ Date: <u>7/8/16</u> <u>MD</u> <u>D.O.</u>			

Send completed forms to:

State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

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JUL 12 2016

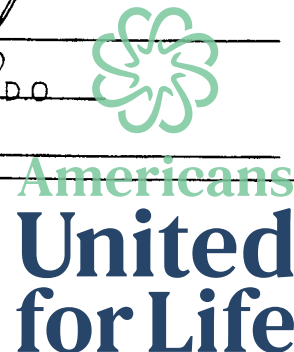
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>June</u> <u>1</u> <u>2016</u>
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Northeast Ohio Women's Ctr</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>21249 State Rd</u> <u>Cuyahoga Falls, OH 44223</u>
4. Date post RU-486 complication began:	<u>6/12/16</u>
5. Event(s) (Please check all that apply):	<div style="text-align: right;">MEDICAL BOARD</div> <div><input checked="" type="checkbox"/> Incomplete abortion</div> <div><input type="checkbox"/> Adverse reaction to RU-486</div> <div><input type="checkbox"/> Patient hospitalized <u>JUN 28 2016</u></div> <div><input type="checkbox"/> Patient received a transfusion</div> <div><input type="checkbox"/> Severe bleeding</div> <div><input type="checkbox"/> Other serious event (specify) _____</div>
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	<u>pt called in little bleed after mife/miso</u> <u>u/s showed sac still present though smaller</u> <u>decided to have suction at pt's request then report MISO</u>
8. a. Name of physician who provided RU-486	<u>D.M. Burkins</u>
8. b. Physician's signature	<u>[Signature]</u> M.D./D.O.
	Date <u>6/27/16</u>

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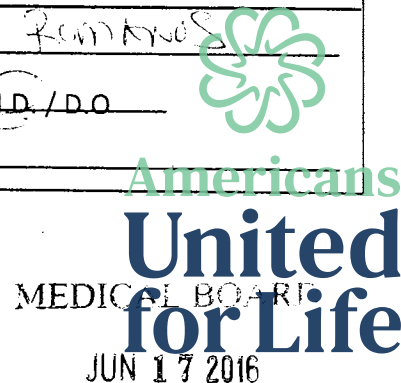
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	June	10	2016
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgical Center			
3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus OH 43213			
4. Date post RU-486 complication began: 6/15/16			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: failed medication abortion slp DC			
8. a. Name of physician who provided RU-486 _____ Reminos			
8. b. Physician's signature _____ (Signature) _____ M.D. / D.O. _____			
Date _____ 6/15/16			

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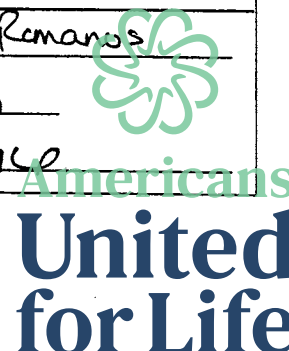
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>June</u> <u>3</u> <u>2016</u>
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood East Surgical</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>3255 E. Main St Columbus OH 43213</u>
4. Date post RU-486 complication began:	<u>6/7/16</u>
5. Event(s) (Please check all that apply):	
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding
<input type="checkbox"/> Other serious event (specify) _____	
6. Duration of event: <u>24</u> Hours _____ Days	
7. Remarks:	<u>incomplete expulsion of POC due to severe fibroid uterus.</u>
8. a. Name of physician who provided RU-486	<u>Catherine Romanos</u>
8. b. Physician's signature	<u>[Signature]</u>
	M.D./D.O. <u>6/9/16</u>
	Date <u>6/9/16</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>04</u>	<u>29</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Proterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>5/13/16</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days <u>unknown</u>			
7. Remarks: <u>Abortion completed surgically elsewhere.</u>			
8. a. Name of physician who provided RU-486 <u>Mitchell Reider, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>6/1/16</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

MAY 12, 2016
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

PREGH

3. Address of medical practice or facility at which RU-486 was provided:

3255 East Main St. Columbus, OH 43213

4. Date post RU-486 complication began:

5/19/2016

5. Event(s) (Please check all that apply):



Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized



Patient received a transfusion

☐ Severe bleeding



Other serious event (specify) _____

6. Duration of event: _____ Hours 6 Days

7. Remarks:

Successful medical abortion managed surgically.

8. a. Name of physician who provided RU-486 _____

8. b. Physician's signature _____

M.D. / D.O. _____

Date 5/25/16



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>03</u>	<u>30</u>	<u>2016</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>04/26/16</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>3</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Mitchell Reider, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD D.O.</u>			
Date <u>4/27/16</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>April</u> <u>21</u> <u>2016</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>3255 E. Main St. Columbus OH 43213</u>
4. Date post RU-486 complication began:	<u>4/22/16</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <u>em 4/27/16</u> <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	_____ Hours _____ Days
7. Remarks:	<u>D.C. for bleeding.</u>
8. a. Name of physician who provided RU-486	<u>Catherine Romanos</u>
8. b. Physician's signature	<u>[Signature]</u> MB/D.O. <u>4/27/16</u> Date

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MAY 2 2016



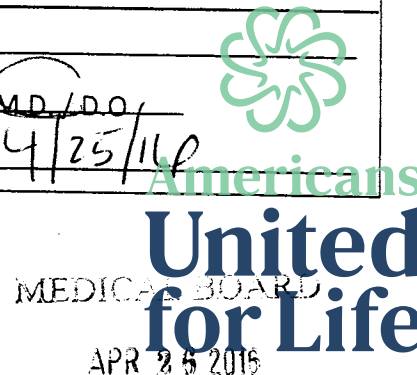
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	April	11	2016
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgical Center			
3. Address of medical practice or facility at which RU-486 was provided: 3255 E Main St., Columbus OH 43213			
4. Date post RU-486 complication began: 4/25/16			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: Failed Medication abortion, continuing pregnancy			
8. a. Name of physician who provided RU-486 ROMANOS			
8. b. Physician's signature _____ Date 4/25/16			

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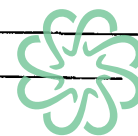
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>3</u>	<u>2</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood Southeast Ohio Region</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave., Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>3/23/16</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>2</u> Days			
7. Remarks: <u>Doing well p & d+L</u>			
8. a. Name of physician who provided RU-486 <u>Dr. [Signature]</u>			
8. b. Physician's signature <u>[Signature]</u> MD/DO			
Date <u>4/7/16</u>			

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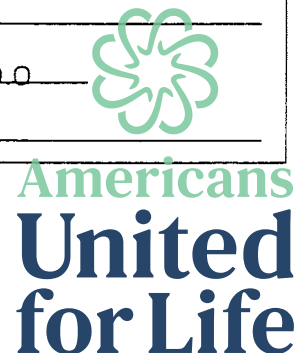
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>02</u>	<u>23</u>	<u>2016</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Proton</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12222 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>03/26/16</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Mohammed Raza</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD</u> <u>DO</u>			
Date <u>4/6/16</u>			

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Columbus, OH 43215-6127



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>02</u>	<u>24</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Mohammad Rozaee</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>4/6/16</u>			

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State Medical Board of Ohio Report of RU-486 Event


(Required pursuant to R.C. 2919.123)

W/15 R 2015

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>2</u>	<u>22</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>3255 E Main St. Columbus OH 43213</u>			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>n/a</u> Hours _____ Days _____			
7. Remarks: <u>failed MAB (non viable IUP) due to FDA regimen</u>			
8. a. Name of physician who provided RU-486: <u>Catherine Romanos</u>			
8. b. Physician's signature: <u>[Signature]</u> <u>MD/DO</u>			
Date: <u>3/3/14</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	Jan	29	2016
Month Day Year			
2. Name of medical practice or facility at which RU-486 was provided: Northeast Ohio Women's Center			
3. Address of medical practice or facility at which RU-486 was provided: 2137 State Rd Cuyahoga Falls, OH 44223			
4. Date post RU-486 complication began: 2/10/16			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours 10 Days			
7. Remarks: pt had persistent but smaller size elevated HCG a P.O. was done on 2/10/16 i completion of ab			
8. a. Name of physician who provided RU-486 David Baikan, M.D.			
8. b. Physician's signature Date 2/15/16 MD/DO			

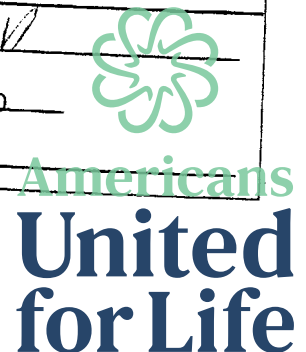
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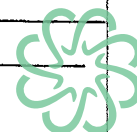
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>11</u>	<u>04</u>	<u>2015</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood SW Ohio Region</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave, Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>11/20/15</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours _____ Days			
7. Remarks: <u>D+C performed w/o incident.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. [Signature]</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>12/4/15</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

October 13, 2015
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

PPOH

3. Address of medical practice or facility at which RU-486 was provided:

3255 East Main St. Columbus, OH 43213

4. Date post RU-486 complication began:

10/29/2015

5. Event(s) (Please check all that apply):



Incomplete abortion

☐ Adverse reaction to RU-486

☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: incomplete medication abortion following FDA approved protocol.

8. a. Name of physician who provided RU-486

Catherine Romanos

8. b. Physician's signature

Date

10/28/15

M.D./D.O.



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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

09 24 15
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

Praterm

3. Address of medical practice or facility at which RU-486 was provided:

12000 Sucker Blvd. Cleveland 44120

4. Date post RU-486 complication began:

10/10/15

5. Event(s) (Please check all that apply):

☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:

Abortion completed surgically.

8. a. Name of physician who provided RU-486

Mitchell Reider, M.D.

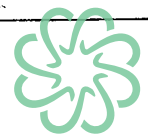
8. b. Physician's signature

[Signature]

M.D./D.O.

Date

10/16/15



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>09</u>	<u>10</u>	<u>15</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preform</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>10/01/15</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Mitchell Rider, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>M.D.</u> / <u>D.O.</u>			
Date <u>10/10/15</u>			

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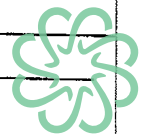
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>2</u>	<u>17</u>	<u>2015</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood Southwest Ohio Region</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave.</u>			
4. Date post RU-486 complication began: <u>3/6/15</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>14</u> Days <u>Follow up period after mifepr.</u>			
7. Remarks: <u>Pt. did well with second dose of misoprostol</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Kulsy</u>			
8. b. Physician's signature <u>[Signature]</u> M.D. / D.O. _____			
Date _____			

Send completed forms to: State Medical Board of Ohio
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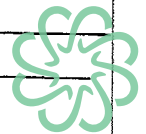
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>1</u> <u>2</u> <u>15</u>
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood Southwest Ohio</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>2314 Auburn Ave Cincinnati, OH 45219</u>
4. Date post RU-486 complication began:	<u>6/18/15</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	_____ Hours <u>30</u> Days <u>Follow up period after med</u>
7. Remarks:	<u>pt. elected to attempt completion with second dose of mifepristone, had D&C on 7/21/15 without problem</u>
8. a. Name of physician who provided RU-486	<u>Baron Lin</u>
8. b. Physician's signature	<u>[Signature]</u> M.D./D.O.
	Date <u>7/24/15</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>06</u>	<u>16</u>	<u>15</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12020 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>7/10/15</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2.5</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Mohammed Rzaee</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>7/14/15</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>06</u>	<u>10</u>	<u>15</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preferm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>7/3/15</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Mitchell Rider</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD / D.O.</u>			
Date <u>7/16/15</u>			

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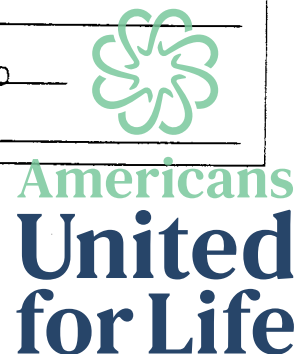
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>06</u>	<u>11</u>	<u>15</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Proform</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>7/7/15</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed Surgically</u>			
8. a. Name of physician who provided RU-486 <u>Mitchell Reider</u>			
8. b. Physician's signature <u>[Signature]</u> <u>M.D./D.O.</u>			
Date <u>7/16/15</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>05</u>	<u>06</u>	<u>2015</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preferon</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>6/2/15</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Mohammed Razaee, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>M.D. / D.O.</u> Date <u>6/2/15</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>03</u>	<u>12</u>	<u>15</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12022 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>03/28/15</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Lisa Anticora</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>4/14/15</u>			

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MEDICAL BOARD

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)


To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>03</u>	<u>10</u>	<u>15</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Proteum</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>04/03/15</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>3</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Mohammed Azam</u>			
8. b. Physician's signature <u>[Signature]</u> M.D. D.O. Date <u>4/14/15</u>			

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MEDICAL BOARD

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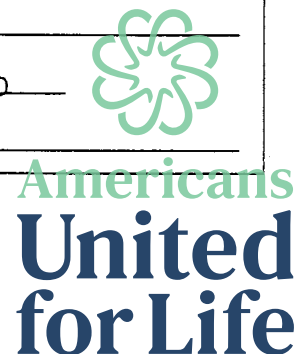
State Medical Board of Ohio Report of RU-486 Event

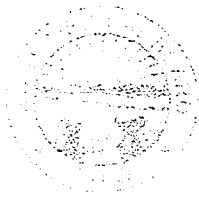
(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>01</u>	<u>22</u>	<u>15</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Proctorm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>2/13/15</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Lisa Harrison</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>2/26/15</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>12</u>	<u>17</u>	<u>2014</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Fernald Parenthood Southwest Ohio</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>5314 Auburn Ave</u> <u>Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>12/30/14</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Sharon Lin</u>			
8. b. Physician's signature _____ M.D./D.O. _____			
Date <u>2/18/15</u>			

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State Medical Board of Ohio

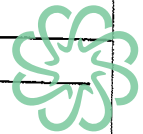
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MEDICAL BOARD

FEB 23 2015



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>01</u>	<u>21</u>	<u>2015</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>02/06/15</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Mitchell Reider</u>			
8. b. Physician's signature <u>[Signature]</u> <u>2/18/15</u> <u>M.D.</u> <u>D.O.</u>			



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>January</u> <u>13</u> , <u>2015</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>PPOH</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>3255 East Main St., Columbus, OH 43213</u>
4. Date post RU-486 complication began:	<u>1/30/15</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>N/A</u> Hours _____ Days _____
7. Remarks:	<u>failed secondary to FDA protocol</u>
8. a. Name of physician who provided RU-486	<u>Catherine Kuman's</u>
8. b. Physician's signature	<u>[Signature]</u> MD/DO
	Date <u>2/3/15</u>

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State Medical Board of Ohio Report of RU-486 Event


(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u> Month	<u>27</u> Day	<u>2014</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>PLANNED PARENTHOOD OF GREATER OHIO</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 ROCKSIDE RD, BEDFORD HTS, OH 44146</u>			
4. Date post RU-486 event began: <u>12/12/2014</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Other serious event (specify) _____ <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Patient hospitalized			
6. Duration of event: <u><1</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>TIMOTHY KRAUSS, MD</u>			
8. b. Physician's signature <u>Timothy Krauss</u> M.D./D.O. Date <u>12/12/14</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>11/18/2014</u>
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>PPDH</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>3255 East Main St. Columbus, OH 43213</u>
4. Date post RU-486 complication began:	<u>12/09/2014</u>
5. Event(s) (Please check all that apply):	
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding
<input type="checkbox"/> Other serious event (specify) _____	
6. Duration of event: <u>NA</u> Hours _____ Days _____	
7. Remarks: <u>failed medical Ab likely result of FDA protocol.</u>	
8. a. Name of physician who provided RU-486	<u>Catherine Kamanos MD</u>
8. b. Physician's signature	<u>[Signature]</u> MD/DO
Date	<u>12/9/14</u>

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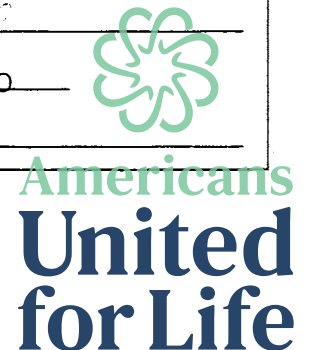
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u>	<u>28</u>	<u>14</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Acetum</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>13022 Flaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Mohammed Rzaee</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/D.O.</u>			
Date <u>11/18/14</u>			

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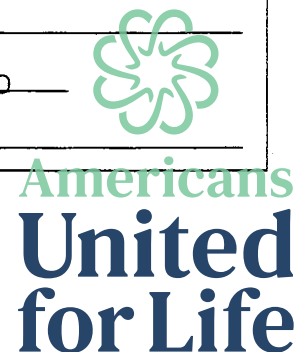
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	
10 Month	23 Day
14 Year	
2. Name of medical practice or facility at which RU-486 was provided: <i>Proforma</i>	
3. Address of medical practice or facility at which RU-486 was provided: <i>12000 Shaker Blvd. Cleveland OH 44120</i>	
4. Date post RU-486 complication began: <i>11/8/14</i>	
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____	
6. Duration of event: <i>2</i> Hours _____ Days	
7. Remarks: <i>Abortion completed surgically.</i>	
8. a. Name of physician who provided RU-486 <i>Lisa Perin</i>	
8. b. Physician's signature <i>[Signature]</i> M.D./D.O. Date <i>11/14/14</i>	

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Columbus, OH 43215-6127





State Medical Board of Ohio Report of RU-486 Event


(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	August Month	26 Day	2014 Year
2. Name of medical practice or facility at which RU-486 was provided: PLANNED PARENTHOOD OF GREATER OHIO			
3. Address of medical practice or facility at which RU-486 was provided: 25350 ROCKSIDE RD, BEDFORD HTS, OH 44146			
4. Date post RU-486 event began: 9/10/14			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Other serious event (specify) _____ <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Patient hospitalized MEDICAL BOARD SEP 20 2014			
6. Duration of event: _____ Hours 14 Days			
7. Remarks: Pt received medication abortion per FDA approved protocol. Intrauterine debris on ultrasound at 14 day followup visit without viable pregnancy. Treated with 2 courses misoprostol without complication. Complete abortion confirmed by ultrasound.			
8. a. Name of physician who provided RU-486 Timothy Kress, MD			
8. b. Physician's signature <u>Timothy S. Kress</u> M.D./D.O. Date 9/24/14			

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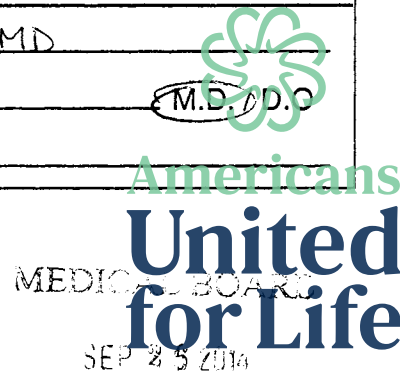
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	May	28	2014
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: PLANNED PARENTHOOD OF GREATER OHIO			
3. Address of medical practice or facility at which RU-486 was provided: 25350 ROCKSIDE RD, BEDFORD HTS, OH 44146			
4. Date post RU-486 event began: 07/17/2014			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Other serious event (specify) _____ <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Patient hospitalized			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: pt underwent FDA approved protocol for medication abortion with @ pregnancy test 6 weeks later, bloodwork confirms incomplete abortion. Treated with misoprostol 800 mcg without complication.			
8. a. Name of physician who provided RU-486 Timothy Kress, MD			
8. b. Physician's signature _____ Date 7/17/14			

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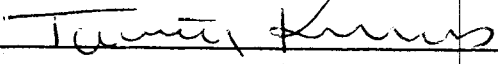





State Medical Board of Ohio Report of RU-486 Event


(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
<u>August</u> Month	<u>20</u> Day	<u>2014</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Greater Ohio</u>		
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 Rockside Rd., Bedford Heights, OH 44146</u>		
4. Date post RU-486 event began: <u>9/6/2014</u>		
5. Event(s) (Please check all that apply):		
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding	
<input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: <u><1</u> Hours _____ Days		
7. Remarks: <u>Pt underwent FDA approved protocol for medication abortion with continuing viable pregnancy at followup Pt elected surgical aspiration which was performed without complication.</u>		
8. a. Name of physician who provided RU-486 <u>Timothy Kress, MD</u>		
8. b. Physician's signature <u>Timothy Kress</u>   M.D./D.O.		
Date <u>9/6/14</u>		

Send completed forms to:

State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127


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SEP 26 2014

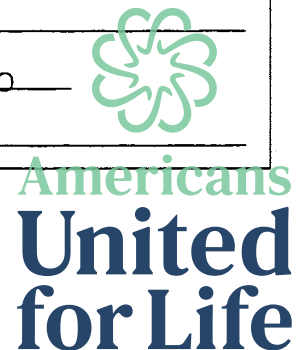
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>08</u>	<u>25</u>	<u>14</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12022 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>09/12/14</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>4</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Lisa Portier</u>			
8. b. Physician's signature <u>[Signature]</u> <u>9/19/14</u> <u>M.D./D.O.</u>			

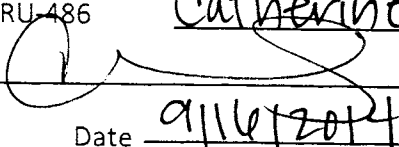
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Columbus, OH 43215-6127



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	August 28, 2014
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	PPDH
3. Address of medical practice or facility at which RU-486 was provided:	3255 East Main Street Columbus, OH 43213
4. Date post RU-486 complication began:	September 12, 2014
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	n/a Hours _____ Days _____
7. Remarks:	D A protocol resulted in incomplete procedure
8. a. Name of physician who provided RU-486	Catherine Karanos MD.
8. b. Physician's signature	 M.D./D.O.
Date	9/16/2014

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SEP 19 2014

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>07</u>	<u>03</u>	<u>14</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Acetown</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd.</u>			
4. Date post RU-486 complication began: <u>8/2/14</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>1</u> Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Lisa A. Ferrara</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>8/8/14</u>			

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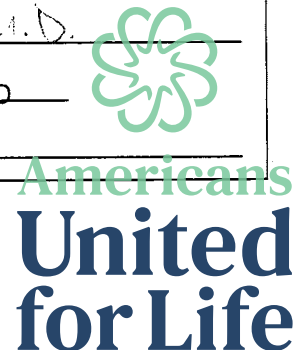
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>06</u>	<u>03</u>	<u>14</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Prieterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12600 Tucker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>06/20/14</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>1</u> Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Mohammed Rezaee, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>M.D. / D.O.</u>			
Date <u>7/9/14</u>			

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Rept # 4

State Medical Board of Ohio Report of RU-486 Event

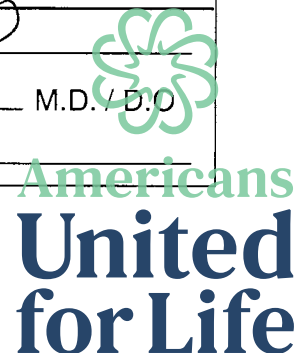
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>12</u>	<u>9</u>	<u>11</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Northeast OH</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>19550 Rockside Rd Bedford OH 44146</u>			
4. Date post RU-486 event began: <u>12/22/11</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			

7. Remarks:	
8. a. Name of physician who provided RU-486	<u>Sarah K. Smith, MD</u>
8. b. Physician's signature	<u>[Signature]</u> M.D. / D.O.
Date	<u>1/24/12</u>

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Columbus, OH 43215-6127



✓ Rpt #5



State Medical Board of Ohio Report of RU-486 Event

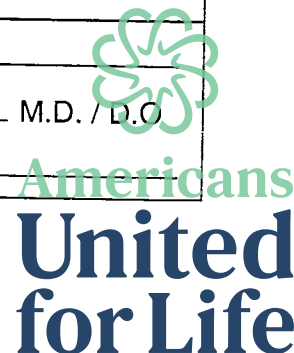
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
12	27	11
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Northeast Ohio		
3. Address of medical practice or facility at which RU-486 was provided: 19660 Rockwell Rd Bedford OH 44146		
4. Date post RU-486 event began: 1/11/12		
5. Event(s) (Please check all that apply):		
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding	
<input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: 2 Hours _____ Days		
7. Remarks: D&C for persistent sac		
8. a. Name of physician who provided RU-486: David Burkens MD		
8. b. Physician's signature: [Signature]		M.D. / D.O.
Date: 1/26/12		

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Columbus, OH 43215-6127

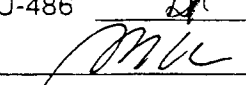


UPR # 28

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	9	12	12
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: CENTRAL OHIO WOMEN'S CENTER			
3. Address of medical practice or facility at which RU-486 was provided: 3755 E. MAIN STREET COLUMBUS, OH. 43213			
4. Date post RU-486 event began: 10/12/12			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 24 Hours <input checked="" type="checkbox"/> Days			
7. Remarks: Pt underwent D&C for incomplete medical abortion.			
8. a. Name of physician who provided RU-486 Dr. Keder			
8. b. Physician's signature  M.D. [Signature]			
Date 10/12/12			

Send completed forms to:

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Columbus, OH 43215-6127

2011-11-15 14:22:00
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Rept 19

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>08</u>	<u>15</u>	<u>12</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Clev. OH 44120</u>			
4. Date post RU-486 event began: <u>09/08/12</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically 9/8/12, no further complications.</u>			
8. a. Name of physician who provided RU-486 <u>Rebecca Lowenthal, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>9/21/12</u> <u>M.D.</u>			

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Rept 20

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>08</u>	<u>30</u>	<u>2012</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Artem</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleve. OH 44120</u>			
4. Date post RU-486 event began: <u>9/12/12</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically 9/12/12, no further complication.</u>			
8. a. Name of physician who provided RU-486 <u>Lisa Pettica, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O.			
Date <u>9/14/12</u>			

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Report of RU-486 Event

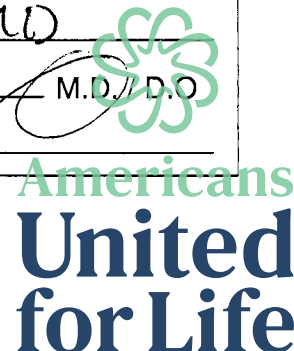
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	June	12	2012
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Northeast Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd Bedford Hts, OH			
4. Date post RU-486 event began: 6/29/12			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: Sarah K Smith MD			
8. b. Physician's signature: _____ M.D./D.O.			
Date: 9/4/12			

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State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 06 07 2012
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

PPNEO

3. Address of medical practice or facility at which RU-486 was provided:

25350 ROCKSIDE RD

BEDFORD HEIGHTS, OH 44146

4. Date post RU-486 event began:

6-21-12

5. Event(s) (Please check all that apply):

☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: 0 Hours 1 Days

7. Remarks:

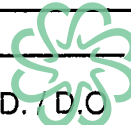
8. a. Name of physician who provided RU-486 DR DAVID BURKINS

8. b. Physician's signature [Signature] M.D. / D.O.

Date 6/27/12

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	5 Month	8 Day	2012 Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Northeast Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd Bedford HTS OH 44146			
4. Date post RU-486 event began: 6/15/12			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: And Burkens MD			
8. b. Physician's signature: _____ M.D. / D.O. Date: _____			

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_____ M.D. / D.O. _____

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Opt 4/16
R



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	11	10	2011
	Month	Day	Year

2. Name of medical practice or facility at which RU-486 was provided: PPNE6
--

3. Address of medical practice or facility at which RU-486 was provided: 19550 ROCKSIDE RD, BEDFORD, OH 44146
--

4. Date post RU-486 event began: 12/3/11

5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>HEMATOMETRA</u>
--

6. Duration of event: <u>1</u> Hours <u>0</u> Days
--

7. Remarks:

8. a. Name of physician who provided RU-486 <u>DR. SARAH SMITH</u>
8. b. Physician's signature <u>[Signature]</u> Date <u>6/12/12</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	05 Month	16 Day	2012 Year
2. Name of medical practice or facility at which RU-486 was provided: <i>CENTRA OHIO WOMAN'S CENTER</i>			
3. Address of medical practice or facility at which RU-486 was provided: <i>3155 E. MAIN STREET COLUMBUS, OH 43213</i>			
4. Date post RU-486 event began: <i>04-04-12</i>			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized	
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding		
<input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: 			
8. a. Name of physician who provided RU-486 <i>Catherine Cassano MD</i>			
8. b. Physician's signature <i>[Signature]</i>		M.D. / D.O. 	
Date <i>6/11/12</i>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 5 29 12
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
PPNEO

3. Address of medical practice or facility at which RU-486 was provided:
25350 ROCKSIDE RD
BEDFORD HTS, OH 44146

4. Date post RU-486 event began:
6-7-12

5. Event(s) (Please check all that apply):

☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: 1 Hours ☒ Days

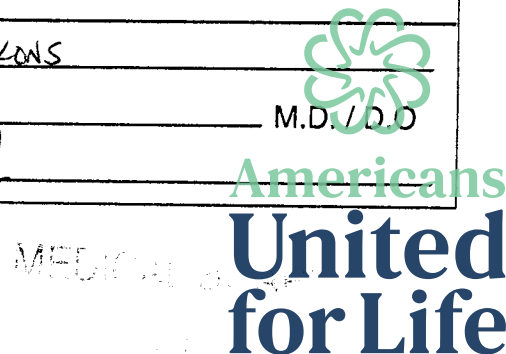
7. Remarks:

8. a. Name of physician who provided RU-486 DR. DAVID BURKONS

8. b. Physician's signature [Signature] M.D./D.O.

Date 6/6/12

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Rept # 13



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>05</u>	<u>17</u>	<u>2012</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>PPNEO</u>			

3. Address of medical practice or facility at which RU-486 was provided: <u>25350 ROCKSIDE RD</u> <u>BEDFORD HEIGHTS, OH 44146</u>
--

4. Date post RU-486 event began: <u>6-6-12</u>

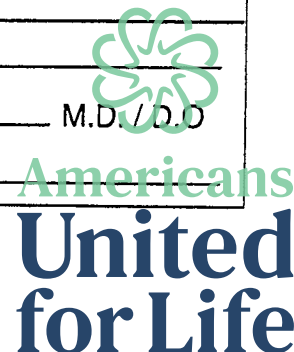
5. Event(s) (Please check all that apply):		
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding	
<input type="checkbox"/> Other serious event (specify) _____		

6. Duration of event: <u>1</u> Hours <u>0</u> Days
--

7. Remarks:	MEDICAL BOARD
8. a. Name of physician who provided RU-486 <u>DAVID BUNKANS, MD</u>	
8. b. Physician's signature <u>[Signature]</u>	M.D./D.O.
Date <u>6/6/12</u>	

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State Medical Board of Ohio Report of RU-486 Event

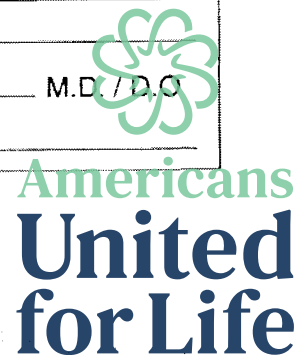
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	4 Month	4 Day	2012 Year
2. Name of medical practice or facility at which RU-486 was provided: <i>Central Ohio Women's Center</i>			
3. Address of medical practice or facility at which RU-486 was provided: <i>3155 E. Main Street Columbus, Ohio 43213</i>			
4. Date post RU-486 event began: <i>4-12-12</i>			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized			
<input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding			
<input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <i>14</i> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486			
8. b. Physician's signature <i>[Signature]</i> M.D. / D.O.			
Date <i>5/30/12</i>			

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Rpt # 11



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

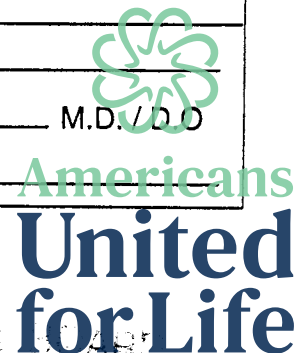
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	10	4	2011
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: PPNEO			
3. Address of medical practice or facility at which RU-486 was provided: 19550 ROCKSIDE RD, BEDFORD, OH 44146			
4. Date post RU-486 event began: 10/18/11			
5. Event(s) (Please check all that apply):			
<input type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized	
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding		
<input checked="" type="checkbox"/> Other serious event (specify) <u>HEMATOMETRA</u>			
6. Duration of event: <u>1</u> Hours <u>0</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>DR. SARAH SMITH</u>			
8. b. Physician's signature <u>[Signature]</u>		M.D./D.O.	
Date <u>5/22/12</u>			

Send completed forms to:

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30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

2012 MAY 29 PM 2:15
STATE MEDICAL BOARD



MAY 22 2012



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 11 01 2011
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
PPNEO

3. Address of medical practice or facility at which RU-486 was provided:
19550 ROCKSIDE RD, BEDFORD, OH 44146

4. Date post RU-486 event began:
11/17/11

5. Event(s) (Please check all that apply):
☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized
☐ Patient received a transfusion ☐ Severe bleeding
☐ Other serious event (specify) _____


6. Duration of event: 1 Hours ☒ Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR. SARAH SMITH
8. b. Physician's signature [Signature] M.D./D.O.
Date 5/22/12

Send completed forms to:

State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

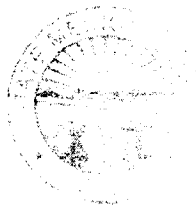

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MEDICAL BOARD

MAY 23 2012

STATE MEDICAL BOARD
OF OHIO
2012 MAY 29 PM 2:15

Rept 79



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>12</u>	<u>01</u>	<u>2011</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>PPN ED</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>19550 ROCKSIDE RD, BEDFORD, OH 44146</u>			
4. Date post RU-486 event began: <u>12/15/11</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>HYPOTENSIVE error</u>			
6. Duration of event: <u>8</u> Hours <u>13</u> Days			

7. Remarks:	
8. a. Name of physician who provided RU-486	<u>DR. DAVID BURKONS</u>
8. b. Physician's signature	<u>[Signature]</u>
	Date <u>5/1/12</u>
	M.D. / D.O.

Send completed forms to:

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MEDICAL BOARD

MAY 29 2012

2012 MAY 29 PM 2:15

ST. MEDICAL BOARD

Prescribed: 5/1/2011

Rept #8



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>01</u>	<u>19</u>	<u>2012</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>PPNEO</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>19550 ROCKSIDE RD. BEDI</u>			
4. Date post RU-486 event began: <u>2/17/12</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours <u>8</u> Days			

7. Remarks: <u>It never returned for F/U so don't know if completed on her own</u>	
8. a. Name of physician who provided RU-486	<u>DR. DAVID BURKONS</u>
8. b. Physician's signature	<u>[Signature]</u>
Date	<u>5/11/12</u>

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MEDICAL BOARD

MAY 22 2012

2012 MAY 29 PM 2:15
STATE MEDICAL BOARD

Rpt # 7

State Medical Board of Ohio Report of RU-486 Event


(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>March</u>	<u>19</u>	<u>2012</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Central Ohio Women's Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>3255 East Main St Columbus, OH</u>			
4. Date post RU-486 event began:			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Catherine Conner</u>			
8. b. Physician's signature <u>[Signature]</u> M.D. / D.O. Date <u>5/14/12</u>			

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Rept #6

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486


1. Date RU-486 was provided:	<u>January</u>	<u>12</u>	<u>2012</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Central Ohio Women's Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>3255 East Main St Columbus, OH 43213</u>			
4. Date post RU-486 event began: <u>2/10/12</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>moderate bleeding</u>			
6. Duration of event: <u>2</u> Hours <u> </u> Days			
7. Remarks: <u>D and C done for moderately heavy bleed. at time of routine followup.</u>			
8. a. Name of physician who provided RU-486 <u>Keder</u>			
8. b. Physician's signature <u>[Signature]</u> M.D. / D.O. Date <u>5/7/12</u>			

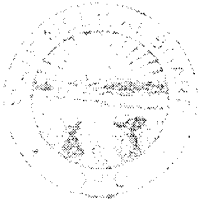
Send completed forms to:

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2012 MAY 21 AM 8:04
STATE MEDICAL BOARD
OF OHIO

Prescribed: 5/--/2011

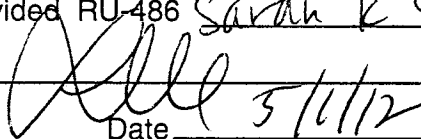

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State Medical Board of Ohio Report of RU-486 Event

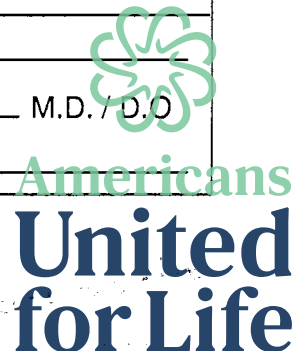
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

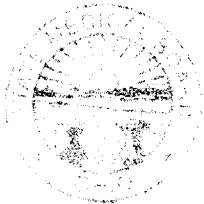
1. Date RU-486 was provided:		
3	13	2012
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Northeast Ohio		
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd Bedford Hts OH 44146		
4. Date post RU-486 event began: 4/5/12		
5. Event(s) (Please check all that apply):		
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding	
<input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: _____ Hours _____ Days		
7. Remarks:		
8. a. Name of physician who provided RU-486 Sarah K Smith MD		
8. b. Physician's signature 		M.D. / D.O.
Date 5/1/12		

Send completed forms to:

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Report # 2-5



State Medical Board of Ohio Report of RU-486 Event

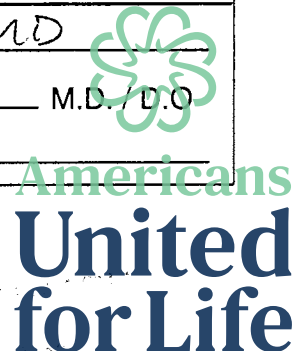
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
3 Month	28 Day	12 Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Northeast Ohio		
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd Bedford Hts OH 44146		
4. Date post RU-486 event began: 4/13/12		
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: 1 Hours _____ Days		
7. Remarks:		
8. a. Name of physician who provided RU-486 David M Burmans MD		
8. b. Physician's signature		M.D. / D.O.
Date		4/19/12

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:

3 27 2012
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

Planned Parenthood of Northeast Ohio

3. Address of medical practice or facility at which RU-486 was provided:

25350 Rockside Rd
Bedford Hts OH 44146

4. Date post RU-486 event began:

4/14/12

5. Event(s) (Please check all that apply):

☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized
☐ Patient received a transfusion ☐ Severe bleeding
☐ Other serious event (specify) _____

6. Duration of event: 1 Hours Days

7. Remarks:

8. a. Name of physician who provided RU-486

Sarah K Smith MD

8. b. Physician's signature

[Signature]

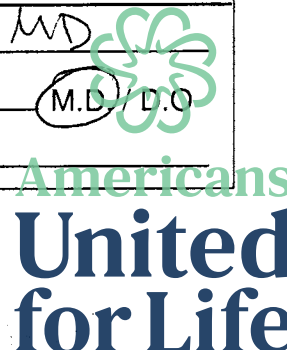
Date

4/24/12

M.D. / D.O.

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Report # 22

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
3	7	2012
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Northeast Ohio		
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd Bedford Hts OH 44146		
4. Date post RU-486 event began: 3/20/12		
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: _____ Hours _____ Days		
7. Remarks:		
8. a. Name of physician who provided RU-486: David Burnons MD		
8. b. Physician's signature: _____ Date: 3/26/12		

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State Medical Board of Ohio
Report of RU-486 Event


(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>3</u>	<u>6</u>	<u>2012</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Northeast Ohio</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 Rockside Rd Bedford Hts OH 44146</u>			
4. Date post RU-486 event began: <u>3/20/12</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Sarah K Smith MD</u>			
8. b. Physician's signature <u>[Signature]</u> M.D. / D.O. Date <u>3/27/12</u>			

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Report #60



State Medical Board of Ohio Report of RU-486 Event

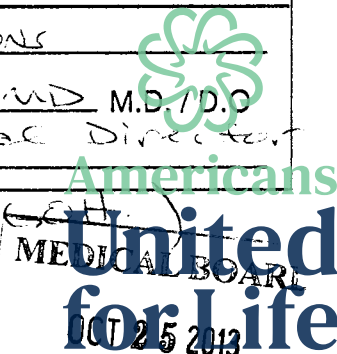
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>09</u> Month	<u>17</u> Day	<u>2013</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>PLANNED PARENTHOOD OF GREATER OHIO</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 ROCKSIDE RD, BEDFORD HTS, OH 44146</u>			
4. Date post RU-486 event began: <u>10-3-2013</u>			
5. Event(s) (Please check all that apply):			
<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>FAILED MEDICATION ABORTION</u>			
6. Duration of event: <u><1</u> Hours <u>X</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>DR DAVID BURKONS</u>			
8. b. Physician's signature <u>Tanya S. Krum</u> (KRESS MD M.D./D.O.) Date <u>10/22/13</u> Medical Director			

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State Medical Board of Ohio Report of RU-486 Event

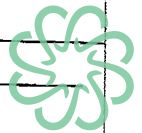
(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

OCT 15 2013

1. Date RU-486 was provided:	4	25	13
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood Southwest Ohio Region			
3. Address of medical practice or facility at which RU-486 was provided: 2314 Auburn Ave. Cincinnati, OH 45219			
4. Date post RU-486 complication began: 5/11/13			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days monitored for w. 3 wks.			
7. Remarks: pt monitored over few weeks since bleeding not heavy and D+C done p oral med's not effective.			
8. a. Name of physician who provided RU-486 _____ Sharon Line			
8. b. Physician's signature _____ MD/DO			
Date 10/6/13			

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 Columbus, OH 43215-6127



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Report 58



State Medical Board of Ohio
Report of RU-486 Event

MEDICAL BOARD

OCT 15 2013

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 6 / 4 / 13
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood Southeast Ohio Region

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave, Cincinnati, OH 45219

4. Date post RU-486 complication began: 6/20/13

5. Event(s) (Please check all that apply):
☐ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized
☐ Patient received a transfusion ☒ Severe bleeding
☐ Other serious event (specify) _____

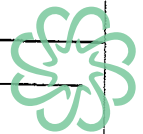
6. Duration of event: 2 Hours _____ Days

7. Remarks: pt. had D+C at Follow up due to drop in Hb and still moderate amount of blood in uterus.

8. a. Name of physician who provided RU-486 Sharon Linn

8. b. Physician's signature [Signature] MD/DO
Date 10/9/13

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State Medical Board of Ohio Report of RU-486 Event

MEDICAL BOARD

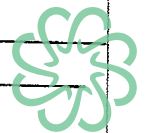
OCT 10 2013

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>6</u>	<u>4</u>	<u>13</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood Southwest Ohio Region</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>6/18/13</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>10</u> Days			
7. Remarks: <u>pt. had non-viable sac at FUA, attempted additional dose of mifepristone x1 and then D+C for retained sac.</u>			
8. a. Name of physician who provided RU-486 <u>Sharon Linn</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>10/9/13</u>			

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Report 56



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 8 13 2013
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

Planned Parenthood of Greater Ohio Bedford Heights Surgical Center

3. Address of medical practice or facility at which RU-486 was provided:

25350 Rockside Rd. Bedford Hts. Ohio 44146

4. Date post RU-486 complication began:

9/6/13

5. Event(s) (Please check all that apply):

☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized

☐ Patient received a transfusion ☐ Severe bleeding

☐ Other serious event (specify) _____

6. Duration of event: 1 Hours Days

7. Remarks:

Pt. delayed returning for medication abortion follow up vs

8. a. Name of physician who provided RU-486

Dr. David Burkow

8. b. Physician's signature

[Signature]

M.D./D.O.

Date

9/24/12

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Report #55



State Medical Board of Ohio Report of RU-486 Event

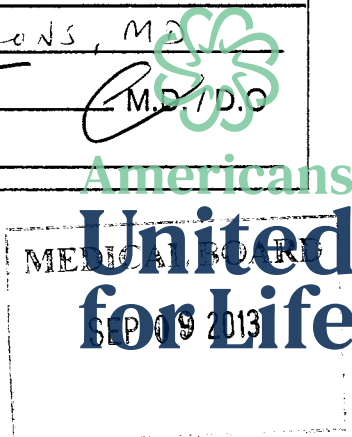
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	7	31	2013
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: PLANNED PARENTHOOD OF GREATER OHIO			
3. Address of medical practice or facility at which RU-486 was provided: 25350 ROCKSIDE RD, BEDFORD HTS, OH 44146			
4. Date post RU-486 event began:			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Other serious event (specify) _____ <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Patient hospitalized			
6. Duration of event: 1 Hours 0 Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 DR. DAVID GURKONS, MD			
8. b. Physician's signature _____ Date 9/4/13			

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Report 53

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>07</u>	<u>09</u>	<u>13</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Proform</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12020 Shaker Blvd. Cleveland OH 44120</u>			
4. Date post RU-486 complication began: <u>7/26/13</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>1</u> Days			
7. Remarks: <u>Abortion completed surgically on 7/26/13, no further complication.</u>			
8. a. Name of physician who provided RU-486 <u>Mohammad Rezaee</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD / D.O.</u> Date <u>8/1/13</u>			



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AUG 12 2013

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Report 52



State Medical Board of Ohio Report of RU-486 Event

MEDICAL BOARD

JUL 22 2013

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	6	29	13
	Month	Day	Year

2. Name of medical practice or facility at which RU-486 was provided:
PLANNED PARENTHOOD OF GREATER OHIO

3. Address of medical practice or facility at which RU-486 was provided:
25350 ROCKSIDE RD, BEDFORD HTS, OH 44146

4. Date post RU-486 event began:
7/12/13

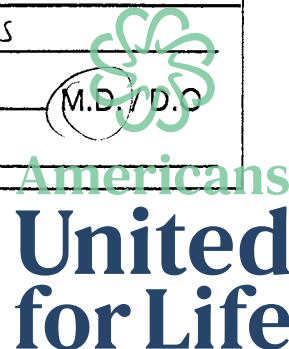
5. Event(s) (Please check all that apply):		
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding	
<input type="checkbox"/> Other serious event (specify) _____		

6. Duration of event:	0	Hours	3	Days
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7. Remarks:

8. a. Name of physician who provided RU-486	DR DAVID BURKINS
8. b. Physician's signature	
Date	7/15/13

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Columbus, OH 43215-6127



Report 46



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

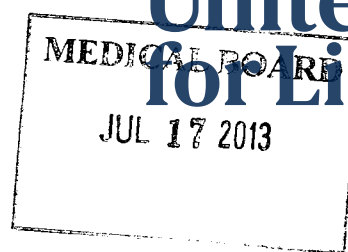
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	04	04	2013
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: PLANNED PARENTHOOD OF GREATER OHIO			
3. Address of medical practice or facility at which RU-486 was provided: 25350 ROCKSIDE RD, BEDFORD HTS, OH 44146			
4. Date post RU-486 event began: 4/6/2013			
5. Event(s) (Please check all that apply):			
<input type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized	
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding		
<input checked="" type="checkbox"/> Other serious event (specify) ALLERGIC REACTION			
6. Duration of event: _____ Hours _____ Days UNKNOWN			

7. Remarks:	
8. a. Name of physician who provided RU-486	DR. David Burrows
8. b. Physician's signature	
Date	6/7/13

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Columbus, OH 43215-6127



Report 47



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	4	4	2013
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: PLANNED PARENTHOOD OF GREATER OHIO			
3. Address of medical practice or facility at which RU-486 was provided: 25350 ROCKSIDE RD, BEDFORD HTS, OH 44146			
4. Date post RU-486 event began: 4/14/13			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized	
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding		
<input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u><1</u> Hours <u>0</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>DR DAVID BURKINS</u>			
8. b. Physician's signature <u>[Signature]</u>		M.D./D.O. <u>[Signature]</u>	
Date <u>4/17/13</u>			

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JUL 17 2013

Report 48

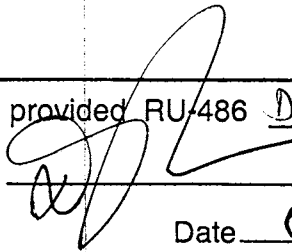


State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		4	2	2013
		Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: PLANNED PARENTHOOD OF GREATER OHIO				
3. Address of medical practice or facility at which RU-486 was provided: 25350 ROCKSIDE RD, BEDFORD HTS, OH 44146				
4. Date post RU-486 event began: 4/16/13				
5. Event(s) (Please check all that apply):				
<input checked="" type="checkbox"/> Incomplete abortion		<input type="checkbox"/> Adverse reaction to RU-486		<input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion		<input type="checkbox"/> Severe bleeding		
<input type="checkbox"/> Other serious event (specify) _____				
6. Duration of event: <u>0</u> Hours <u>7</u> Days				
7. Remarks:				
8. a. Name of physician who provided RU-486 <u>Dr. David Burkows</u>				
8. b. Physician's signature				
		Date <u>4/16/13</u>		

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Report 49



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

MEDICAL BOARD

JUL 17 2013

1. Date RU-486 was provided:	4	9	13
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: PLANNED PARENTHOOD OF GREATER OHIO			
3. Address of medical practice or facility at which RU-486 was provided: 25350 ROCKSIDE RD, BEDFORD HTS, OH 44146			
4. Date post RU-486 event began: 4/24/13			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized	
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding		
<input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: < 1 Hours 0 Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: DR SARAH LINGEN			
8. b. Physician's signature: M.D./D.O.			
Date: 7/11/13			

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Report 52



State Medical Board of Ohio Report of RU-486 Event

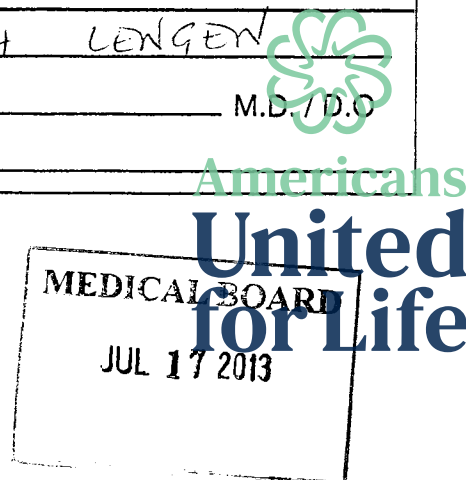
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
06	18	2013
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:		
PLANNED PARENTHOOD OF GREATER OHIO		
3. Address of medical practice or facility at which RU-486 was provided:		
25350 ROCKSIDE RD, BEDFORD HTS, OH 44146		
4. Date post RU-486 event began:		
6/25/13		
5. Event(s) (Please check all that apply):		
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding	
<input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: <u>21</u> Hours <u>8</u> Days		
7. Remarks:		
8. a. Name of physician who provided RU-486 <u>DR SARAH LINGEN</u>		
8. b. Physician's signature <u>[Signature]</u>		M.D./D.O.
Date <u>7/2/13</u>		

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Report 51



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>6</u>	<u>29</u>	<u>13</u>
	Month	Day	Year

2. Name of medical practice or facility at which RU-486 was provided:
PLANNED PARENTHOOD OF GREATER OHIO

3. Address of medical practice or facility at which RU-486 was provided:
25350 ROCKSIDE RD, BEDFORD HTS, OH 44146

4. Date post RU-486 event began:
7/12/13

5. Event(s) (Please check all that apply):		
<input type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding	
<input checked="" type="checkbox"/> Other serious event (specify) <u>INFECTION ADEQUATELY TREATED WITH PC AND ANTIBIOTICS</u>		

6. Duration of event:	<u>0</u> Hours	<u>14</u> Days
-----------------------	----------------	----------------

7. Remarks:

8. a. Name of physician who provided RU-486	DR. DAVID BURKENS, M.D.
8. b. Physician's signature	<u>[Signature]</u>
	Date <u>7/18/13</u>

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Report 45



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

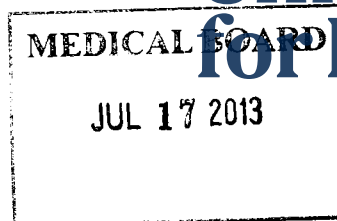
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	3	6	13
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: PLANNED PARENTHOOD OF GREATER OHIO			
3. Address of medical practice or facility at which RU-486 was provided: 25350 ROCKSIDE RD, BEDFORD HTS, OH 44146			
4. Date post RU-486 event began: 3/21/13			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Other serious event (specify) _____ <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Patient hospitalized			
6. Duration of event: 21 Hours 0 Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 DR SARAH LUNGER			
8. b. Physician's signature _____ M.D./D.O. Date 7/11/13			

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Report 44

State Medical Board of Ohio Report of RU-486 Event

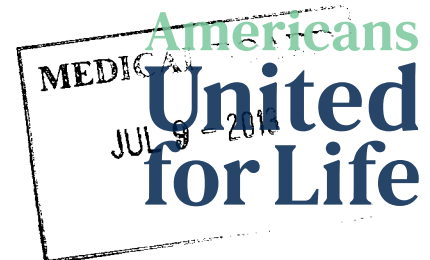
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>9</u> Month	<u>12</u> Day	<u>12</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Central Ohio Women's Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>3155 E. MAIN STREET COLUMBUS, OHIO 43213</u>			
4. Date post RU-486 event began: <u>9-18-12</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: <u>No heavy bleeding desired D&C for completion so IUD could be inserted.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Hader</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. Date <u>11/21/12</u>			

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Report 43

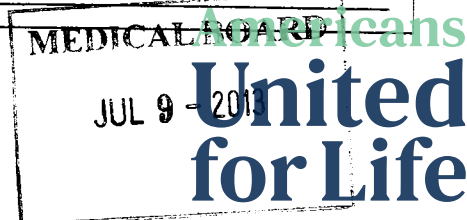
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>05</u>	<u>22</u>	<u>2013</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Central Ohio Women's Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>3255 E. MAIN STREET COLUMBUS, OHIO 43213</u>			
4. Date post RU-486 complication began: <u>6/7/13</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ / _____ Hours _____ Days			
7. Remarks: <u>plc done</u>			
8. a. Name of physician who provided RU-486 <u>DR. Keder</u>			
8. b. Physician's signature <u>[Signature]</u> <u>(M.D.) / D.O.</u>			
Date <u>6/26/13</u>			

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report #42

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>03</u>	<u>27</u>	<u>2013</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Procterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12022 Shaker Blvd. Cleveland OH 44130</u>			
4. Date post RU-486 complication began: <u>4/19/13</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>1</u> Days			
7. Remarks: <u>Abortion completed surgically on 4/20/13, no further complications.</u>			
8. a. Name of physician who provided RU-486 <u>Mohammed Rezak</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>4.24.13</u>			

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Report 54

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>07</u>	<u>30</u>	<u>2013</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Proterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland, Ohio 44120</u>			
4. Date post RU-486 complication began: <u>8/14/13</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>1</u> Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Mohammed Rzaee, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>(M.D./D.O.)</u> Date <u>8/20/13</u>			

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AUG 23 2013

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Report # 38



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
7	17	12
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: PLANNED PARENTHOOD OF GREATER OHIO		
3. Address of medical practice or facility at which RU-486 was provided: 25350 ROCKSIDE RD, BEDFORD HTS, OH 44146		
4. Date post RU-486 event began:		
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: <u><1</u> Hours <u>0</u> Days		
7. Remarks:		
8. a. Name of physician who provided RU-486 <u>DR SARAH LINGEN</u>		
8. b. Physician's signature <u>[Signature]</u>		M.D./D.O. <u>[Signature]</u>
Date <u>4/9/13</u>		

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APR 15 2013

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report #4

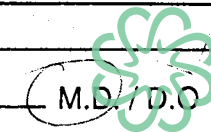
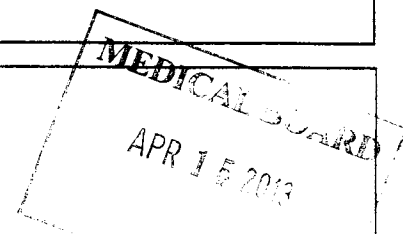


State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
<u>2</u> Month	<u>26</u> Day	<u>2013</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>PLANNED PARENTHOOD OF GREATER OHIO</u>		
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 RECKSIDE RD, BEDFORD HTS, OH 44146</u>		
4. Date post RU-486 event began: <u>3-14-13</u>		
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: <u>< 1</u> Hours <u>6</u> Days		
7. Remarks:		
8. a. Name of physician who provided RU-486 <u>DR SARAH LUNGEN</u>		
8. b. Physician's signature <u>[Signature]</u> Date <u>4/9/13</u>		



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Report # 40



State Medical Board of Ohio Report of RU-486 Event

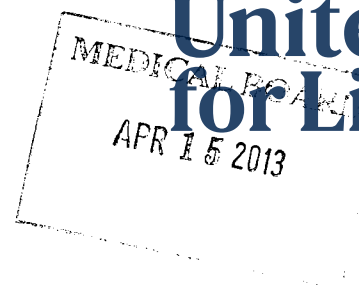
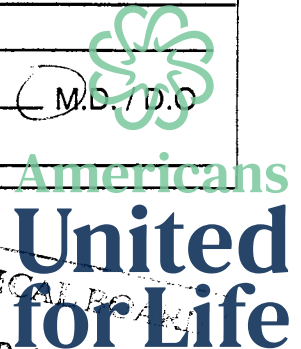
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	2	5	2013
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: PLANNED PARENTHOOD OF GREATER OHIO			
3. Address of medical practice or facility at which RU-486 was provided: 25350 ROCKSIDE RD, BEDFORD HTS, OH 44146			
4. Date post RU-486 event began: 2-22-13			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized	
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding		
<input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <1 Hours 4 Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 DR SARAH LUNGEN			
8. b. Physician's signature		 Date 4/9/13	

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Report # 39

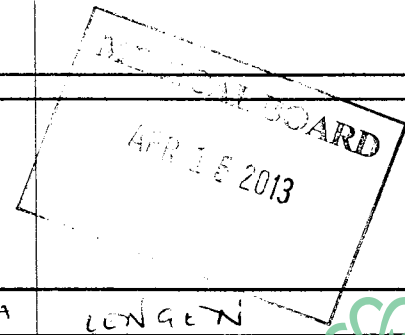


State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	19	13
Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <div style="text-align: center; font-family: cursive;">Planned Parenthood of Greater Ohio</div>		
3. Address of medical practice or facility at which RU-486 was provided: <div style="text-align: center; font-family: cursive;">15350 Lakeside Dr. Parma Hills, OH 44130</div>		
4. Date post RU-486 event began: <div style="text-align: center; font-family: cursive;">3/7/13</div>		
5. Event(s) (Please check all that apply):		
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding	
<input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: <u>2</u> Hours <u>1</u> Days		
7. Remarks:		
8. a. Name of physician who provided RU-486 <div style="text-align: center; font-family: cursive;">DR SARAH LONGEN</div>		
8. b. Physician's signature _____		
Date <div style="font-family: cursive; font-size: 1.5em;">9/9/13</div>		



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Report # 29



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	July	3	2012
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd Bedford Hts, OH 44146			
4. Date post RU-486 event began: 7/19/2012			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>1</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>David Burkons, MD</u>			
8. b. Physician's signature <u>[Signature]</u> M.D. / D.O. Date <u>1/18/13</u>			

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Report #30



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	August	30	2012
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd, Bedford Hts, OH 44146			
4. Date post RU-486 event began: 9/15/2012			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>1</u> ^{hour} Days			

7. Remarks:	
8. a. Name of physician who provided RU-486	David Burkons, MD
8. b. Physician's signature	
Date	1/18/13

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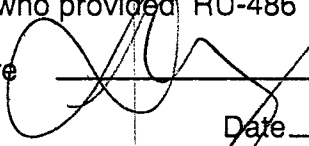
Report #31



State Medical Board of Ohio Report of RU-486 Event

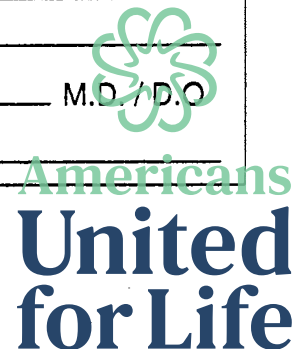
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	Sept Month	18 Day	2012 Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd, Bedford Hts, OH 44146			
4. Date post RU-486 event began: 10/2/12			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Other serious event (specify) _____ <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Patient hospitalized			
6. Duration of event: _____ Hours <u>1</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Sarah Smith, MD</u>			
8. b. Physician's signature  _____ M.D. / D.O. Date <u>11/15/13</u>			

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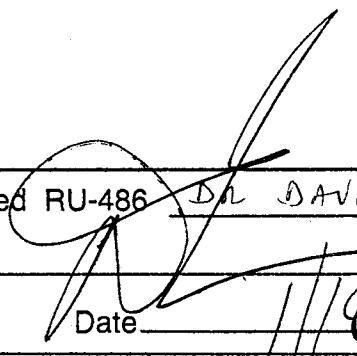
Report # 33



State Medical Board of Ohio Report of RU-486 Event


(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	10 Month	17 Day	2012 Year
2. Name of medical practice or facility at which RU-486 was provided: PLANNED PARENTHOOD OF GREATER OHIO			
3. Address of medical practice or facility at which RU-486 was provided: 25350 ROCKSIDE RD BEDFORD HTS, OH 44146			
4. Date post RU-486 event began: 11-8-12			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Other serious event (specify) _____ <input type="checkbox"/> Adverse reaction to RU-486 <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Patient hospitalized			
6. Duration of event: 1 Hours 0 Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: DR DAVID BURROWS, MD			
8. b. Physician's signature:  M.D./D.O. Date: 11/8/12			

Send completed forms to:

State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127


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Report # 34



State Medical Board of Ohio Report of RU-486 Event

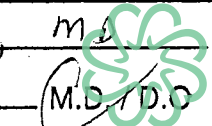
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>11</u> Month	<u>8</u> Day	<u>2012</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>PLANNED PARENTHOOD OF GREATER OHIO</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 ROCKSIDE RD, BEDFORD HTS, OH 44146</u>			
4. Date post RU-486 event began: <u>11/27/12</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>8</u> Hours <u>3</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>DR DAVID BURKONS, MD</u>			
8. b. Physician's signature _____ Date <u>11/8/12</u>			

Send completed forms to:

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Legal Department
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Report # 35



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>11</u> Month	<u>14</u> Day	<u>2012</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>PLANNED PARENTHOOD OF GREATER OHIO</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2535D ROCKSIDE RD</u> <u>BEDFORD HTS, OH 44146</u>			
4. Date post RU-486 event began: <u>11/30/12</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>HEMATOMETRA TREATED WITH REASPIRATION</u>			
6. Duration of event: <u>< 1</u> Hours <u>8</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>DR DAVID BURKONS, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>11/18/12</u> Date <u>M.B.D.O.</u>			

Send completed forms to:

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Report # 36



State Medical Board of Ohio Report of RU-486 Event

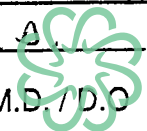
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u> Month	<u>17</u> Day	<u>2012</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>PLANNED PARENTHOOD OF GREATER OHIO</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 ROCKSIDE RD</u> <u>BEDFORD HTS, OH 44146</u>			
4. Date post RU-486 event began: <u>10/27/12</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Other serious event (specify) _____ <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Patient hospitalized			
6. Duration of event: <u>8</u> Hours <u>2</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>DR DAVID BURTONS, M.D.</u>			
8. b. Physician's signature _____ M.D. D.O.			
Date <u>11/18/13</u>			

Send completed forms to:

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Legal Department
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Report # 32



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u> Month	<u>31</u> Day	<u>2012</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>PLANNED PARENTHOOD OF GREATER OHIO</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 ROCKSIDE RD</u> <u>BEDFORD HTS, OH 44146</u>			
4. Date post RU-486 event began: <u>11/16/12</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>INFECTION</u>			
6. Duration of event: <u>8</u> Hours <u>14</u> Days			
7. Remarks: <u>TREATED WITH PO ANTIBIOTICS x 14 DAYS</u>			
8. a. Name of physician who provided RU-486 <u>DR DAVID BURKENS, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>11/16/12</u> Date			

Send completed forms to:

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Legal Department
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Report # 37

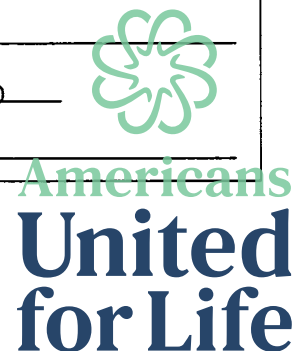
State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>15</u>	<u>11</u>	<u>2012</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Proctorm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland OH 44120</u>			
4. Date post RU-486 complication began: <u>1/2/13</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>7</u> Hours <u>7</u> Days			
7. Remarks: <u>Abortion completed surgically on 1/9/13, no further complication.</u>			
8. a. Name of physician who provided RU-486 <u>Mohammed Rzaee</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. <u>[Signature]</u> Date <u>1/22/13</u>			

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127



State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: Oct 4 2011
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Northeast Ohio

3. Address of medical practice or facility at which RU-486 was provided:
19550 Rockside Rd Bedford OH 44146

4. Date post RU-486 event began:
10/21/11

5. Event(s) (Please check all that apply):
☒ Incomplete abortion ☐ Adverse reaction to RU-486 ☐ Patient hospitalized
☐ Patient received a transfusion ☐ Severe bleeding
☐ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: in-clinic suction performed without complication
for failed medication abortion

8. a. Name of physician who provided RU-486 SSMIR, M
8. b. Physician's signature [Signature] 11/8/11 M.D. / D.O.
Date

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127


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Kept #3

State Medical Board of Ohio Report of RU-486 Event

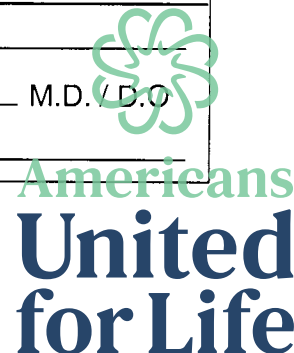
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>July</u>	<u>12</u>	<u>2011</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Northwest Ohio</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1455 Ridge Rd. Bedford, OH 44146</u>			
4. Date post RU-486 event began: <u>8/15/11</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input checked="" type="checkbox"/> Patient hospitalized <input checked="" type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>3.5</u> Hours _____ Days <u>per pt report</u>			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>David Buckens, MD</u>			
8. b. Physician's signature <u>[Signature]</u> M.D. / D.O. Date <u>9/2/11</u>			

Send completed forms to:

State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127



Rept #2

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>05</u>	<u>04</u>	<u>2011</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 event began: <u>05/11/11</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically 5/11/11, no further complication.</u>			
8. a. Name of physician who provided RU-486 <u>Lisa Pereira, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. Date <u>7/12/11</u>			

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127



Sept #1

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>04</u>	<u>13</u>	<u>2011</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 event began: <u>04/27/2011</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>2</u> Days			
7. Remarks: <u>Abortion completed surgically 4/29/11, no further complication.</u>			
8. a. Name of physician who provided RU-486 <u>Rebecca Lowenthal, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>7/13/11</u> <u>M.D./D.O.</u>			

Send completed forms to:

State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

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Planned Parenthood of Northeast Ohio
444 West Exchange St.
Akron, OH 44302

May 18, 2011

State Medical Board of Ohio
30 East Broad Street, 3rd Floor
Columbus, Ohio 43215-6127

To whom it may concern:

This is to report, pursuant to Ohio Rev. Code § 2919.123(C), that during the time period March 1, 2011 to April 30, 2011, there were 3 women who experienced an incomplete abortion following a mifepristone medication abortion at Planned Parenthood of Northeast Ohio. During that time period, no women who received mifepristone experienced severe bleeding or an adverse reaction, and no women were hospitalized, received a transfusion, or experienced any other serious event.

Sincerely,



Regan Clawson
VP of Health Services
Planned Parenthood of Northeast Ohio



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MEDICAL BOARD
MAY 23 2011