Pennsylvania Department of Health

	IMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION: (X3) DATE SURVEY OF CORRECTION (POC) IDENTIFICATION NUMBER: A. BLDG:00 04/25/2019 8-3910 B. WING: 04/25/2019		ΞY				
PLANNED ALLENTC	VIDER OR SUPPLIER: • PARENTHOOD KEYST(• WN • SE NUMBER: 00218701	I DNE -	STREET ADDRESS 29 NORTH 97 ALLENTOW	TH STREET	P CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEED IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE .	OULD BE	(X5) COMPLETE DATE	
M 0000	INITIAL COMMENT			M 0000			
M 0001	This report is the resul survey conducted on A Parenthood Keystone - Allentown). It was de compliance with the re Pennsylvania Departm 28 Pa Code, Chapter 2 Ambulatory Gynecolo Clinics.	April 25, 2019, at Pla - Allentown (PPKey termined the facility equirements of the nent of Health Regula 9, Subchapter D, gical Surgery in Hos	nned - was not in ations § spitals and	M 0001	TITLE:	(X6) DATE:	
LABORATORY	DIRECTOR'S OR PROVIDER/SUPPL	IER REPRESENTATIVE'S SIGN	IATURE		TITLE:	(X6) DATE:	
State Form		6TDG1	1			IF CONTINUAT	ION SHEET Page 1 of 5

IF CONTINUATION SHEET Page 1 of 5

Pennsylvania Department of Health

PLAN OF COF	OF DEFICIENCIES AND RECTION (POC) VIDER OR SUPPLIER: PARENTHOOD KEYSTO	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-3910 DNE -		A. BLDG: _ B. WING: _ CITY, STATE, Z	л	(X3) DATE SURV COMPLETED: 04/25/2019	EY
				,111 1010	•		
(X4) ID PREFIX TAG	NSE NUMBER: 00218701 SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
M 0001	Continued from page 1 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 f ready 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 s (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 at tray balance	M 0001	The corrective actions for th deficiency were performed b Center Manager on the day of inspection, 4/25/2019 as the had the equipment on site. To monitor, the Center Mana audit the cutdown down tray end of each calendar month ensure all required equipment contained in the tray. The re- the audit will be documented Center Manager will report a deviations to the Director of and Quality Management.	by the of facility ager will by the to nt is esults of d and the any	Completion Date: 04/25/2019 Status: APPROVED Date: 06/04/2019

6TDG11

IF CONTINUATION SHEET Page 2 of 5

Pennsylvania Department of Health

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	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:		
				A. BLDG: <u>0</u> B. WING:		04/25/2019		
		8-3910		D. WING.		04/25/2019		
	OVIDER OR SUPPLIER:	TANE		S, CITY, STATE, ZIF TH STREET	CODE:			
PLANNEI ALLENT(D PARENTHOOD KEYS DWN	STONE -		VN, PA 18101				
(X4) ID	SE NUMBER: 00218701	ENT OF DEFICIENCIES (FACH DE	FICIENCY	ID	DROVIDED'S DI AN OF CODDI		(X5)	
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFI MUST BE PRECEEDED BY FULL REGULATORY OR IDENTIFYING INFORMATION)			PREFIX TAG	PROVIDER'S PLAN OF CORRI CORRECTIVE ACTION SI CROSS-REFERENCED TO THE	HOULD BE	COMPLETE DATE	
M 0001	Continued from page 2			M 0001				
	Based on observation	on and staff interview (I	EMP), it					
	was determined the	facility failed to ensure	all					
	required equipment was contained in the fac							
cut-down instrument tray in each procedure			e room.					
	Findings include:							
	-	of EMP2 on April 25,	-					
		icy, procedure or guide						
		ding ensuring each cut-						
	instrument tray cont None was provided.	pment.						
	Review on April 25, 2019, of the facility's							
		l Equipment Checklist"						
		018, revealed " Other						
		ites one cut-down tra						
	(includes two disposable scalpels and two sterile hemostats) - tray is sealed and hemostat pack has							
	not been compromis	-	CK Has					
	-	il 25, 2019, of the facil	-					
	procedure room three	a managed and a model and T	EMD2				1	

6TDG11

IF CONTINUATION SHEET Page 3 of 5

Pennsylvania Department of Health

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER 8-3910)	(X3) DATE SURV COMPLETED: 04/25/2019	MPLETED:	
	OVIDER OR SUPPLIER: D PARENTHOOD KEYST(DWN	I ONE -	STREET ADDRESS, 29 NORTH 97 ALLENTOWN	TH STREET	CODE:			
STATE LICEN	se number: 00218701							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
M 0001	Continued from page 3			M 0001				
	 identified the red box instrument tray. Furth of the red box revealed tray did not contain twi instrument used to con- vessels). Interview with EMP2 of the observation com- box cut-down instrum- sterile hemostats. Observation on April 1 procedure room 4 reve- identified the red box instrument tray. Furth of the red box revealed tray did not contain two disposable scalpels (a bladed instrument use Interview with EMP2 of the observation com- 	her observation of the d the cut-down instru- vo sterile hemostats (mpress or treat bleed on April 25, 2019, a firmed the contents of ent tray did not conta 25, 2019, of the facil ealed a red box. EMF was the facility's cut her observation of the d the cut-down instru- vo sterile hemostats of small and extremely d to make an incision on April 25, 2019, a	e contents ument (an ing t the time of the red ain two lity's 22 -down e contents ument or two r sharp n). t the time					

6TDG11

IF CONTINUATION SHEET Page 4 of 5

Pennsylvania Department of Health

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULT	IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
					_00		
		8-3910		B. WING:		04/25/2019	
	VIDER OR SUPPLIER:	ONE	STREET ADDRESS,				
PLANNED ALLENTC	PARENTHOOD KEYST(UNE -	29 NORTH 97 ALLENTOW				
				.,			
STATE LICENS (X4) ID	E NUMBER: 00218701	T OF DEFICIENCIES (EACH DE	FIGHENCY	ID			(25)
PREFIX	MUST BE PRECEED	ED BY FULL REGULATORY O		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH		(X5) COMPLETE
TAG	IDENTI	IFYING INFORMATION)			CROSS-REFERENCED TO THE	APPROPRIATE	DATE
M 0001	Continued from page 4			M 0001			
	hav aut darm instrum	ant trave did not acret	in two				
	box cut-down instrume sterile hemostats or tw						
	sterne nemostats or tw	o disposable scalper	5.				

6TDG11

IF CONTINUATION SHEET Page 5 of 5

Pennsylvania Department of Health

	partment of freath						
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBE 8-3910			(X2) MULTIPLE CONSTRUCTION: A. BLDG: B. WING:		(X3) DATE SURVEY COMPLETED: 04/25/2019	
	VIDER OR SUPPLIER: PARENTHOOD KEYST(WN	DNE -	STREET ADDRESS 29 NORTH 97 ALLENTOW	TH STREET	P CODE:		
STATE LICENS	e number: 00218701						
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE /	OULD BE	(X5) COMPLETE DATE	
S 0000	INITIAL COMMENT This report is the resul survey conducted on A Parenthood Keystone -	pril 25, 2019, at Pla	S 0000				
S 0119	Parenthood Keystone - Allentown (PPKey - Allentown). It was determined the facility was no compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Ambulatory Care Facilities, Anne A, Title 28, Part IV, Subparts A and F, Chapters 551-573, November 1999.			0.0110			
5 0119				S 0119			
LABORATORY	DIRECTOR'S OR PROVIDER/SUPPL	ER REPRESENTATIVE'S SIGN.	ATURE		TITLE:	(X6) DATE:	
State Form			1			IF CONTINUEST	TON SHEET Page 1 of 5

IF CONTINUATION SHEET Page 1 of 5

Pennsylvania Department of Health

PLAN OF COR NAME OF PRO PLANNED ALLENTO	e number: 00218701 summary statement must be preceede	IDENTIFICATION NUMBER: A. BLDG:00 COMPLETED: 8-3910 B. WING: 04/25/2019 O KEYSTONE - STREET ADDRESS, CITY, STATE, ZIP CODE: 29 NORTH 9TH STREET ALLENTOWN, PA 18101 ALLENTOWN, PA 18101 ALLENTOWN, PA 18101		EY (X5) COMPLETE DATE			
S 0119		HORIZATION TO OP GICAL FACILITY II meet the following cri- II be required for the op such a facility shall be tion Association for e Joint Commission on e Organizations, the Am tation of Ambulatory Su Ily recognized accrediting e Medicare program in of mbulatory surgery.	ERATE Iteria: eration the nerican rgical ng	S 0119	The corrective actions for the deficiency were performed b Center Manager on the day of inspection. The cleaning solution was m its own storage cabinet and t noted food was disposed. To monitor, the Center Mana conduct an audit by the end of calendar month to ensure pro- storage of these items is in compliance with Planned Pai Keystone policies and proceed The results of the audits will documented and any deviation be reported to the Director of and Quality Management.	y the of oved to he ager will of each oper renthood dures. be ons will	Completion Date: 04/25/2019 Status: APPROVED Date: 06/04/2019

State Form

6TDG11

IF CONTINUATION SHEET Page 2 of 5

Pennsylvania Department of Health

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	DF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 8-3910		(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING:		(X3) DATE SURVEY COMPLETED: 04/25/2019	
	VIDER OR SUPPLIER: PARENTHOOD KEYSTC WN	DNE -	STREET ADDRESS, 29 NORTH 9T ALLENTOWN	'H STREET	л		
STATE LICENS	e number: 00218701						
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OI FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	DULD BE	(X5) COMPLETE DATE
S 0119	Continued from page 2			S 0119			
	Based on observation a was determined the fac minimum Medicare sta Infection control progr established by the facil by failing to ensure che instruments were not st and medications and th was not stored in a faci Findings include: 1) A request was made 2019, for the facility's p for staff to follow regat used to clean instrument supplies and medication Observation on April 2 storage closet revealed of cleaning solution] on revealed this cleaning so ultrasound transvagina	cility failed to meet the indard 416.51 (b) State am for compliance, in ity's accrediting orga- emicals used to clear tored with patient success tored with	he andard: that is anization pplies nsure food area. 25, guideline micals f patient ded. ity's f [Name P2 ean the				

6TDG11

IF CONTINUATION SHEET Page 3 of 5

Pennsylvania Department of Health

	T OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		8-3910		A. BLDG: <u>0</u> B. WING: <u></u>			
NAME OF PRO	AME OF PROVIDER OR SUPPLIER:			CITY, STATE, ZII	P CODE:		
	D PARENTHOOD KEYS	STONE -	29 NORTH 9T				
ALLENT	UWN		ALLENTOWN	N, PA 18101			
STATE LICEN	ISE NUMBER: 00218701		<u> </u>				
(X4) ID PREFIX TAG	MUST BE PRECE	ENT OF DEFICIENCIES (EACH DE EEDED BY FULL REGULATORY O ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
5 0119	Continued from page 3			S 0119			
	from the top there w	vere 18 boxes of Levon	orgestrel				
	-	control medication).	•				
	third from the top there were four boxes of T Extra Strength, nine boxes of Misoprostol (a						
	medication used for	m abortion) 200 millig	rams (mg),				
16 boxes of Doxycycline Monicagate (a medi			edication				
		100 mg and six boxes					
	`	ntrol nausea) 4 mg. On					
	fourth shelf contained	n tubing.					
	Interview with EMF						
		closet with the two 4-					
	bottles of [Name of	-					
		ng solution is used to c inal probe; the 18 boxe					
	-	Ethinyl on the second					
	e	2					
	the top; the four boxes of Tylenol Extra Strength, the nine boxes of Misoprostol, the 16 boxes of						
	Doxycycline Monicagate and the six boxes of						
		from the top and the fo					
	of suction tubing on	-					
	1						

6TDG11

IF CONTINUATION SHEET Page 4 of 5

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: 04/25/2019	
NAME OF BROD		·	STREET ADDRESS,	CITY STATE 7			
	VIDER OR SUPPLIER:	NE	29 NORTH 91				
PLANNED PARENTHOOD KEYSTONE -							
ALLENTO	W IN		ALLENTOW	N, PA 1810	1		
STATE LICENSE 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		COMPLETE DATE
IAG	IDENTI	r mo mrokmanon)			CROSS-REFERENCED TO THE	APPROPRIATE	DATE
S 0119	Continued from page 4			0.0110			
5 0119	Continued from page 4			S 0119			
	approximately 11:25 A	M confirmed the cle	eaning				
	solutions should not be	e stored in an area w	here				
	patient medications and	a supplies are stored					
	2) Observation on April	il 25-2019 of the fa	cility				
	· -		-				
	identified dirty area rev						
	package of crackers in	the top drawer next	to				
	bio-hazard bags and a	tourniquet (a band u	sed to				
	-						
	limit blood flow when						
	revealed this dirty area	is used for drawing	blood				
	and performing urine p	regnancy testing					
	and performing and p						
	Interview with EMP2 of	on April 25, 2019, at	the time				
	of the observation conf	firmed the two lollin	ops and				
		•	•				
	package of crackers in	-					
	bio-hazard bags and a t						
	the lollipops and crack	ers are not to be stor	ed in this				
	dirty area.						

State Form

6TDG11

IF CONTINUATION SHEET Page 5 of 5



Certified End Page

PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: 00218701 SURVEY EXIT DATE: 04/25/2019

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