Department of Health and Human Services
Medicare/Medicaid/CLIA Complaint Form

Control Number: R8KB11 (OH00074116 OH00074144 OH00074148 OH00074154 OH00074159 OH00074193 OH00074225 OH00074228)

Part I - To Be Completed by Component First Receiving Complaint (SA or RO)

1. Medicare/Medicaid Identification Number
02,88 A5

Facility Name and Address
PRETERM
12000 SHAKER BOULEVARD
CLEVELAND, OH 44120

3. Date Complaint Received
0 3 3 1 1 4
M M D D Y Y

4. Receiving Component
1 State Survey Agy.
[1] 2 RO

5. Date Acknowledged
0 3 3 1 1 4
M M D D Y Y

6A. Source of Complaint
1 [4]
2 [5]
3 [ ]

1 Resident/Patient Family
2 Ombudsman
3 Facility Employee/Ex-Employ
4 Anonymous
5 Other

6B. Total Number of Complainants
0 8

7. Allegations

7.A. Category

1 [1 8]
2 [ ]
3 [ ]
4 [ ]
5 [ ]

1 Resident Abuse
2 Resident Neglect
3 Resident Rights
4 Patient Dumping
5 Environment
6 Care or Services
7 Dietary
8 Misuse of Funds/ Property
9 Certification/Un-authorized Testing
10 Proficiency Test
11 Falsification of Records / Reports
12 Unqualified Personnel
13 Quality Control
14 Specimen Handling
15 Diagnostic Erroneous Test Results
16 Fraud/False Billing
17 Fatality/Transfusion Fatality
18 Other (Specify) Death - General
19 Life Safety Code
20 State Monitoring

7.B. Findings (To be completed following investigation)

1 [0 2]
2 [ ]
3 [ ]
4 [ ]
5 [ ]

01 Substantiated
02 Unsubstantiated/ Unable to Verify

7.C. Number of Complainants per Allegation

1 [0 8]
2 [ ]
3 [ ]
4 [ ]
5 [ ]

8. Action (if multiple actions, indicate earliest action)

[1]

1 Investigate within 2 working days
2 Investigate within 10 working days
3 Investigate within 45 working days
4 Investigate during next onsite
5 Referral (Specify) _____
6 Other Action (Specify) _____
7 None

Part II - To Be Completed By Component Investigating Complaint (SA or RO)

9. Investigated by
[1]
1 State Survey Agency
2 RO
3 Other (Specify) _____

10. Complaint Survey Date
0 4 0 3 1 4
M M D D Y Y

11. Findings (Under 7B Above)
Unsubstantiated

12. Proposed Actions Taken by SA or RO

1: [2 1]
2: [ ]
3: [ ]

1 Recommend Termination (23-day)
2 Recommend Termination (90-day)
3 Recommend Intermediate Sanction
4 POC (No Sanction)
5 Fine
6 Denial of Payment for New Admissions
7 License Revocation
8 Receivership
9 Provisional License
10 Special Monitor
11 Directed POC
12 Limitation of Certificate
13 Suspension of Certificate
14 Revocation of Certificate
15 Injunction
16 Civil Monetary Penalty
17 TA & Training for Unsuccessful PT
18 State Onsite Monitoring
19 Suspension of Part of Medicare Payments
20 Suspension of All Medicare Payments
21 None
22 Other (Specify) _____
23 Enforcement Action

13. Date of Proposed Action
0 4 0 3 1 4
M MD D Y Y

14. Parties Notified and Dates

	Party	Date
1 Facility	1. [1]	0 4 0 3 1 4
2 Complainant	2. [ ]	
3 Representative	3. [ ]	
4 Other (Specify) _____		M M D D Y Y

15. Date Forwarded to CMS RO or Medicaid SA (MSA) (Attach HCFA-2567)
M MD DY Y

Part III - To Be Completed By Component Taking Final Close-Out Action (RO/MSA)

16. Date of CMS/MSA Receipt
M M D D Y Y

17. CMS RO/MSA Action
[ ]

1 None
2 Termination (23-day)
3 Termination (90-day)
4 Intermediate Sanction
5 Move Routine Survey Date Forward
6 Limitation of Certificate
7 Suspension of Certification
8 Revocation of Certificate
9 Injunction
10 Civil Monetary Penalty
11 TA & Training For Unsuccessful PT
12 Cancellation of Medicare Approval
13 Other (Specify) _____
14 Enforcement Action

18. Date of Final Action Sign-off
M M D D Y Y

Ohio Dept Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0288AS	A. BUILDING: _____ B. WING _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRETERM	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 Complaint Inspection Complaint Numbers OH00074225, OH00074228, OH74193, OH00074159, OH00074154, OH00074144, OH00074148, and OH00074116 Administrator: Chrisse France, Executive Director County: Cuyahoga Number of ORs: 5 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.	C 000		

Ohio Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE