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	8-5144	A. BLDG: 00 B. WING:	11/04/2015

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PPSP FAR NORTHEAST HEALTH CENTER STATE LICENSE NUMBER: **9HEG8701**	**2751 COMLY ROAD** **PHILADELPHIA, PA 19154**

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M 0000	INITIAL COMMENT This report is the result of an unannounced Revisit survey conducted on November 4, 2015, following an annual Registration survey conducted on August 19, 2015 at PPSP Far Northeast Health Center. It was determined the facility was in compliance with the requirements of the Pennsylvania Department of Health Regulations § 28 Pa Code, Chapter 29, Subchapter D, Ambulatory Gynecological Surgery in Hospitals and Clinics.	M 0000		

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

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S 0000	INITIAL COMMENT This report is the result of an unannounced Revisit survey conducted on November 4, 2015, following a full State Licensure survey completed on August 19, 2015, at PPSP Far Northeast Health Center. It was determined 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 6701		S 6701		

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S 6701	Continued from page 1 567.1 Principle CHAPTER 567 - ENVIRONMENTAL SERVICES 567.1 Principle The ASF shall have a sanitary environment, properly constructed, equipped and maintained to protect surgical patients and ASF personnel from cross-infection and to protect the health and safety of patients. This REGULATION is not met as evidenced by:	S 6701	PPSP is committed to providing a safe and sanitary environment and has made the following corrections in addition to ones made previously (see POC submitted and approved 9/28/2015): 1) PPSP will address the issues related to medication preparation (use of multi-dose vials and location of medication preparation) by implementing an updated PPSP Infection Control Plan that includes the CDC recommendations for Injection Safety, dated March 2, 2011. Specifically, a medication preparation area will be designated in the procedure room and maintained as a clean area allowing no potentially contaminated items to be placed nearby, signage will be posted to designate the area and cleaning procedures for the medication preparation area will be instituted between each patient case. Additionally, aseptic technique will always be used when preparing medications, single-dose vials will be used whenever possible to avoid	Completion Date: **12/15/2015** Status: **APPROVED** Date: **11/23/2015**

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S 6701	Continued from page 2	S 6701	need for multi-dose vials, and if multi-dose vials are used they will be stored and disposed in accordance to CDC recommendations. If multi-dose vials are used for more than one patient, they will not be kept or accessed in the immediate patient treatment areas. If a multi-dose vial enters the immediate patient care area, it will be dedicated to that patient only and discarded after use. By 12/15/15, facility staff will be apprised and trained on these injection safety procedural updates. The ASF person-in-charge is responsible for ensuring the medication preparation area and process meets the requirements of the updated Infection Control Plan and monitoring staff for compliance. Any issues will be brought to the attention of the Director of Anesthesia and the Director of Risk and Quality Management for immediate intervention. Additionally, the Director of Risk and Quality Management will monitor compliance via scheduled and unannounced site visits.	

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S 6701	Continued from page 3	S 6701	2) On 10/1/2015, we instituted the performance of positive and negative controls with each newly opened bottle of Metricide Test Strips. This was detailed in our facility's plan of correction submitted 8/28/15 and approved. The bottle of test strips found on 11/4/15 was opened before this new procedure was in place. This new quality control procedure was performed by our facility staff on their first clinic day following the new QC practice, 10/2/15, using the already opened bottle. On 11/20/15, the Director of Risk and Quality Management and the ASF person-in-charge reviewed the QC procedure and the control logs finding appropriate documentation and compliance. On 11/21/15, the previously opened bottle will be disposed of and a new bottle of test strips opened and controls run. The ASF person-in-charge is is responsible for ongoing monitoring of compliance. In addition, the Director of Risk and Quality Management will	

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S 6701	Continued from page 4	S 6701	monitor compliance through scheduled and unannounced site inspections. 3) On 11/20/15, the Director of Risk and Quality Management made a announced site visit to the facility to observe sterile processing and review the communication and training plan with the ASF person-in-charge. She observed two runs in both machines and found wrapped surgical packs placed on the rack with sufficient air flow and the loads came out dry. Also on 11/20/15, the ASF person-in-charge reviewed the DOH findings with her team and instructed them that stacking packs is not allowed per policy as it does not allow sufficient air flow. The ASF person-in-charge will provide increased monitoring and by 12/15/15 will directly observe each staff person assigned to sterile processing to ensure compliance with policy. Any staff person found stacking packs or overloading the autoclave will receive remedial training and increased supervision.	

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S 6701	Continued from page 5	S 6701	Additionally, by 12/15/15 the PPSP Infection Control Policy will be updated to reflect the CDC Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008. The policy will state when loading the sterilizer staff will arrange items on rack to allow the passage of steam; will not overload the sterilizer; when possible, sterilize like materials together; and ensure basins, trays, surgical cups, etc. will be set on edge or upside down to allow air to flow out freely as steam flows in. Also, when removing load from sterilizer the load should be dry and cool; care must be taken to keep sterile items separated from non-sterile items. The Director of Risk and Quality Management will monitor compliance via scheduled and unannounced site visits.	

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S 6701	Continued from page 6 Based on review of facility policy and procedures, observation and interview with staff (EMP), it was determined the facility failed to provide a safe and sanitary environment. Findings include: 1) Review of facility administrative policy, "Pharmaceuticals," dated August 2015, revealed " .... B. 1. When a multi-dose vial is used, appropriate infection prevention procedures to prevent contamination should be employed. ... " Review of facility policy, "Infection Control Plan," dated October 15, 2015, revealed " ... Safe Injection Practices ... Use aseptic technique when preparing ... medications ... " Review of Centers for Disease Control and Prevention (CDC) recommendations "Injection Safety," dated March 2, 2011, revealed " ... 1. Parenteral medications should be accessed in an aseptic manner. ... 2. ... Medications should be	S 6701		

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S 6701	Continued from page 7 drawn up in a designated clean medication area that is not adjacent to areas where potentially contaminated items are placed." Observation on November 4, 2015, at 09:30 AM, of the procedure room revealed EMP3 was standing near the medication cabinet while filling syringes from an open multi-dose vial of Midazolam 10 mg/10 ml (intravenous medication that is used for preoperative sedation) and an open multi-dose vial of Lidocaine HCL 2% 20 mg/ml (intravenous medication that is used for prevention and control of pain). Further observation of the procedure room revealed EMP3 had a basin with three prefilled syringes labeled Midazolam 1 mg/ml and dated November 4, 2015. Interview on November 4, 2015, at 09:40 AM, with EMP3 confirmed the Midazolam and Lidocaine HCL injections were drawn up in the procedure room, which is considered a potentially contaminated area.	S 6701		

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S 6701	Continued from page 8 2) Observation on November 4, 2015, at 9:45 AM of the facility's exam room, where ultrasounds are performed, revealed an opened bottle of MetriCide OPA Plus Test Strips. Further, observation of the facility log book for testing the MetriCide OPA Plus Test Strips revealed the bottle was opened on September 12, 2105, and the date the controls on the test strips was conducted was on October 2, 2015. Interview with EMP4 on November 4, 2015, at 9:45 AM confirmed the MetriCide OPA Plus Test Strips located in the facility's exam room were the test strips that EMP4 would currently be utilizing. Further, EMP4 confirmed that the Test Strips bottle was opened on September 12, 2105, and the date the controls on the test strips was conducted was on October 2, 2015. EMP4 confirmed that the newly opened bottle of Metricide OPA Test Strips were not tested per manufacturer instructions as identified in the facility's plan of correction. 3) Review of the facility's "Infection Control Plan,"	S 6701		

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S 6701	Continued from page 9 dated August 15, 2015, revealed " ... Steam Sterilization ... The kits are placed side by side in the autoclave. Do not overfill. ... " Observation on November 4, 2015, at 9:50 AM of the facility's sterile processing room revealed the facility's sterilizer had two table top sterilizers. Both sterilizer number one and sterilizer number two each contained three sterilized wraps stacked on top of each other. The facilty did not follow their submitted POC by ensuring proper management of the sterilizers as evidenced by stacking three sterilized wraps on top of each other. Interview on November 4, 2015, at 9:50 AM, with EMP1 confirmed both sterilizer number one and sterilizer number two contained three sterilized wraps stacked on top of each other. Interview on November 4, 2015, at 11:00 AM, with EMP3 revealed the training the facility's employees received regarding the use of the sterilizers was not on table top sterilizers that the	S 6701		

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S 6701	Continued from page 10 facility utilizes. EMP3 confirmed that the facility's infection control plan does not state to stack the wraps on top of each other.	S 6701		

Certified End Page

PPSP FAR NORTHEAST HEALTH CENTER

STATE LICENSE NUMBER: 9HEG8701

SURVEY EXIT DATE: 11/04/2015

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 Coble
Deputy Secretary for Quality Assurance

Rachel L. Levine, MD
Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

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THIS PAGE IS NOW PART OF THIS SURVEY