STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
		A. BLDG: 00 B. WING:	06/08/2012

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: **00218701**	**29 NORTH 9TH STREET ALLENTOWN, PA 18101**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	(X5) COMPLETE DATE
S 0000	INITIAL COMMENT This report is the result of an unannounced on-site pre-licensure survey completed on May 31 - June 1, 2012, at Planned Parenthood of Northeast and Mid-Penn in Allentown. It was determined that the facility was not in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Ambulatory Care Facilities, Annex A, Title 28, Part IV, Subparts A and F, Chapters 551-573, November 1999.	S 0000		
S 033H		S 033H		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 033H	Continued from page 1 553.3 (8) Governing Body Responsibilities 553.3 Governing Body responsibilities include: (8) Establishing personnel policies and practices which adequately support sound patient care to include, the following: This REGULATION is not met as evidenced by:	S 033H	Plan of Correction: As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. PPNMP-Allentown will ensure that is Employee Handbook contains the requirement that PPNMP – Allentown identify employees with "significant likelihood of regular contact with children"; assure that all required background checks are completed, reviewed and documented in employee personnel files; retain a copy of each of the background clearances and notate that the original documents have been reviewed; assure that, until all background information has been received and reviewed, persons may be employed on provisional status;	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 033H	Continued from page 2	S 033H	assure that the provisional employee must work in the immediate presence of a regular employee and not work alone with children; assure that if the information that is obtained that the provisional employee is disqualified from employment, the individual must be immediately dismissed; and assure that an individual may be provisionally employed for a maximum of 90 days for out of state residents and 30 days for Pennsylvania residents.	

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S 033H	Continued from page 3 Based on review of facility documents, personnel files (PF), and staff interview (EMP), it was determined the facility failed to ensure processes were in place to meet the requirements for background checks as required by Act 179 of 2006 and Act 73 of 2007. Findings include: The Child Protective Services Law (CPSL), 23 Pa.C.S. § 6344.2 requires that employees hired after July 1, 2008, who have a significant likelihood of regular contact with children in the form of care, guidance, supervision or training must obtain three background checks as condition of employment: Pennsylvania State police Clearance, Department of Public Welfare (DPW) Childline Clearance and Federal (FBI) Criminal Background Check." Review on June 1, 2012, of the facility's policy and procedure manual revealed no documentation the facility developed a policy to ensure employees hired after July 1, 2008, who have a significant	S 033H		

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S 033H	Continued from page 4 likelihood of regular contact with children in the form of care, guidance, supervision or training must obtain three background checks as condition of employment: Pennsylvania State Police (PSP) Clearance, Department of Public Welfare (DPW) Childline Clearance and Federal (FBI) Criminal Background Check. Interview with EMP4 on June 1, 2012, at approximately 2:00 PM confirmed the facility performs surgery on pediatric patients. Further interview with EMP4 confirmed there were no policies and procedures in place that required the three background checks for CPSL.	S 033H		
S 033I		S 033I		

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S 033I	Continued from page 5 553.3 (8)(i) Governing Body Responsibilities 553.3 Governing Body responsibilities include: (8) Establishing personnel policies and practices which adequately support sound patient care to include, the following: (i) Require the employment of personnel with qualifications commensurate with a job's responsibilities and authority, including appropriate licensure and certification. This REGULATION is not met as evidenced by:	S 033I	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - PPNMP-Allentown will ensure that is Employee Handbook contains the requirement that PPNMP – Allentown identify employees with "significant likelihood of regular contact with children"; assure that all required background checks are completed, reviewed and documented in employee personnel files; retain a copy of each of the background clearances and notate that the original documents have been reviewed; assure that, until all background information has been received and reviewed, persons may be employed on provisional status; assure that the provisional employee	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 033I	Continued from page 6	S 033I	must work in the immediate presence of a regular employee and not work alone with children; assure that if the information that is obtained that the provisional employee is disqualified from employment, the individual must be immediately dismissed; and assure that an individual may be provisionally employed for a maximum of 90 days for out of state residents and 30 days for Pennsylvania residents.	

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S 033I	Continued from page 7 Based on a review of facility documents and staff interview (EMP), it was determined the facility failed to include all the required components of the Child Protective Services Law in facility policy as referenced in the Department of Public Welfare Bulletin 3490-08-03 of June 28, 2008, and the Child Protective Services Law (CPSL), 23 Pa.C.S. § 6344.2. Findings include: The Child Protective Services Law (CPSL), 23 Pa.C.S. § 6344.2 requires that employees hired after July 1, 2008 who have a significant likelihood of regular contact with children in the form of care, guidance, supervision or training must obtain three background checks as condition of employment: Pennsylvania State police Clearance, Department of Public Welfare (DPW) Childline Clearance and Federal (FBI) Criminal Background Check. ... The requirements apply to all persons employed after July 1, 2008. Those individuals employed prior to July 1, 2008 who fall into the classification of having	S 033I		

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S 033I	Continued from page 8 significant likelihood of regular contact with children in the form of care, guidance, supervision or training do not have to undergo the background checks. Those individuals employed prior to July 1, 2008 who were not working in a position with significant likelihood of regular contact with children in the form of care, guidance, supervision or training, but who subsequently transfer to a job that falls within classification, must undergo the background checks at the time of job transfer. Those individual employed after July 1, 2008 who do not fall within this classification at the date of hire but who subsequently transfer to a job that falls within this classification, must undergo the background checks at the time of job transfer. Employees who have undergone the background check and transfer to another job in the same facility do not need to undergo the background check again. Employees who leave one facility and commence employment at another facility must undergo the background checks, unless the previous background checks were completed within the past year. ... To assure compliance with the requirements of the Law,	S 033I		

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S 033I	Continued from page 9 facilities must: review employment policies and procedures to provide for identification of employees with 'significant likelihood of regular contact with children'. Assure that all required background checks are completed, reviewed and documented in employee personnel files. Retain a copy of each of the background clearances and notate that the original documents have been reviewed. ... until all background information has been received and reviewed ... persons may be employed on provisional status ... The provisional employee must work in the immediate presence of a regular employee and not work alone with children ... if the information that is obtained revealed that the provisional employee is disqualified from employment, the individual must be immediately dismissed and an individual may be provisionally employed for a maximum of 90 days for out of state residents and 30 days for Pennsylvania residents. ..." Review on June 1, 2012, of the facility's "Employee Handbook" last Board approved revisions-June	S 033I		

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S 033I	Continued from page 10 2009, revealed "Section 3: Employment and Staffing, 3.4 Background Checks- [They] recognizes the importance of maintaining a safe workplace with employees who are honest, trustworthy, qualified, reliable, nonviolent, and who do not present a risk of harm to their co-workers or others ... [They] complies with all applicable federal and state laws pertaining to background checks, including providing the job applicant or employee with the required notices and forms." Review on June 1, 2012, of the facility's "Child Abuse Policy for Staff" last updated June 1, 2009, revealed no documentation the facility included the requirement of reviewing employment policies and procedures to provide for identification of employees with significant likelihood of regular contact with children; assuring that all required background checks are completed, reviewed and documented in employee personnel files; that the original documents have been reviewed; that until all background information has been received and reviewed persons may be employed on provisional	S 033I		

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S 033I	Continued from page 11 status; that the provisional employee must work in the immediate presence of a regular employee and not work alone with children; if the information that is obtained revealed that the provisional employee is disqualified from employment, the individual must be immediately dismissed and that an individual may be provisionally employed for a maximum of 90 days for out of state residents and 30 days for Pennsylvania residents. Interview with EMP2 and EMP4 on June 1, 2012, at approximately 4:00 PM confirmed that the facility's Child Abuse Policy did not include the required information and this policy did not meet the criteria of the Child Protective Services Law as referenced in the Department of Public Welfare Bulletin 3490-08-03 of June 28, 2008.	S 033I		
S 033V		S 033V		

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S 033V	Continued from page 12 553.3 (16) Govern Body Responsibilities 553.3 Governing Body responsibilities include: (16) Assuring that at least one medical professional in the facility when patients are present is currently and on an ongoing basis certified in advanced cardiac life support, or its successor. If a pediatric patient is present in the facility, the certification of the medical professional shall be in advanced pediatric life support as defined in section 551.22 (A)(4). This REGULATION is not met as evidenced by:	S 033V	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - Policy has been drafted (06/11) by the VP for Medical Services and Human Resources Department. - It will be approved by the Governing Body on 07/31/12. - The requirement for ACLS and PALS has been included in new contracts for all abortion providers and/or medical staff who work in abortion locations. - Medical professional was certified in ACLS by 06/11/12 - Medical professional will be certified in PALS by 07/30/12 - Contracts will be signed by 07/01/12 - Contracts and credentialing will be	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 033V	Continued from page 13	S 033V	approved by the Governing Body on 07/31/12 - Human Resources will ensure that a copy of the policy and a facsimile of the contract will be in the facility ASF notebook - Medical Services Administration will draft a policy re emergency meds for pediatric patients - Policy will be reviewed by the Associate Medical Director with facility staff by 08/10/12 - Emergency meds will be put in the emergency drug cart by Associate Medical Director after 08/10/12 - The pediatric emergency meds will be added to the weekly emergency drug inspection log to be performed by the CRNP working in abortion care	

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S 033V	Continued from page 14 Based on review of facility documents, credential files, and staff interview (EMP), it was determined the facility failed to ensure the medical professional in the facility when patients were present maintained current certification in advanced cardiac life support and pediatric advanced life support and failed to ensure guidance for correct dosing and administration of emergency medications for the pediatric patient requiring emergency treatment at the facility. Findings include: 1) Review on June 1, 2012, of CF1 revealed no current advanced cardiac life support (ACLS) certification or pediatric advanced life support (PALS) certification. Interview on June 1, 2012, with EMP3 and EMP4, confirmed CF1 was the medical professional designated to remain in the facility when patients were present. Further interview confirmed ACLS and PALS were not required certifications, and	S 033V		

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S 033V	Continued from page 15 there was no policy or job description requiring those certifications. 2) Observation on May 31, 2012, of the facility's emergency drug cart revealed medication dosage documentation dedicated to the adult patient. Further observation revealed no documentation of guidance for correct dosing and administration of emergency medications for the pediatric patient requiring emergency treatment at the facility. Interview with EMP1 on May 31, 2012, confirmed the facility's emergency drug cart was dedicated to the adult patient who may require emergency care. Further interview with EMP1 confirmed there was no guidance for correct dosing and administration of emergency medications for the pediatric patient requiring emergency treatment at the facility.	S 033V		
S 312D		S 312D		

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S 312D	Continued from page 16 553.12 (b)(3) Implementation 553.12 (b) The following are minimal provisions for the patient's bill of rights: (3) A patient has the right to consideration of privacy concerning his own medical care program. Case discussion, consultation, examination and treatment are considered confidential and shall be conducted discreetly. This REGULATION is not met as evidenced by:	S 312D	Plan of Correction: As per our letter to the Department of Health dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. We are optimistic that we will be able to obtain accreditation, but in the event that we are not successful, we will pursue licensure as a Class B ASF. To that end, if the Class A accreditation process concludes unsuccessfully, we will pursue the alternate plan of compliance submitted by the Planned Parenthood health centers seeking licensure as Class B ASF, adjusting the dates as appropriate. Accordingly, at that time and if necessary, PPNMP- Allentown – will confer with its architect and Division of Safety and Inspection to identify feasible alterations to its health center and seek any necessary exceptions.	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/29/2012**

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S 312D	Continued from page 17 Based on observation and staff interview (EMP), it was determined the facility failed to ensure patient privacy in the facility's recovery area. Findings include: Observation on May 31, 2012, of the facility's post-operative recovery area revealed six reclining chairs. Further observation revealed no cubicle curtains or privacy curtains between these six reclining chairs to provide patient privacy during the post-operative recovery and care. Interview with EMP1 on May 31, 2012, at approximately 3:15 PM confirmed there were no cubicle curtains or privacy curtains between these six reclining chairs to provide patient privacy during the post-operative recovery and care. Cross reference 571.1 Chapter 571 - Construction Standards	S 312D		

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S 312D	Continued from page 18	S 312D		
S 552B	555.22 (b) Surgical Services - Preoperative Care 555.22 Pre-operative Care (b) A written statement indicating informed consent, obtained by the practitioner, and signed by the patient, or responsible person, for the performance of the specific procedures shall be procured and made part of patient's clinical record. It shall contain a statement which evidences the appropriateness of the proposed surgery, as well as any alternative treatments discussed with the patient. It shall also identify any practitioner who shall participate in the surgery. This REGULATION is not met as evidenced by:	S 552B	Plan of Correction: As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - The CIIC for in-clinic abortion has been changed by the RQM Coordinator to add documentation that the physician obtains informed consent. - Monthly audits of the charts by various staff will ensure compliance - Chart review findings are discussed at the RQM committee meetings and forwarded to the Governing Body by the VP Medical Services	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 552B	Continued from page 19 Based on review of facility documents and staff interview (EMP), it was determined the facility failed to ensure the informed consent for the performance of a specific procedure is obtained by the practitioner and signed by the patient or responsible party. Findings include: Interview with EMP2 on June 1, 2012, at approximately 9:20AM confirmed the informed consent for the performance of a specific procedure was not obtained by the practitioner and signed by the patient or responsible party. Further interview with EMP2 revealed the facility's non-medical assistants obtained the consent for the performance of the surgical procedure.	S 552B		

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S 552B	Continued from page 20	S 552B		
S 554A		S 554A		

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S 554A	Continued from page 21 555.24 (a) Surgical Services - Postoperative Care 555.24 Postoperative Care (a) The findings and techniques of an operation shall be accurately and completely written or dictated immediately after procedure by the practitioner medical staff member who performed the operation. If a physician assistant or certified registered nurse practitioner performed part of the operation, the findings and techniques of the procedure shall be accurately and completely recorded and the report shall be countersigned by the medical staff member. This description shall become a part of the patient's medical record. This REGULATION is not met as evidenced by:	S 554A	Plan of Correction: As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - The Surgical and Medication Abortion Operative Notes form has a several places to write post operative reports on various components of the procedure –e.g. # cc of lidocain, cervix dilated to #, # mm cannula used, post evacuation curettage done, estimated blood loss, other medications administered - Monthly audits of the charts by various staff will ensure compliance with this form - Chart review findings are discussed at the RQM committee meetings and forwarded to the Governing Body by the VP Medical	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 554A	Continued from page 22	S 554A	Services - Failure to follow this policy will result in re-training and/or disciplinary action by Medical Services Administration	

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S 554A	Continued from page 23 Based on review of facility documents and staff interview (EMP), it was determined the facility failed to ensure the post operative surgical reports were written or dictated immediately after the procedure by the operating practitioner. Findings include: Interview with EMP2 on June 1, 2012, at approximately 9:30AM confirmed the operating practitioner does not complete a written or dictated post operative immediately after completing the procedure.	S 554A		

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S 5559	555.33 (d)(1) Anesthesia Policies and Procedures 555.33 Anesthesia policies and procedures (d) Anesthesia procedures shall provide at least the following: (1) A patient requiring anesthesia shall have a pre-anesthesia evaluation by a practitioner, with appropriate documentation of pertinent information regarding the choice of anesthesia. This REGULATION is not met as evidenced by:	S 5559	Plan of Correction: As per our letter to the Department of Health dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - PPNMP – Allentown provides only local anesthesia no sedation. - VP of Medical Services will request an exception to this regulation.	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/29/2012**

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S 5559	Continued from page 25 Based on review of facility documents and staff interview (EMP), it was determined the facility failed to develop a policy to ensure a pre-anesthesia evaluation was completed by a practitioner prior to the administration of anesthesia. Findings include: Review on June 1, 2012, of the facility's policy and procedure manual revealed no documentation the facility developed a policy to ensure a pre-anesthesia evaluation was completed by a practitioner prior to the administration of anesthesia. Interview with EMP2 on June 1, 2012, at approximately 9:00AM confirmed the facility does not have a policy to ensure the completion of a pre-anesthesia evaluation by a practitioner prior to the administration of anesthesia. Further interview with EMP2 confirmed the facility's practitioners do not complete a pre-anesthesia evaluation on any patient prior to the administration of anesthesia.	S 5559		

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S 5559	Continued from page 26	S 5559		
S 5910	559.1 Nursing Department 559.1 Nursing Department The ASF shall have an organized nursing department under the supervision of a registered nurse who has responsibility and accountability for the Nursing Service. This REGULATION is not met as evidenced by:	S 5910	As per our letter to the Department of Health dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - PPNMP-Allentown requested an exception from this requirement -559.1 -to permit the organized nursing department to be under the supervision of the Medical Director - By letter from Department of Health dated April 19, 2012, the Department granted this exception - The Human Resource department will ensure that the facilities organizational chart will be updated to indicate that the Medical Director is the Director of Nursing by 07/01/12	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/29/2012**

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S 5910	Continued from page 27 Based on review of facility documents and staff interview (EMP), it was determined the facility failed to have a Director of Nursing who was responsible and accountable to the person in charge of the facility. Findings include: Review on May 31, 2012, of the facility's organizational chart revealed no position for a Director of Nursing (DON). Interview with EMP2 on June 1, 2012, confirmed the facility does not have a position for a DON, and there was no registered nurse responsible and accountable for the Nursing Service.	S 5910		
S 6124		S 6124		

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S 6124	Continued from page 28 561.11 Pharmaceutical Facilities - Principle 561.11 Principle The ASF shall provide equipment and supplies for the pharmaceutical service to implement its professional and administrative functions and to ensure patient safety through the proper storage and dispensing of drugs. Facilities shall be provided for the storage, safeguarding, preparation, and dispensing of drugs. This REGULATION is not met as evidenced by:	S 6124	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - The RQM coordinator has written a policy (including a log)for medication storage which includes the storing of refrigerated medication and biological and monitoring and what to do if the refrigerator goes out of range - This will be reviewed with facility Center Managers on 07/06/12 - Center Mangers will discuss with their staff and all staff will have reviewed and signed off by 07/21/12 - Refrigerator thermostats have been purchased by our facilities manager which alert staff if the refrigerator went "out of range" during the	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 6124	Continued from page 29	S 6124	weekend. - Non-compliance will result in re-training and/or disciplinary actions by Medical Service Administration Note: All medications have been moved to a separate location and refrigerators properly labeled.	

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S 6124	Continued from page 30 Based on review of facility documents, observation and staff interview (EMP), it was determined the facility failed to ensure medications were stored according to acceptable standards of practice and failed to ensure the temperature was maintained for refrigerated medications and biologicals. Findings include: 1) On May 31, 2012, the survey team requested the facility's policy and procedures for medication storage for review. No policies or procedures for medication storage were provided during the two day survey. Observation on May 31, 2012, of the facility's laboratory work room located in the hallway adjacent to the reception area revealed a countertop refrigerator labeled "Biohazard." Further observation revealed the contents in the refrigerator included one bottle of flu vaccine and one box of test controls (used to perform tests to ensure an instrument is functioning properly) for the testing of antibodies.	S 6124		

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S 6124	Continued from page 31 Interview with EMP1 on May 31, 2012, confirmed medications and test controls were stored in the same refrigerator in the laboratory work room. 2) On May 31, 2012, the survey team requested the facility's policy and procedures for storing refrigerated medications and biologicals. No policy or procedures for storing refrigerated medications and biologicals was provided during the two day survey. Observation on May 31, 2012, of the facility's laboratory work room in the hallway adjacent to the reception area revealed a countertop refrigerator labeled "Biohazard". Further observation revealed biologicals and medication stored in the refrigerator. There was a log sheet recording the temperature of the refrigerator Monday thru Saturday. The facility was unable to provide documentation the refrigerator temperature was adequately maintained on Sunday. Interview on May 31, 2012, with EMP1 confirmed	S 6124		

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S 6124	Continued from page 32 the refrigerator temperature was not monitored everyday of the week and the facility was not able to ensure the proper storage temperatures for refrigerated medication and biologicals.	S 6124		
S 6126		S 6126		

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S 6126	Continued from page 33 561.13 Storage 561.13 Storage The area in the ASF where drugs are stored shall be periodically checked by a responsible pharmacist or practitioner and proper logs maintained. This REGULATION is not met as evidenced by:	S 6126	As per our letter to the Department of Health ated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - A revised policy and log will be developed by our Associate Medical Director. It will be presented and reviewed with the Center Managers on 6/28/12. The facility staff will review and sign off with completion by 07/21/12 - The checking of medication storage will be added to the CRNPs weekly checklist and will take effect on 07/14/12 after all staff have been trained on the new policy - PPNMP Governing Body will be informed of this deficiency and any corrective action at its meeting on	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/29/2012**

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S 6126	Continued from page 34	S 6126	07/21/12 - Failure to comply with this policy will result in re-training and/or disciplinary action by Medical Services Administration	

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S 6126	Continued from page 35 Based on observation and staff interview (EMP), it was determined the facility failed to ensure medication storage areas were periodically checked by a pharmacist or responsible practitioner and proper logs maintained. Findings include: On May 31, 2012, the survey team requested the facility's policy and procedures for checking medication storage by a pharmacist or responsible practitioner. No policy and procedures were provided for checking medication storage by a pharmacist or responsible practitioner during the two day survey. Interview with EMP1 on May 31, 2012, at approximately 3:00 PM confirmed a pharmacist or responsible practitioner did not periodically check the areas where medications were stored. Further interview with EMP1 confirmed the facility did not have a policy or procedure for checking medication storage by a pharmacist or responsible practitioner	S 6126		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
		A. BLDG: __00_____ B. WING: _____	**06/08/2012**

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S 6126	Continued from page 36 or maintaining documentation that the pharmacist or responsible practitioner checked stored medications.	S 6126		
S 6142		S 6142		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 6142	Continued from page 37 561.25 Distressed drugs, devices and cosmetics 561.25 Distressed drugs, devices and cosmetics Drugs, devices and cosmetics which are outdated, visibly deteriorated, unlabeled or inadequately labeled, recalled, discontinued or obsolete shall be identified by the licensed pharmacist or responsible practitioner and shall be disposed of in compliance with applicable Commonwealth and Federal regulations. This REGULATION is not met as evidenced by:	S 6142	As per our letter to the Department of Health dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - All opened medications and chemicals have been labeled with an "opened" date - A pharmacy policy including procedures for opening, labeling, discarding and shelf life of medications and biologicals will be developed by Medical Services Administration. - This will be reviewed with facility Center Managers on 07/06/12 - Center Mangers will discuss with their staff and all staff will have reviewed and signed off by 07/14/12 * A monthly audit will be done by the recovery room CRNP * Non-compliance will be addressed at the quarterly RQM meetings	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/29/2012**

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S 6142	Continued from page 38	S 6142	* Failire to comply with this policy will result in re-traning and/or diciplinary action	

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S 6142	Continued from page 39 Based on observation and staff interview (EMP), it was determined the facility failed to ensure medications and biologicals were labeled when opened and discarded when expired. Findings include: On May 31, 2012, the survey team requested the facility's pharmacy policy and procedures for labeling opened medications and biologicals. No policy or procedure for labeling opened medications and biologicals was provided during the two day survey. Tour of the facility on May 31, 2012, between 10:00 AM and 12:00 PM revealed the following opened medication vials and biologicals: "Exam Room 1" contained one opened, dark brown vial with a dropper dispenser labeled "saline" (salt water used for preparing microscope slides). There was no further information on the bottle, indicating the day it was opened or the discard date. Further	S 6142		

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S 6142	Continued from page 40 observation revealed a tall red waste can measuring approximately 12" long by 10" wide by 32" tall. The can was labeled biohazard and was filled with approximately six inches of a clear fluid. There was no identification of the contents in the red biohazard waste can and no date of expiration. "Exam Room 2" contained one opened, dark brown vial with a dropper dispenser labeled "saline." There was no further information on the bottle indicating the day it was opened or the discard date. Further observation revealed white and black debris floating in the vial. The "Lab" contained one 250 ml (milliliters) clear plastic bottle of saline that was opened and not dated. There were two brown dropper bottles labeled saline that were opened and not dated, and one bottle of trichloracetic acid cauterant (used to treat genital warts) opened, partially used, and not dated. The "Storage Room" located adjacent to the nurses'	S 6142		

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S 6142	Continued from page 41 station contained one bottle of surgical instrument enzymatic pre-soak that was opened, partially used, and not dated. "Exam Room 3" contained three canisters of swabs labeled "75% silver nitrate and 25% potassium nitrate, expiration date December 2014, opened, partially used, and not dated. Interview with EMP3 on May 31, 2012, confirmed the brown bottles of saline, used to prepare microscope slides, were not labeled with the date the solution should be discarded. EMP3 confirmed there was no way to determine how long the saline had been in the dropper vial. Further interview revealed the brown dropper vials were filled from a larger bottle of saline stored in the "Lab." EMP3 also confirmed the saline dropper bottles were not disinfected between patients. EMP3 confirmed the trichloracetic acid cauterant bottle was used for multiple patients by dipping an unsterile cotton tip applicator into the vial to absorb the medication and then removing the cotton tip applicator. EMP3	S 6142		

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S 6142	Continued from page 42 stated "It is nowhere near the patient." Interview with EMP1 on May 31, 2012, confirmed the facility did not have a policy and procedure for the expiration of medication and biologicals after opened. EMP1 also confirmed the facility was not aware there was a "time limit" on the bottle of enzymatic cleaner after it was opened. Further interview confirmed the red biohazard waste can was filled with an enzymatic cleaner. Speculums used for vaginal exams were placed in the fluid after use, for cleaning at the end of the day. EMP1 stated "I did not know there was expiration for the enzyme cleaner."	S 6142		
S 6350		S 6350		

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S 6350	Continued from page 43 563.5 Storage of Medical Records 563.5 Storage of Medical Records Medical records shall be stored to provide protection from loss, damage or unauthorized access. This REGULATION is not met as evidenced by:	S 6350	As per our letter to the Department of Health dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. We are optimistic that we will be able to obtain accreditation, but in the event that we are not successful, we will pursue licensure as a Class B ASF. To that end, if the Class A accreditation process concludes unsuccessfully, we will pursue the alternate plan of compliance submitted by the Planned Parenthood health centers seeking licensure as Class B ASF, adjusting the dates as appropriate. Accordingly, at that time and if necessary, PPNMP- Allentown – will confer with its architect and Division of Safety and Inspection to identify feasible alterations to its health center and seek necessary exceptions. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012.	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/29/2012**

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S 6350	Continued from page 44	S 6350	PPNMP-Allentown has taken the following steps to ensure compliance. - A roofing contractor has been hired to determine leaks - Any purged charts will be sent for storage (at appropriate time) to reduce amount of stored charts	

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S 6350	Continued from page 45 Based on review of facility documents, observation and staff interview (EMP), it was determined the facility failed to ensure medical records were stored in a manner to provide protection from water and fire damage. Findings include: Review on May 1, 2012, of the facility's "Record Retention" policy, last revised February 2012, revealed "Policy: To ensure medical services documents are retained according to applicable laws ... " Observation on May 31, 2012, of the facility's medical record room revealed eight wooden shelving racks containing 20 cardboard boxes of patient medical records. Observation on May 31, 2012, of the facility's storage room revealed three shelving racks containing 34 cardboard boxes of patient medical records.	S 6350		

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S 6350	Continued from page 46 Observation on May 31, 2012, of the facility's storage room revealed several ceiling tiles with brown areas of discoloration. These ceiling tiles were located over the area were medical records were stored in cardboard boxes. Interview with EMP1 on May 31, 2012, at approximately 12:00 PM confirmed the facility stored patient medical records in cardboard boxes on wood racks and these medical records were not protected from possible fire damage. Further interview confirmed the ceiling tiles were stained from water damage.	S 6350		
S 6390		S 6390		

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S 6390	Continued from page 47 563.9 Confidentiality of Medical Record 563.9 Confidentiality of medical records Records shall be treated as confidential. Only authorized personnel shall have access to the records. The written authorization of the patient shall be presented and then maintained in the original record as authority for release of medical information outside the ASF. This REGULATION is not met as evidenced by:	S 6390	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - Patient Confidentially policy has been edited to include the following situations: Charts left unattended Visible computers/computer screens Logging out of computer when leaving station Contents of bulletin boards - This policy will be presented by Medical Services Administration to the Center Managers on 07/12/12 - Center Managers will inform their staff by 07/19/12 - Medical Services Administration	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 6390	Continued from page 48	S 6390	will do unannounced "walk-bys" to ensure confidentiality of patients. - Failure to comply with this policy will result in re-training and/or disciplinary action by Medical Services Administration	

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S 6390	Continued from page 49 Based on review of facility documents, observation and staff interview (EMP), it was determined the facility failed to ensure the security of confidential patient information on a computer and failed to ensure the security of confidential patient medical files for 17 of 17 patient medical files. Findings include: Review on May 31, 2012, of the facility's "Planned Parenthood of Northeast and Mid-Penn confidentially Policy," no review date, revealed "Planned Parenthood of Northeast and Mid-Penn (PPNMP) services are strictly confidential. ..." 1) Observation on May 31, 2012, of the facility's nurses' station revealed the nurses' station was unattended by facility staff. There were 17 patient medical records on the desk in full view. There was an open computer screen with a blank medical record. Further observation revealed OTH1 sitting near the nurses' station.	S 6390		

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S 6390	Continued from page 50 Interview with EMP1 on May 31, 2012, at approximately 11:00 AM confirmed the nurses' station was unattended by facility staff; there were 17 patient medical records on the desk in full view; and the computer screen was open. Further interview with EMP1 revealed confidential patient information could be accessed by moving the mouse; clicking on an icon and opening up a patient medical record. EMP1 confirmed OTH1 was a patient; OTH1 was left unattended for approximately 45 minutes; and OTH1 had the potential to access the facility's computer and view confidential patient information. 2) Observation on May 31, 2012, of the facility's nurses' station revealed a bulletin board alongside the computer with a 4 x 4 piece of paper with a password clearly written on it. Interview with EMP1 on May 31, 2012, at approximately 11:05 AM confirmed the password written on the 4 x 4 piece of paper pinned to the bulletin board next to the computer was the	S 6390		

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S 6390	Continued from page 51 password to enter the computer at the nurses' station which contained confidential patient information.	S 6390		
S 6710	567.3 (a) Policies and Procedures 567.3 Policies and procedures (a) Only authorized persons, who are properly attired, shall be allowed int he surgical area. This REGULATION is not met as evidenced by:	S 6710	As per our letter to the Department of Health dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - The Infection Control policy will be updated to ensure that only authorized persons with the proper attire are in the procedure rooms * The Center Manager of the facility will be responsible for enforcing the policy * Staff who do not comply with the policy will face disciplinary actions by Medical Services Administration	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/29/2012**

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S 6710	Continued from page 52 Based on review of facility policy and procedures and interview with staff (EMP), it was determined the facility failed to ensure Infection Control policies were established for authorized persons and the proper attire in the surgical area. Findings include: Review on May 31, 2012, of the facility policy "Infection Control," undated, revealed no provision for authorized persons with the proper attire in the surgical area. Interview on May 31, 2012, with EMP1 confirmed the facility's "Infection Control" policies and procedures were not established for authorized persons and the proper attire in the surgical area.	S 6710		

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S 6715	567.3 (b) (5) Policies and Procedures 567.3 Policies and procedures (b) Current written policies and procedures to assure definite and valid infection control shall include,but not be limited to, the following: (5) Housekeeping This REGULATION is not met as evidenced by:	S 6715	As per our letter to the Department of Health dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - The Risk & Quality Management Coordinator will revise the infection control manual to include terminal cleaning procedure rooms between patients. - This policy will be presented by Medical Services Administration to the Center Managers on 07/12/12 - Center Managers will inform their staff and staff will sign off on the policy by 07/21/12 * Unannounced spot checks will be performed by Medical Services Adminstration to ensure staff are following policy * Failure to comply with this policy will result in re-training and/or disciplinary action by Medical Services Management	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/29/2012**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 6715	Continued from page 54 Based on review of facility policy and procedures and interview with staff (EMP), it was determined the facility failed to ensure Infection Control policies were established for terminally cleaning the procedure room between patients Findings include: Review on May 31, 2012, of the facility policy "Infection Control," undated, revealed no provision for terminal cleaning procedure rooms between patients. Observation on May 31, 2012, of examination room 4 (facility references as procedure room 4) revealed a clear glass storage cylinder that contained large-tipped cotton swabs sitting on the countertop. Further observation revealed a white dusty film on the bottom of this container and a spot of a red substance on the bottom inside of the glass container. Interview on May 31, 2012, with EMP1 confirmed	S 6715		

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S 6715	Continued from page 55 the white dusty film. EMP1 confirmed there was a spot of a red substance on the bottom inside of the glass container and identified it as dried blood. Further interview with EMP1 confirmed the facility did not have a terminal cleaning policy and procedure. EMP1 confirmed the procedures performed in the room created the potential for the splatter of blood and body fluids. EMP1 also confirmed only horizontal surfaces were "wiped down".	S 6715		
S 6721		S 6721		

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S 6721	Continued from page 56 567.3 (b) (11) Policies and Procedures 567.3 Polcies and procedures (b) Current written policies and procedures to assure definite and valid infection control shall include,but not be limited to, the following: (11) Staff health status requirements This REGULATION is not met as evidenced by:	S 6721	As per our letter to the Department of Health dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - The Human Resource Manager will perform an audit of facility staff by 07/13/12 - All deficiencies will be corrected by 07/21/12 * The Human Resource department will perform quarterly audits on personel records * Any discrepancies will be presented at the RQM committee and corrective actions will be determined by the committee	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/29/2012**

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S 6721	Continued from page 57 Based on review of personnel files (PF), facility policies and interview with staff (EMP), it was determined the facility failed to follow established policy and maintain health status files on 6 of 6 personnel files reviewed (PF1, PF2, PF3, PF4, PF5, and PF6). Findings include: A review on June 1, 2012, of the facility policy "Section 3 Employment and Staffing, 3.13, Personnel Records, Board approved revisions-June 2009" revealed "The HR (Human Resources) Department maintains a personnel file of employment records for each employee ... Documents containing an employee's medical information are kept in a separate file in the HR Department and are released only with an employee's authorization, unless otherwise allowed by law. [They] cooperates with federal, state, and local governmental requests to investigate an employee, if the investigation does not violate an employee's legal rights, and if the investigator	S 6721		

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S 6721	Continued from page 58 furnishes proper identification and proof of legal authority to investigate." A request was made for employee health files on June 1, 2012, at approximately 9:30 AM. The files requested were for current staff working in the facility (PF1, PF2, PF3, PF4, PF5, and PF6). Interview on June 1, 2012, with EMP4 at approximately 09:30 AM confirmed the facility policy was not followed and health status files were not maintained for PF1, PF2, PF3, PF4, PF5, and PF6.	S 6721		
S 6737		S 6737		

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S 6737	Continued from page 59 567.23 Clean Linen 567.23 Clean Linen Clean linen shall be available to meet the daily and emergency needs of the ASF. Clean linen shall be handled and stored to minimize contamination from surface contact or airborne deposits. This REGULATION is not met as evidenced by:	S 6737	Plan of Correction: As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - Medical Services Administration is in the process of asking for bids for a company to provide us with professionally laundered scrubs and blankets thus eliminating the need for using the washer & dryer - Company informs us that there is 6 week "turn on" date from date of contract - All drape sheets and chuck pads have been placed in cabinets away from any chance of " fluid splatter"	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 6737	Continued from page 60 Based on observation and staff interview (EMP), it was determined the facility failed to store clean scrubs in a manner to minimize contamination from surface contact and failed to store clean disposable linen in a manner to minimize contamination during procedures in the facility's procedure rooms. Findings include: 1) Observation on May 31, 2012, of the facility's staff bathroom revealed a stackable washer and dryer. Further observation revealed approximately four sets of staff scrubs on top of the washer. Interview with EMP1 revealed these scrubs were considered clean. Interview with EMP1 on May 31, 2012, at approximately 11:05 AM revealed facility staff bring the soiled linens and scrubs from the procedure rooms to the staff bathroom, separate the soiled linens and scrubs, and place the soiled linens and scrubs in the washer.	S 6737		

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S 6737	Continued from page 61 The facility was not able to provide documentation the washer lid was cleaned and sanitized in a manner to minimize contamination from surface contact to the clean scrubs following the laundering of the soiled linens and scrubs. 2) Observation on May 3, 2012, of Exam Rooms three and four revealed each room contained an open metal cart with three shelves. Located on the middle shelf and the bottom shelf were white disposable drapes and blue disposable drapes. The drapes were used to cover the procedure table and pillow for patient use. Interview with EMP1 on May 31, 2012, at approximately 1:45 PM confirmed the metal carts remained in the rooms during the surgical procedures and had the potential to be exposed to blood and body fluid splatters.	S 6737		
S 6738		S 6738		

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S 6738	Continued from page 62 567.24 Soiled Linen 567.24 Soiled Linen Soiled linen shall be collected and stored to avoid microbial dissemination into the environment. Soiled linen shall be kept segregated from clean linen. Soiled linen from isolation areas shall be identified and separately bagged. Precautions shall be taken in the subsequent processing of soiled linen from isolation areas to prevent microbial dissemination and infection. This REGULATION is not met as evidenced by:	S 6738	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - Medical Services Administration is in the process of asking for bids for a company to provide us with professionally laundered scrubs and blankets thus eliminating the need for using the washer & dryer - Company informs us that there is 6 week "turn on" date from date of contract - Until the company is on board all soiled linens are placed in the "dirty" container. After laundered they are placed in the "clean" container	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 6738	Continued from page 63 Based on observation and staff interview (EMP), it was determined the facility failed to store soiled linen separate from the clean linen storage and failed to ensure soiled linen was washed at a temperature to prevent microbial dissemination. Findings include: 1) Observation on May 31, 2012, of the facility's staff bathroom revealed a stackable washer and dryer. Further observation revealed scrubs on top of the washer and a storage closet containing linens. Interview with EMP1 revealed that scrubs on top of the washer and the linens in the storage closet were considered clean. Interview with EMP1 on May 31, 2012, at approximately 11:00 AM revealed facility staff bring the soiled linens from the procedure rooms to the staff bathroom, separate the soiled linens and scrubs, and place the soiled linens and scrubs in the washer. Further interview confirmed the clean linen and scrubs were stored in the staff bathroom with	S 6738		

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S 6738	Continued from page 64 the soiled linen and scrubs. 2) Observation on May 31, 2012, revealed a sign posted on the front of the facility dryer instructing staff that soiled clothing and soiled items were to be washed in hot water. Further observation revealed the water temperature setting of the washer was set at warm. Interview with EMP1 on May 31, 2012, at approximately 11:00 AM confirmed the sign posted on the front of the facility dryer instructed staff to wash soiled clothing and soiled items in hot water and the water temperature setting of the washer was set at warm. Further interview with EMP1 confirmed the facility did not measure the temperature of the water in the washer to determine if the temperature was adequate to prevent microbial dissemination.	S 6738		

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S 6743	567.33 (c) Waste Disposal 567.33 Waste disposal (c) Pathological, bacteriological, surgical, gynecological and contaminated waste and similar materials shall be disposed of by a method approved by the Department of Environmental Resources under 25 Pa. Code Chapter 75 (relating to solid waste management) and in compliance with local ordinance. This REGULATION is not met as evidenced by:	S 6743	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - Center Manager now checks the sharps containers daily - All biohazard trash containers will be lined with red biohazard bags –(ordered 06/21/12) - Medical Services Administration will re-train staff on the infection control policy by 07/06/12 - Included in this training will be: - sharps containers -use of red-biohazard bags & contents -disposing of contents of POC jars	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 6743	Continued from page 66 Based on observation, review of facility documents, and staff interview (EMP), it was determined the facility failed to follow established guidelines for containing, storing and disposing of medical waste and body fluids. Findings include: A review on June 1, 2012, of the facility policy "Chapter 4 Medical Waste Disposal," revised June 2012, revealed "Sharps are discarded in containers that are: puncture resistant, Sealable, Leak-proof if potential for fluid spill or leakage exists, Labeled with the appropriate biohazard warning label, Sealed and discarded when they become 3/4 full. The following procedures are used with all of this waste: Red bags are used for non-sharps and regulated medical waste, which includes discarded blood, products of blood and anything caked, soaked or dripping with blood ... Saturated material containing free-flowing blood, blood products or bloody body fluids ... wastes, tissue including POC (products of conception) ... Containers for	S 6743		

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S 6743	Continued from page 67 Regulated Medical Waste (red bag waste) are located throughout the facility within access of employees and as close as possible to the source. Waste containers are maintained upright, covered, routinely replaced and not allowed to overfill ... Waste Disposal Method; Biological: Category/location; Patient Care Areas ... Body Fluids/Patient Care Areas; Substance; Solids and disposable medical supplies in contact with patient, e.g. empty I.V. (intravenous) bags and tubing, disposable towels, gowns, aprons, chux, gloves, masks, non-bloody dressing material, Pap spatulas, cotton tipped applicators, Bag/Container; clear bags, Disposal Method; Private Hauler. Substance; Body fluids (blood, vaginal secretions) in tightly covered, stoppered, break-resistant containers, Bag/Container; Red bags, Disposal Method; off-site treatment ... Substance; Items dripping or saturated with human blood or caked with dried human blood. Bag/Container; red bags, Disposal Method; Off-site treatment. Category/Location; Pathological: Surgical sites; Substance; all tissue POC (products of conception), body fluids, blood, Bag/Container;	S 6743		

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S 6743	Continued from page 68 Red bags. Special arrangements are made with the Pathology departments and the waste is transported in impervious bags or leak proof biohazard drums, Disposal Method; Off-site incineration ... " 1) Observation on May 31, 2012, of the facility's laboratory work room, laboratory, examination rooms one and two and procedure rooms three and four, and recovery room revealed sharps containers more than three quarters full with used needles and syringes. Interview with EMP1 on May 31, 2012, at the time of the observation confirmed the sharps containers in these rooms were filled more than three quarters full with used needles and syringes. Further interview with EMP1 confirmed these sharps containers were to be emptied before reaching the three quarter full mark. 2) Observation on May 31, 2012, of examination room 1, 2, and 3 revealed red waste receptacles labeled biohazard. Further observation revealed	S 6743		

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S 6743	Continued from page 69 these waste receptacles were lined with a black plastic trash bag. Interview with EMP1 on May 31, 2012, at approximately 10:30 AM confirmed the red waste receptacles in examination room 1, 2, and 3 were labeled biohazard and these waste receptacles were lined with a black plastic trash bag. Further interview with EMP1 revealed contaminated items were placed in these trash receptacles and these trash receptacles were to be lined with red biohazard trash liners. Further observation revealed a tall red waste receptacle measuring approximately 12" long by 10" wide, labeled biohazard. This receptacle was filled with approximately six inches of clear fluid. There was no identification of the contents in the red biohazard waste receptacle. 3) Observation of examination room three revealed a red waste receptacle marked "Do Not Use Staff Only".	S 6743		

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S 6743	Continued from page 70 Interview with EMP1 on May 31, 2012, at approximately 3:30 PM revealed the red waste receptacle in examination room three marked "Do Not Use Staff Only" was for biohazard material. Further interview revealed this container should be labeled with a biohazard sticker. 4) Observation on May 31, 2012, of the facility's laboratory revealed one white waste receptacle labeled biohazard. The receptacle was lined with a black plastic bag. Interview with EMP1 on May 31, 2012, at approximately 11:15 AM confirmed the white waste receptacle was labeled biohazard and was lined with a black plastic bag. Further interview with EMP1 confirmed the waste receptacle was to be lined with a red biohazard trash liner. 5) Observation on May 31, 2012, of the facility's vestibule revealed two cardboard medical waste containers. The approximate dimensions were 24"	S 6743		

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S 6743	Continued from page 71 long by 24" wide and approximately 48" high. These were lined with red plastic medical waste bags. There were no tightly fitting lids on the waste containers. Interview with EMP1 on May 31, 2012, at approximately 12:00 PM confirmed the two cardboard medical waste containers, with approximate dimensions of 24" long by 24" wide and approximately 48" high, lined with red plastic medical waste bags. EMP1 confirmed there were no tightly fitting lids on the waste containers. Further interview with EMP1 confirmed the vestibule was a carpeted area, was used as a fire exit and for deliveries. 6) Observation on May 31, 2012, of the facility's soiled area revealed a two basin sink. Interview with EMP1 on May 31, 2012, revealed the facility had no provision for the disposal of bloody body fluid waste. EMP1 was uncertain if the facility had approval from the Department of	S 6743		

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S 6743	Continued from page 72 Environmental Resources for disposal of bloody body fluid waste down the sink in the soiled area. Further interview with EMP1 confirmed "we pour the bloody liquid from the procedure down the sink"	S 6743		
S 6747		S 6747		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 6747	Continued from page 73 567.43 Ventilation System The ventilation system shall be inspected and maintained in accordance with the written maintenance schedule to ensure that a properly conditioned air supply meeting minimum filtration, humidity and temperature requirements is provided in critical areas such as the surgical and recovery suites under Chapter 571 (relating to construction standards). This REGULATION is not met as evidenced by:	S 6747	Plan of Correction: As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - Temperature & humidity monitors for procedure rooms and recovery room will be purchased by our purchasing department by 06/29/12 - A policy will be developed by Medical Services Administration/RQM regarding the monitoring of temperature and humidity levels in the procedures rooms and recovery room. - Center Managers and staff will be trained by Training Manager/Medical Services administration on how to use this monitor by 07/13/12 - A log will be developed by the	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 6747	Continued from page 74	S 6747	RQM coordinator to document temperature and humidity levels - The use of the log will be part of the training - Regular audits will be done by Medical Service administration to ensure policy is being followed and temperature and humidity are noted	

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S 6747	Continued from page 75 Based on observation and staff interviews (EMP), it was determined the facility failed to monitor temperature and humidity in two of two rooms used by the facility to perform procedures and the recovery area. Findings include: The survey team requested the temperature and humidity documentation for rooms three and four where the facility to performed procedures and the recovery area. Interview with EMP1 on May 31. 2012, at approximately 3:40 PM confirmed the facility did not monitor or maintain a record of the temperature and humidity levels in rooms three and four or the recovery room in order to ensure these areas were meeting proper temperature and humidity levels.	S 6747		

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S 6900	569.1 CHAPTER 569 - FIRE & SAFETY - Principle 569.1 Principle The ASF shall have an organized fire, safety and disaster program under the direction and supervision of 1 or more persons qualified to implement the program. This REGULATION is not met as evidenced by:	S 6900	Plan of Correction: As per our letter to the Department of Health dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - 569.1 requires an ASF to have an "organized fire, safety, and disaster program under the direction and supervision of 1 or more persons qualified to implement the program" - We have such a policy - Everything in the mechanical room was moved into a large storage room	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/29/2012**

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S 6900	Continued from page 77 Based on observation and staff interview (EMP), it was determined that the facility failed to ensure the building was protected from fire with a water sprinkler system and failed to store paper products and flammable liquids in a manner to prevent potential fire. Findings include: 1) Observation on May 31, 2012, of the facility's hallways, examination rooms, storage rooms, mechanical room, nurse station and waiting area revealed no evidence of a water sprinkler system. Interview with EMP1 and EMP2 on June 1, 2012, at approximately 1:30 PM confirmed the facility does not have a water sprinkler system to protect the facility from the spread of fire. 2) Observation on May 31, 2012, of the facility's mechanical room revealed electrical power panels, a water heater, boxes of toilet paper and tissues, open and partially used cans of paint and cleaning	S 6900		

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S 6900	Continued from page 78 supplies. Interview with EMP1 on May 31, 2012, confirmed the mechanical room contained the electrical power panels, water heater, boxes of toilet paper and tissues, open and partially used cans of paint and cleaning supplies.	S 6900		
S 6905		S 6905		

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S 6905	Continued from page 79 569.12 Fire Warning and Safety Systems 569.12 Fire Warning and Safety Systems An ASF shall have an automatic and manually activated fire alarm system installed to transmit an alarm automatically to the fire department by the most direct and reliable method approved by local ordinances. This REGULATION is not met as evidenced by:	S 6905	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - A fire and safety training is scheduled for July 2 & 3 with an outside consultant - Staff will sign off on the training and it will be kept in their personnel file - Ongoing, this training will be added to the RQM work plan and provided on an annual basis	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 6905	Continued from page 80 Based on observation and staff interview (EMP), it was determined the facility failed to ensure staff were adequately trained regarding the manual fire alarm. Findings include: Observation on June 1, 2012, of the facility revealed no manual fire alarm systems [pull stations] in the facility to transmit an alarm automatically to the fire department. Interview with EMP1 and EMP2 on June 1, 2012, at approximately 2:00 PM confirmed the facility did not have manual fire alarm systems [pull stations] in the facility to transmit an alarm automatically to the fire department. An additional interview with EMP2 on June 8, 2012, at approximately 2:15 PM revealed the facility has two manual fire alarm systems. EMP2 confirmed the facility staff did not know the location of the manual fire alarm stations which automatically	S 6905		

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S 6905	Continued from page 81 transmitted the alarm to the fire department.	S 6905		
S 6907	569.14 Internal Disaster and Fire Plans 569.14 Internal Disaster and Fire Plans The ASF shall have an internal disaster and fire plan incorporating evacuation procedures and the safety of both closed records and the records of those patients being evacuated. These plans shall be made available to personnel and evacuation diagrams shall be posted throughout the ASF. This REGULATION is not met as evidenced by:	S 6907	Plan of Correction: As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - The evacuation plan for charts will be added to the fire and safety plan by 07/21/12 - PPNMP-Allentown will be switching to an electronic health records system in January 2013	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 6907	Continued from page 82 Based on review of facility documents and staff interview (EMP), it was determined the facility failed to ensure facility internal disaster and fire plan incorporated evacuation procedures and the safety of both closed medical records and the records of those patients being evacuated. Findings include: Review on June 1, 2012, of the facility's internal disaster and fire safety plan revealed no documentation the facility incorporated evacuation procedures for the safety of both closed medical records and the records of those patients being evacuated. Interview with EMP1 and EMP2 on June 1, 2012, at approximately 2:15 PM confirmed the facility's internal disaster and fire safety plan did not contain documentation the facility incorporated evacuation procedures for the safety of both closed medical records and the records of those patients being evacuated.	S 6907		

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S 6907	Continued from page 83	S 6907		
S 6915		S 6915		

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S 6915	Continued from page 84 569.31 SAFETY PRECAUTIONS - Emergency Power 569.31 Emergency Power The emergency electric power source and associated equipment shall be regularly inspected, tested and maintained in accordance with current NFPA Standards. A written record shall be maintained of inspection, performance, exercising period and repairs of emergency power equipment. This REGULATION is not met as evidenced by:	S 6915	Plan of Correction: As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - Section 569.31 does not require an emergency electric power source; rather only that any power source if the ASF have one, be regularly inspected, tested and maintained. - An emergency plan for lack of power has been written by Medical Services Administration - In the event of a power loss, we have manual suction to complete procedures in process - We have adequate battery lighting to complete any procedure in process and to safely evacuate all patients - This will be shared with Center	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 6915	Continued from page 85 Based on observation and staff interview (EMP), it was determined that the facility failed to have an emergency electric power source should the facility loose power during a procedure. Findings include: Observation on June 1, 2012, revealed the facility did not have an emergency electric power source should the facility loose power during a procedure. Interview with EMP1 and EMP2 on June 1, 2012, at approximately 2:30 PM confirmed the facility did not have an emergency electric power source should the facility loose power during a procedure.	S 6915	Managers on 07/12/12 - All staff will be signed off on this policy by 07/21/12	

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S 6916	569.32 Fire Inspection 569.32 Fire Inspection The ASF shall request an annual inspection by its local fire department. This REGULATION is not met as evidenced by:	S 6916	Plan of Correction: As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on May 31 & June 1, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - The Center Manager requested (by phone) a visit by the fire department. - The Fire Department came to the health center and did an annual inspection on May 30, 2012 * Phone requests for the report were ignored - A request letter for an annual inspection and report was sent on 06/21/12 - The report of the inspection was received 06/22/12 - The RQM Coordinator will add this step to our fire and safety policy by 07/21	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 6916	Continued from page 87 Based on review of facility documents and staff interview (EMP), it was determined the facility failed to request an annual inspection by the local fire department. Finding include: Review on June 1, 2012, of the facility's internal disaster and fire plans revealed no documentation the facility requested an annual inspection by the local fire department. Interview with EMP1 and EMP2 on June 1, 2012, at approximately 2:00 PM confirmed the facility did not request an annual inspection by the local fire department. Further interview with EMP2 revealed the facility did not have a policy to address the request for an annual inspection by the local fire department.	S 6916		
S 6919		S 6919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
		A. BLDG: __00_____ B. WING: _____	**06/08/2012**

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: **00218701**	**29 NORTH 9TH STREET ALLENTOWN, PA 18101**

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S 6919	Continued from page 88 569.35 (1-7) General Safety Precautions 569.35 General Safety Precautions The following safety precautions shall be met: (1) Doorway, corridors and stairwells shall be properly lighted and free of obstructions. (2) Doors into patient rooms may not be locked. (3) Exit doors may not be locked from the inside while patients are in the ASF. (4) Doors opening to shafts shall be equipped with self-closing devices and positive latches. (5) Wastebaskets, cubicle curtains, window shades and drapes shall be rendered flame retardant. (6) Call bells in the shower, tub room or water closet shall be easily accessible to patients. (7) Only nonflammable agents may be present in a surgical suite. This REGULATION is not met as evidenced by:	S 6919	As per our letter to the Department of Health dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. PPNMP-Allentown has taken the following steps to ensure compliance. - Patients are not left alone after the procedure. - Patients are occasionally left alone before the procedure and they will be instructed to use the phone in case of emergency - A sticker will be put on the phone saying "emergency – dial ####" - Toilet rooms in the recovery room will have call bells	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/29/2012**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
		A. BLDG: 00 B. WING:	06/08/2012

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: **00218701**	**29 NORTH 9TH STREET ALLENTOWN, PA 18101**

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S 6919	Continued from page 89 Based on observation and staff interview (EMP), it was determined the facility failed to ensure call bells were installed in two of two examination rooms (used by the facility to perform procedures) and in toilet rooms utilized by patients. Findings include: Observation on May 31, 2012, of the facility's examination room three and four and in toilet rooms utilized by patients revealed no call bells for patients to utilize to summon facility staff if help is required. Interview with EMP1 on May 31, 2012, at approximately 2:30 PM confirmed the facility's examination room three and four and in toilet rooms utilized by patients did not have call bells for patients to utilize to summon facility staff if help is required.	S 6919		
S 7100		S 7100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: **00218701**	**29 NORTH 9TH STREET ALLENTOWN, PA 18101**

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S 7100	Continued from page 90 571.1 CHAPTER 571 - Construction Standards 571.1 Minimum Standards ASF construction shall be in accordance with the latest edition of the "Guidelines for Design and Construction of Hospital and Health Care Facilities," as published by the American Institute of Architects/Academy of Architecture for Health including those guidelines established for various outpatient facilities. In the alternative, a facility shall meet the construction guidelines for specified types of surgical procedures as listed in appendix A. Where renovation or replacement work is performed within an existing facility, all new work or additions shall comply with the requirements for new construction. This REGULATION is not met as evidenced by:	S 7100	As per our letter to the Department of Health dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. We are optimistic that we will be able to obtain accreditation, but in the event that we are not successful, we will pursue licensure as a Class B ASF. To that end, if the Class A accreditation process concludes unsuccessfully, we will pursue the alternate plan of compliance submitted by the Planned Parenthood health centers seeking licensure as Class B ASF, adjusting the dates as appropriate. Accordingly, at that time and if necessary, PPNMP- Allentown – will confer with its architect and Division of Safety and Inspection to identify feasible alterations to its health center and seek exceptions to the construction requirements of 28 PA. Code section 571.1 where necessary. PPNMP-Allentown has taken the	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/29/2012**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 7100	Continued from page 91	S 7100	following steps to ensure compliance. - Toilet rooms will have breakaway door jambs	

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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S 7100	Continued from page 92 Based on review of the current edition of the "Guidelines for Design and Construction of Hospital and Health Care Facilities," observation and staff interview (EMP), it was determined that the facility failed meet the construction standards for curtains or privacy curtains in the post-operative area, the provision for disposal of fluid waste, and patient toilet room doors that open out-ward. Findings include: 1) Review of the Guidelines for Design and Construction of Hospital and Health Care Facilities, Edition 2010," revealed "3.8-3.4.2.2 Cubicle curtains or other provisions for privacy during post-operative care shall be provided." Observation on May 31, 2012, of the facility's post-operative recovery area revealed six reclining chairs. Further observation revealed no cubicle curtains or privacy curtains between these six reclining chairs to provide patient privacy during the post-operative recovery and care.	S 7100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 7100	Continued from page 93 Interview with EMP1 on May 31, 2012, at approximately 3:15 PM confirmed there were no cubicle curtains or privacy curtains between these six reclining chairs to provide patient privacy during the post-operative recovery and care. 2. Review of the Guidelines for Design and Construction of Hospital and Health Care Facilities, Edition 2010," revealed "3.8-3.6.10 Soiled Storage/Workroom A soiled handling/storage area, including provisions for disposal of fluid waste, shall be provided." Interview with EMP1 and EMP2 on June 1, 2012, revealed the facility had no provision for the disposal of fluid waste. Further interview with EMP1 confirmed the facility disposes fluid waste down the sink drain. 3) Review of the Guidelines for Design and Construction of Hospital and Health Care Facilities, Edition 2010," revealed "3.8-7.2.2.2(2) Toilet room	S 7100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 7100	Continued from page 94 doors for patient use shall open outward or be equipped with hardware that permits access from the outside in emergencies." Observation on May 31, 2012, of the toilet rooms utilized by patients revealed the doors open into the toilet room. Interview with EMP1 on May 31, 2012, at approximately 1:00 PM confirmed the toilet room doors utilized by patients open into the toilet room and not out-ward as required. Cross reference 553.12(b)(3) Implementation. 567.33(c) Waste Disposal	S 7100		
S 7102		S 7102		

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S 7102	Continued from page 95 571.2 (b) Modifications 571.2 Modifications to HHS requirements The following provisions modify and supplement the HHS requirements cited in 572.2 (relating to minimum standards); (b) Adequate storage areas shall be provided to meet the needs of the facility. This REGULATION is not met as evidenced by:	S 7102	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. We are optimistic that we will be able to obtain accreditation, but in the event that we are not successful, we will pursue licensure as a Class B ASF. To that end, if the Class A accreditation process concludes unsuccessfully, we will pursue the alternate plan of compliance submitted by the Planned Parenthood health centers seeking licensure as Class B ASF, adjusting the dates as appropriate. Accordingly, at that time and if necessary, PPNMP- Allentown – will confer with its architect and Division of Safety and Inspection to identify feasible alterations to its health center and seek any necessary exceptions. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPNMP-Allentown has taken the	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 7102	Continued from page 96	S 7102	following steps to ensure compliance. - The colposcope has been moved to a storage area - The ultrasounds are kept in room 4 on non-abortion days - On abortion days, the ultra-sounds are distributed to room 1 for ultra-sound and room 3 and 4 if needed during procedures	

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S 7102	Continued from page 97 Based on review of the current edition of the "Guidelines for Design and Construction of Health Care Facilities," observation and staff interview (EMP), it was determined the facility failed to ensure there was adequate storage space for equipment used to perform surgery and diagnostic imaging. Findings include: Review on May 31, 2012, of the "Guidelines for Design and Construction of Health Care Facilities, 2010 edition" revealed "...3.8-3.6.9 Clean storage - a clean storage area, including space for preparing instruments and supplies for surgery shall be provided." Observation on May 31, 2012, of the facility's storage alcove revealed a piece of equipment located adjacent to Room 4 and covered with a dust cover. Interview with EMP1 revealed this piece of equipment was a colposcopy (a machine used to illuminate and magnify the view of the cervix and the tissues of the vagina and vulva) machine.	S 7102		

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S 7102	Continued from page 98 Observation on May 31, 2012, of the facility's examination room four revealed three ultrasound machines. Interview with EMP1 on May 31, 2012, confirmed there were no clean storage areas available for the colposcopy machine and the ultrasound machines.	S 7102		

Certified End Page

PLANNED PARENTHOOD KEYSTONE - ALLENTOWN

STATE LICENSE NUMBER: 00218701

SURVEY EXIT DATE: 06/08/2012

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Anna Marie Sossong
Deputy Secretary For Quality Assurance

Eli N. Avila, MD, JD, MPH, FCLM
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY