Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN 8-3910				<u>10</u>	(X3) DATE SURVEY COMPLETED: 02/07/2013		
STATE LICEN	se number: 00218701						
(X4) ID PREFIX TAG	REFIX MUST BE PRECEEDED BY FULL REGULATORY O			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	(X5) COMPLETE DATE	
M 0000	INITIAL COMMENT This report is the resul survey conducted on F Planned Parenthood of Buck County (PPNMF determined that the fac with the requirements Department of Health Chapter 29, Subchapte Gynecological Surgery The facility is required for the deficiency cited for abortion. Safe and Sanitary reco to the facility in Tag 9 facility is encouraged to Correction for the reco required.	Pebruary 7, 2013, at t f Northeast Mid-Pen PBC - Allentown). If cility was not in com of the Pennsylvania Regulations §28 Pa er D, Ambulatory y in Hospitals and Cl to submit a plan of d in Tag 0001 - Requ mmendations were p 999 - Recommendat to provide a Plan of ommendations, but it	the n and t was pliance Code, linics. correction uirements provided ions. The is not	M 0000			
LABORATORY	DIRECTOR'S OR PROVIDER/SUPPL	IER REPRESENTATIVE'S SIGN	IATURE		TITLE:	(X6) DATE:	
State Form		QYT71	1			IF CONTINUATI	ON SHEET Page 1 of 11

IF CONTINUATION SHEET Page 1 of 11

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-3910 NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: 0218701 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O		STREET ADDRESS, 29 NORTH 91 ALLENTOWN FICIENCY	A. BLDG: _ B. WING: _ CITY, STATE, Z			EY (X5) COMPLETE	
TAG M 0001	29.33(1) Requirements for A Each medical facility shall I and drugs necessary for resu- is utilized to perform an abo- the first trimester, then the first trimester, then the first trimester, then the fiready to use for resuscitativ (i) Suction Source (ii) Oxygen Source (iii) Assorted size oral airv (iv) Laryngoscope (v) Bag and mask and bag attachments for assisted ver (vi) Intravenous fluids inc (vii) Intravenous catheters (viii) Emergency drugs for (ix) An individual to monit pressure and heart rate. This REGULATION is not	have readily available ec uscitation. If local anest ortion in a medical facili following equipment sha e purposes: ways and endotracheal tube stilation luding blood volume exp and cut-down instrument shock and metabolic imite or respiratory rate, blood	hesia ty during ill be ibes panders t tray palance	M 0001	CROSS-REFERENCED TO THE A Center Manager will docume completed training re: "Prev Maintenance Policy" by 3/8/ will train pertinent staff by 3 All expired 0.9% sodium chl solution in the building has b removed and replaced with c stock by 3/4/13. The Emergency Box checkli audited monthly by RQM Coordinator to ensure there a expired supplies in stock for months.	ent entative (13 and /15/13. loride oeen current st will be are no	DATE Completion Date: 09/30/2013 Status: APPROVED Date: 03/15/2013

QYT711

IF CONTINUATION SHEET Page 2 of 11

Pennsylvania Department of Health

	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER 8-3910		: A. BLDG: _	A (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: <u></u>		(X3) DATE SURVEY COMPLETED: 02/07/2013			
	ROVIDER OR SUPPLIER: ED PARENTHOOD KEYST FOWN	ONE -	STREET ADDRESS, CITY, STATE, ZIP CODE: 29 NORTH 9TH STREET ALLENTOWN, PA 18101						
STATE LICE	NSE NUMBER: 00218701								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF C CORRECTIVE ACTION CROSS-REFERENCED TO	ON SHOULD BE	(X5) COMPLETE DATE			
M 0001	1 Continued from page 2		M 0001						
	 Based on review of fa and staff interview (E facility failed to ensur- solution was not expi- and the emergency dr Findings include: A request was made to 2013, for the policy/p expiration dates of the intravenous solution. 	EMP), it was determin re emergency intraver red in the examination rug cart. to EMP1 on February plan/procedure for mo e facility's emergency	ed the nous n rooms 7, nitoring						
1) Observation on February 7, 2013, of the Examination Room's 3 and 4 revealed each contained one 1000 milliliter bag of 0.9 per Sodium Chloride intravenous solution (use replace blood volume when excessive blee occurs and provide an intravenous route fo medications when a patient requires emerg Further observation of the intravenous solu in Examination Room's 3 and 4 revealed ex dates of November 2012.			n room rcent d to ding r ent care). ttion bags						

State Form

QYT711

IF CONTINUATION SHEET Page 3 of 11

Pennsylvania Department of Health

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER 8-3910			(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING:		(X3) DATE SURVEY COMPLETED: 02/07/2013		
NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN			STREET ADDRESS, 29 NORTH 97 ALLENTOW	TH STREET	ſ		
STATE LICENSE NUMBER: 00218701							
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION (EACH PREFIX TAG CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETE DATE
M 0001	Continued from page 3 Interview with EMP4 on February 7, 2013, at approximately 10:45 AM confirmed Examination Room 3 and 4 each room contained one 1000			M 0001			
	milliliter bag of 0.9 per intravenous solution th						
	2) Observation on Febr Emergency Drug Cart in intravenous bag of 0.9 intravenous solution w November 2012.)00 cc) oride					
	Interview with EMP2 of approximately 10:45 A of 0.9 percent Sodium on the Emergency Drug 2012.	liter bag s solution					
M 9999				M 9999			

State Form

QYT711

IF CONTINUATION SHEET Page 4 of 11

Pennsylvania Department of Health

	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER 8-3910				(X3) DATE SURVEY COMPLETED: 02/07/2013		
NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE: 29 NORTH 9TH STREET ALLENTOWN, PA 18101				
STATE LICEN	ISE NUMBER: 00218701						
(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		OULD BE	(X5) COMPLETE DATE			
M 9999	Continued from page 4		M 9999				
	Recommendation This REGULATION is no	ot met as evidenced by:		POC is optional and not requ Containers for wall mounted bins have been ordered. Who are in place, all unsecured sh containers will be disposed of only secured sharps contained be used. Center Manager will monitor appropriate disposal sharps for 6 months. Privacy curtains are not a requirement of the Abortion Act; Planned Parenthood is i compliance. The reclining cl appropriate for client care sin are awake, fully dressed and similar post op instructions. must have unobstructed view clients for monitoring purpos A new "Controlling Prescrip Pads" policy is effective 3/8/ Center Manager will docume completed training on this po 3/8/15 and will train pertinent by 3/15/13. Center Manager monitor appropriate staorage prescription pads for 6 mont	l sharps en they harps of and ers will ll d of Control n full hairs are nee they receive Nurses v of ses. tion (13. ent blicy by nt staff will e of	Completion Date: 09/30/2013 Status: APPROVED Date: 03/15/2013	

State Form

QYT711

IF CONTINUATION SHEET Page 5 of 11

Pennsylvania Department of Health

		i		i			
	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/ PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER 8-3910			(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: <u>10</u>		(X3) DATE SURVEY COMPLETED: 02/07/2013	
NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN		STREET ADDRESS, 29 NORTH 97 ALLENTOW	TH STREET	ſ			
STATE LICENS	SE NUMBER: 00218701						
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEED	f OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
M 9999	Continued from page 5			M 9999			
					The Ultrasound Machine win expired inspection sticker ha moved out of the facility as	is been	

QYT711

IF CONTINUATION SHEET Page 6 of 11

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-3910				0	(X3) DATE SURVEY COMPLETED: 02/07/2013		
NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN			STREET ADDRESS, CIT 29 NORTH 9TH ALLENTOWN, 1	STREET	P CODE:		
STATE LICEN	SE NUMBER: 00218701						
(X4) ID PREFIX TAG	MUST BE PRECEED	r of DEFICIENCIES (EACH DE ED BY FULL REGULATORY O IFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE /	OULD BE	(X5) COMPLETE DATE
M 9999	Continued from page 6		М	9999			
	 Based on review of fac and staff interview (EI Planned Parenthood of Buck County (PPNME maintain a safe and sat Findings include: 1) Review on February "Sharps Safety Policy, revealed "Policy: P a safe environment for all facilities by keepin Procedures: Use of Sharps bins must be lo height, and never place surfaces, or where a pa with them" Observation on Februa Examination Room 3 a Pre-procedure/Post-pro- unsecured sharps contaiting 	MP), it was determin f Northeast Mid-Pent PBC - Allentown) fai nitary environment. y 7, 2013, of the faci " last revised May 24 lanned Parenthood n staff, patients and v g all 'sharps' safely s Sharps Containers cated at approximate ed on the floor, on to atient or visitor can ta and 4 and the occedure room reveal	ed n and iled to lity's 012, naintains isitors to tored ely waist op of high amper cility's ed				

QYT711

IF CONTINUATION SHEET Page 7 of 11

Pennsylvania Department of Health

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	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/A PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER 8-3910			(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: <u></u>		(X3) DATE SURVEY COMPLETED: 02/07/2013	
		0-5710					
	VIDER OR SUPPLIER:	NIE	STREET ADDRESS, 29 NORTH 9T				
PLANNED PARENTHOOD KEYSTONE - ALLENTOWN			ALLENTOWN				
ALLEI (10				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-		
STATE LICENS	e number: 00218701						
(X4) ID PREFIX TAG	MUST BE PRECEEDI	[°] OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	DULD BE	(X5) COMPLETE DATE
M 9999	Continued from page 7			M 9999			
	containing used needle	-					
	the countertop. Furthe						
	lockable wall mounted	-					
	each of these rooms. T						
	sharps container holde	rs in each room were	e empty.				
	Interview with EMP1, February 7, 2013, at ap confirmed the unsecure each room, containing the countertop in Exan the Pre-procedure/Post EMP2, EMP3 and EM had lockable wall mou which were empty. Fu confirmed sharp contain wall mounted sharps contained the countertop. 2) Review on February "Patient Rights [and] F review date, revealed " presents these Patient F	AM , one in arps on d 4 and in MP1, oom r holders EMP3 d in the not left on lity's cy, no					

State Form

QYT711

IF CONTINUATION SHEET Page 8 of 11

Pennsylvania Department of Health

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	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIED IDENTIFICATION NUMBER STATEMENT OF CORRECTION (POC) (XI) PROVIDER/SUPPLIED IDENTIFICATION NUMBER STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIED IDENTIFICATION NUMBER STATEMENT OF CORRECTION (POC) (XI) PROVIDER/SUPPLIED (XI) PROVIDER (XI) PRO			(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING:		(X3) DATE SURVEY COMPLETED: 02/07/2013	
NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE -			STREET ADDRESS, 29 NORTH 91				
ALLENTOWN			ALLENTOW				
ALLENIO				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•		
STATE LICENS	e number: 00218701						
(X4) ID		OF DEFICIENCIES (EACH DE		ID	PROVIDER'S PLAN OF CORREC	· · · · · · · · · · · · · · · · · · ·	(X5)
PREFIX TAG		ED BY FULL REGULATORY O FYING INFORMATION)	R LSC	PREFIX TAG	CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A		COMPLETE DATE
					CR055-REFERENCED TO THE /	AT KOT KIATE	5.112
M 9999	Continued from page 8			M 9999			
	Responsibilities to refle	ect the commitment	to				
	providing quality patie	nt care 9. The pa	tient has				
	the right to every consi						
	throughout his or her n						
	•	•	ice,				
	including but not limited	•					
	Confidentiality and dis	creet conduct during	g case				
	discussions, consultation	ons, examinations ar	nd				
	treatments"						
	Observation on Februa	ry 7, 2013, of the fa	cility's				
	Pre-procedure/Post-pro	•	-				
	reclining chairs for pat						
		-					
	and to recover followin	•					
	observation revealed ne		hese				
	chairs to provide privat	cy to patients.					
	Interview with EMP3 of						
	Pre-procedure/Post-pro						
	approximately 11:30 A	M revealed patient					
	interviews were compl	eted in this room. El	MP3				
	revealed the patient int						
	medical history and me		•				
	with EMP3 confirmed						
	with Eivir 3 continned	mere were no curtar	115				

State Form

QYT711

IF CONTINUATION SHEET Page 9 of 11

Pennsylvania Department of Health

	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER 8-3910				(X3) DATE SURVEY COMPLETED: 02/07/2013	
	OVIDER OR SUPPLIER: D PARENTHOOD KEYS OWN	FONE -	STREET ADDRESS, CITY, STATE, Z 29 NORTH 9TH STREET ALLENTOWN, PA 1810			
STATE LICE	NSE NUMBER: 00218701					
(X4) ID PREFIX TAG	SUMMARY STATEME MUST BE PRECEE	NT OF DEFICIENCIES (EACH DE EDED BY FULL REGULATORY O ITIFYING INFORMATION)		PROVIDER'S PLAN OF COR CORRECTIVE ACTION CROSS-REFERENCED TO T	SHOULD BE	(X5) COMPLETE DATE
M 9999	Continued from page 9		M 9999			
	 patient privacy was r interviews. Repeat recommendat May 1, 2012. 3) A request was may 2013, for the policy/p prescription pads. N Observation on Febre Pre-procedure/Post-p unlocked cabinet cor Interview with EMP? 2013, at approximate cabinet containing the not locked, and the c locked to prevent unage 	procedure room and the not provide during patient ion cited June 16, 201 de to EMP1 on Februa plan/procedure for sec one was provided. uary 7, 2013, of the fa procedure room reveal training two prescription 3 and EMP4 on Februa ely 11:40 AM confirm ese two prescription p abinet should have be	ient 1, and ury 7, uring of cility's ed an on pads. ary 7, ed the ads was en			

QYT711

IF CONTINUATION SHEET Page 10 of 11

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER NAME OF PROVIDER OR SUPPLIER: 8-3910 NAME OF PROVIDER OR SUPPLIER: ALLENTOWN				(X3) DATE SURVEY COMPLETED: 02/07/2013			
STATE LICENS	e number: 00218701						
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
M 9999	Continued from page 10 storage room revealed sticker indicating the n to be completed Octob documentation the prev completed on this ultra 2012. Interview with EMP4 of approximately 10:50 A machine had a sticker in preventative maintenan 2012, and no current pr completed on this mach	ext preventative main er 2012. There was no ventative maintenand sound machine after on February 7, 2013. M confirmed the ult ndicating the next nee to be completed reventative maintena	intenance no ce was r October , at trasound October ance was	M 9999			

QYT711

IF CONTINUATION SHEET Page 11 of 11



Certified End Page

PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: 00218701 SURVEY EXIT DATE: 02/07/2013

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

Susan Cope

Susan Coble Deputy Secretary for Quality Assurance



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

Rachel L. Levine, MD Secretary of Health