Pennsylvania Department of Health

PLAN OF CC	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER 8-5144		t:	A. BLDG:0 B. WING:	LE CONSTRUCTION: <u>0</u>	(X3) DATE SURVEY COMPLETED: 11/04/2015				
PPSP FAI	NAME OF PROVIDER OR SUPPLIER: <b>PPSP FAR NORTHEAST HEALTH CENTER</b> STATE LICENSE NUMBER: <b>9HEG8701</b>			STREET ADDRESS, CITY, STATE, ZIP CODE: 2751 COMLY ROAD PHILADELPHIA, PA 19154						
(X4) ID PREFIX TAG	MUST BE PRECEED	F OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION (E PREFIX TAG CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR			(X5) COMPLETE DATE			
M 0000	INITIAL COMMENT This report is the resul survey conducted on N an annual Registration 19, 2015 at PPSP Far N was determined the fac the requirements of the Health Regulations § 2 Subchapter D, Ambula in Hospitals and Clinic	Jovember 4, 2015, fo survey conducted o Northeast Health Cer cility was in complia e Pennsylvania Depa 28 Pa Code, Chapter atory Gynecological es.	ollowing n August nter. It ance with artment of 29, Surgery	M 0000						
LABORATOR	Y DIRECTOR'S OR PROVIDER/SUPPLI	IER REPRESENTATIVE'S SIGN	NATURE		TITLE:	(X6) DATE:				
State Form		ZJT912	>			IF CONTINUAT	TON SHEET Page 1 of 1			

IF CONTINUATION SHEET Page 1 of 1

Pennsylvania Department of Health

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY		
		8-5144		A. BLDG: B. WING: 11/04/2			/2015		
NAME OF PRO	VIDER OR SUPPLIER:		STREET ADDRESS	5, CITY, STATE, ZI	P CODE:				
	PPSP FAR NORTHEAST HEALTH CENTER			ROAD					
			PHILADELP	HIA, PA 191	54				
STATE LICENS	E NUMBER: 9HEG8701								
(X4) ID		T OF DEFICIENCIES (EACH DE		ID	PROVIDER'S PLAN OF CORRE		(X5)		
PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY O			PREFIX TAG	CORRECTIVE ACTION SE CROSS-REFERENCED TO THE		COMPLETE DATE		
IAG	IDENI	II TING IN ORMATION)			CR055-REFERENCED TO THE	APPROPRIATE	DAIL		
S 0000	INITIAL COMMENT			S 0000					
5 0000				3 0000					
	This report is the result	lt of an unannounced	Revisit						
	survey conducted on I	November 4, 2015, fc	ollowing						
	a full State Licensure								
	19, 2015, at PPSP Far								
	was determined the fa	cility was not in com	pliance						
	with the requirements	of the Pennsylvania							
	Department of Health	's Rules and Regulati	ons for						
	Ambulatory Care Faci	-							
	-		20, 1 art						
	IV, Subparts A and F,	Chapters $551-5/3$ ,							
	November 1999.								
S 6701				S 6701					
LABORATORY	DIRECTOR'S OR PROVIDER/SUPPL	IER REPRESENTATIVE'S SIGN.	ATURE		TITLE:	(X6) DATE:			
~ -									
State Form		ZJT912				IF CONTINUATION	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/SUPPLIE IDENTIFICATION NUMB 8-5144			IA       (X2) MULTIPLE CONSTRUCTION:       (X3) DATE SURV         A. BLDG:00			VEY
NAME OF PROVIDER OR SUPPLIER: <b>PPSP FAR NORTHEAST HEALTH CENTER</b> STATE LICENSE NUMBER: <b>9HEG8701</b>			STREET ADDRESS, 2751 COMLY PHILADELPI	ROAD			
(X4) ID PREFIX TAG	SUMMARY STATEMEN MUST BE PRECEEI IDENT		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
S 6701	Continued from page 1 567.1 Principle CHAPTE SERVICES 567.1 Principle The ASF shall have a constructed, equipped and maintained t ASF personnel from cross-infection and to prot patients. This REGULATION is no	sanitary environment, pr o protect surgical patients ect the health and safety o	roperly s and	S 6701	<ul> <li>PPSP is committed to provide safe and sanitary environment has made the following correction addition to ones made preent (see POC submitted and app 9/28/2015):</li> <li>1) PPSP will address the issue related to medication preparation of medication preparation by implementing an updated PP Infection Control Plan that in the CDC recommendations of Injection Safety, dated Marce 2011. Specifically, a medica preparation area will be designed to designate the area and no potentially contaminated be placed nearby, signage with posted to designate the area and instituted between each patie Additionally, aseptic technique always be used when preparation area will be designed to assign the procedures for the medication preparation area instituted between each patie Additionally, aseptic technique always be used when preparation area will be designed to assign the preparation area and preparation area and preparation area and preparation area and preparation area will be designed to designate the area and preparation preparation area and prepar</li></ul>	nt and ections viously roved les ation location y PSP ncludes for h 2, tion gnated llowing items to ill be and will be ent case. jue will ing ls will be	Completion Date: 12/15/2015 Status: APPROVED Date: 11/23/2015

State Form

ZJT912

IF CONTINUATION SHEET Page 2 of 11

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)       (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER         8-5144         NAME OF PROVIDER OR SUPPLIER: PPSP FAR NORTHEAST HEALTH CENTER         STATE LICENSE NUMBER:         9HEG8701         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES (EACH DE		STREET ADDRESS, 2751 COMLY PHILADELPI	A. BLDG: _ B. WING: _ CITY, STATE, Z ROAD HIA, PA 19		(X3) DATE SURVE COMPLETED: 11/04/2015	Υ 	
(X4) ID PREFIX TAG	MUST BE PRECEED	T OF DEFICIENCIES (EACH DE DED BY FULL REGULATORY OF IFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
S 6701	Continued from page 2			S 6701	need for multi-dose vials, an multi-dose vials are used the stored and disposed in accor to CDC recommendations. I multi-dose vials are used for than one patient, they will no kept or accessed in the immo- patient treatment areas. If a multi-dose vial enters the im- patient care area, it will be d to that patient only and disca after use. By 12/15/15, facili will be apprised and trained injection safety procedural u The ASF person-in-charge is responsible for ensuring the medication preparation area process meets the requireme the updated Infection Contro and monitoring staff for corr Any issues will be brought to attention of the Director of Anesthesia and the Director and Quality Management for immediate intervention. Add the Director of Risk and Qua Management will monitor compliance via scheduled ar unannounced site visits.	ey will be dance f more ot be ediate anded ity staff on these updates. s and ents of ol Plan upliance. o the of Risk r ditionally, ality	

State Form

ZJT912

IF CONTINUATION SHEET Page 3 of 11

Pennsylvania Department of Health

		i		•				
	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/ PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER 8-5144			A. BLDG: <u>00</u>		(X3) DATE SURVI COMPLETED: 11/04/2015	MPLETED:	
NAME OF PROVIDER OR SUPPLIER:			STREET ADDRESS,	CITY STATE 7	ZIP CODE <sup>.</sup>			
NAME OF PROVIDER OR SUPPLIER: PPSP FAR NORTHEAST HEALTH CENTER			2751 COMLY					
PPSP FAR NORTHEAST HEALTH CENTER			PHILADELPI		154			
STATE LICENSE NUMBER: 9HEG8701				<b></b> , <b>.</b>				
(X4) ID	SUMMARY STATEMENT	Γ OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORREC	CTION (EACH	(X5)	
PREFIX	MUST BE PRECEED	ED BY FULL REGULATORY O	R LSC	PREFIX TAG	CORRECTIVE ACTION SHO		COMPLETE	
TAG	IDENTI	IFYING INFORMATION)			CROSS-REFERENCED TO THE A	APPROPRIATE	DATE	
S 6701	Continued from page 3			S 6701				
				-				
					2) 0= 10/1/2015 ==== in stitut	1 -41		
					2) On 10/1/2015, we institute			
					performance of positive and			
					negative controls with each i	-		
					opened bottle of Metricide T			
					Strips. This was detailed in c	our		
					facility's plan of correction s	ubmitted		
					8/28/15 and approved. The b			
					test strips found on 11/4/15			
					opened before this new proc			
					was in place. This new quali			
						-		
					control procedure was perfor	-		
					our facility staff on their firs			
					day following the new QC p			
					10/2/15, using the already op			
					bottle. On 11/20/15, the Dire	ector of		
					Risk and Quality Manageme	ent and		
					the ASF person-in-charge re	viewed		
					the QC procedure and the co			
					logs finding appropriate			
					documentation and compliar	nce. On		
					11/21/15, the previously ope			
					bottle will be disposed of an			
				bottle of test strips opened an	na			
				controls run. The ASF				
					person-in-charge is is respon	sible		
					for ongoing monitoring of			
					compliance. In addition, the	Director		
					of Risk and Quality Manage	ment will		

State Form

ZJT912

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         8-5144       8-5144         NAME OF PROVIDER OR SUPPLIER:       PSP FAR NORTHEAST HEALTH CENTER         STATE LICENSE NUMBER:       9HEG8701         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX		STREET ADDRESS, 2751 COMLY PHILADELPI FICIENCY	A. BLDG: _ B. WING: _ CITY, STATE, Z ROAD	ID PROVIDER'S PLAN OF CORRECTION (EACH		EY (X5) COMPLETE	
TAG S 6701	Continued from page 4	IFYING INFORMATION)		S 6701	CROSS-REFERENCED TO THE / monitor compliance through scheduled and unannounced inspections. 3) On 11/20/15, the Director and Quality Management ma announced site visit to the fa observe sterile processing an review the communication a training plan with the ASF person-in-charge. She observ runs in both machines and fc wrapped surgical packs place the rack with sufficient air fl the loads came out dry. Also 11/20/15, the ASF person-in reviewed the DOH findings team and instructed them tha stacking packs is not allowed policy as it does not allow su air flow. The ASF person-in- will provide increased monit and by 12/15/15 will directly each staff person assigned to processing to ensure complia with policy. Any staff person stacking packs or overloadin autoclave will receive remed training and increased super-	site of Risk ade a ccility to ad nd ved two bund ed on ow and o on -charge with her at d per afficient -charge to sterile ance a found g the lial	DATE

State Form

ZJT912

IF CONTINUATION SHEET Page 5 of 11

Pennsylvania Department of Health

PLAN OF COI	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIEN IDENTIFICATION NUMBER 8-5144 NAME OF PROVIDER OR SUPPLIER:			A. BLDG: B. WING:	PLE CONSTRUCTION: 00 	(X3) DATE SURVEY COMPLETED: 11/04/2015	
PPSP FAR NORTHEAST HEALTH CENTER state license number: 9HEG8701		2751 COMLY PHILADELPI		154			
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY ( TAG IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION (EACH PREFIX TAG CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE	
S 6701	Continued from page 5			S 6701	Additionally, by 12/15/15 th Infection Control Policy wil updated to reflect the CDC C for Disinfection and Steriliz Healthcare Facilities, 2008. policy will state when loadin sterilizer staff will arrange it rack to allow the passage of will not overload the steriliz possible, sterilize like mater together; and ensure basins, surgical cups, etc. will be se edge or upside down to allow flow out freely as steam flow Also, when removing load fl sterilizer the load should be cool; care must be taken to k sterile items separated from non-sterile items. The Director of Risk and Qu Management will monitor compliance via scheduled ar unannounced site visits.	l be Guideline ation in The ng the tems on steam; er; when ials trays, et on w air to vs in. from dry and ceep	

State Form

ZJT912

IF CONTINUATION SHEET Page 6 of 11

Pennsylvania Department of Health

ri							
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER 8-5144			A. BLDG: _	IPLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 11/04/2015	ΞY
NAME OF PROVIDER OR SUPPLIER: <b>PPSP FAR NORTHEAST HEALTH CENTER</b> STATE LICENSE NUMBER: <b>9HEG8701</b>			STREET ADDRESS, 2751 COMLY PHILADELPH	ROAD			
(X4) ID     SUMMARY STATEMENT OF DEFICIENCIES (EACH DI       PREFIX     MUST BE PRECEEDED BY FULL REGULATORY OF       TAG     IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE /	OULD BE	(X5) COMPLETE DATE
S 6701	Continued from page 6		S 6701				
	<ul> <li>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.</li> <li>Findings include: <ol> <li>Review of facility administrative policy,</li> <li>Pharmaceuticals," dated August 2015, revealed "</li> <li>B. 1. When a multi-dose vial is used, appropriate infection prevention procedures to prevent contamination should be employed "</li> </ol> </li> <li>Review of facility policy, "Infection Control Plan,"</li> </ul>						
	dated October 15, 2015, revealed " Safe Injection Practices Use aseptic technique preparing medications "						
	Review of Centers for Disease Control and Prevention (CDC) recommendations "Inje Safety," dated March 2, 2011, revealed ". Parenteral medications should be accessed aseptic manner 2 Medications shou						

ZJT912

IF CONTINUATION SHEET Page 7 of 11

Pennsylvania Department of Health

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-5144		A. BLDG: _	PLE CONSTRUCTION: 00	(X3) DATE SURVEY COMPLETED: 11/04/2015	
NAME OF PROVIDER OR SUPPLIER: <b>PPSP FAR NORTHEAST HEALTH CENTER</b> STATE LICENSE NUMBER: <b>9HEG8701</b>			STREET ADDRESS, 2751 COMLY PHILADELPH	ROAD			
(X4) ID PREFIX TAG	FIX MUST BE PRECEEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE /	OULD BE	(X5) COMPLETE DATE
S 6701	Continued from page 7 drawn up in a designat is not adjacent to areas contaminated items are Observation on Noven of the procedure room standing near the medi syringes from an open 10 mg/10 ml (intraven preoperative sedation) of Lidocaine HCL 2% medication that is used pain). Further observat revealed EMP3 had a t syringes labeled Midaz November 4, 2015. Interview on November with EMP3 confirmed HCL injections were d room, which is conside contaminated area.	where potentially e placed." her 4, 2015, at 09:30 revealed EMP3 was cation cabinet while multi-dose vial of M ous medication that is and an open multi-d 20 mg/ml (intravence for prevention and ion of the procedure pasin with three prefi- colam 1 mg/ml and c er 4, 2015, at 09:40 <i>A</i> the Midazolam and rawn up in the proce	0 AM, filling fidazolam is used for ose vial ous control of room illed lated	S 6701			

State Form

ZJT912

IF CONTINUATION SHEET Page 8 of 11

Pennsylvania Department of Health

i			i				
	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER PLAN OF CORRECTION (POC) IDENTIFICATION NUMBE 8-5144			(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING:		(X3) DATE SURVEY COMPLETED: 11/04/2015	
NAME OF PROVIDER OR SUPPLIER: <b>PPSP FAR NORTHEAST HEALTH CENTER</b> STATE LICENSE NUMBER: <b>9HEG8701</b>			STREET ADDRESS, 2751 COMLY PHILADELPH	ROAD			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE /	OULD BE	(X5) COMPLETE DATE	
S 6701	Continued from page 8 2) Observation on Nov of the facility's exam re- performed, revealed and OPA Plus Test Strips. facility log book for test Test Strips revealed the September 12, 2105, and the test strips was cond 2015. Interview with EMP4 of 9:45 AM confirmed the Strips located in the fact test strips that EMP4 we Further, EMP4 confirm was opened on Septem the controls on the test October 2, 2015. EMP opened bottle of Metric not tested per manufac in the facility's plan of 3) Review of the facility	oom, where ultrasou opened bottle of Me Further, observation sting the MetriCide ( e bottle was opened on the date the contro- lucted was on Octob on November 4, 201 e MetriCide OPA Pl cility's exam room w yould currently be ut ned that the Test Stri iber 12, 2105, and the strips was conducted P4 confirmed that the cide OPA Test Strips turer instructions as correction.	nds are etriCide n of the OPA Plus on ols on er 2, 5, at us Test vere the ilizing. ps bottle e date d was on e newly s were identified	S 6701			

ZJT912

IF CONTINUATION SHEET Page 9 of 11

Pennsylvania Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER 8-5144			A. BLDG: _	IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 11/04/2015	
NAME OF PROVIDER OR SUPPLIER: <b>PPSP FAR NORTHEAST HEALTH CENTER</b> STATE LICENSE NUMBER: <b>9HEG8701</b>			STREET ADDRESS, 2751 COMLY PHILADELPF	ROAD			
(X4) ID PREFIX TAG	MUST BE PRECEED	<sup>C</sup> 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 2	OULD BE	(X5) COMPLETE DATE
S 6701	Continued from page 9 dated August 15, 2015 Sterilization The kit autoclave. Do not ove Observation on Noven the facility's sterile pro facility's sterilizer had sterilizer number one a contained three steriliz each other. The facilty submitted POC by ens the sterilizers as evider sterilized wraps on top Interview on Novembe EMP1 confirmed both sterilizer number two of wraps stacked on top of Interview on November with EMP3 revealed th employees received re- sterilizers was not on t	s are placed side by rfill " aber 4, 2015, at 9:50 be be a starting room reveal two table top sterilized and sterilizer number and sterilizer number and sterilizer number and did not follow their uring proper manage anced by stacking three of each other. er 4, 2015, at 9:50 Å <sup>2</sup> sterilizer number on contained three sterilies of each other. er 4, 2015, at 11:00 Å the training the facilitit garding the use of th	AM of ed the ters. Both two each top of ement of ee M, with he and ized	S 6701			

ZJT912

IF CONTINUATION SHEET Page 10 of 11

Pennsylvania Department of Health

PLAN OF COR NAME OF PRO <b>PPSP FAR</b>	OF DEFICIENCIES AND RECTION (POC) VIDER OR SUPPLIER: NORTHEAST HEALTH ( NORTHEAST HEALTH (	(XI) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBER 8-5144 CENTER	STREET ADDRESS, 2751 COMLY	A. BLDG:00 B. WING: STREET ADDRESS, CITY, STATE, ZIP CODE: 2751 COMLY ROAD PHILADELPHIA, PA 19154		(X3) DATE SURVEY COMPLETED: 11/04/2015	
(X4) ID     SUMMARY STATEMENT OF DEFICIENCIES (EACH D       PREFIX     MUST BE PRECEEDED BY FULL REGULATORY (       TAG     IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH (X5 CORRECTIVE ACTION SHOULD BE COMPL CROSS-REFERENCED TO THE APPROPRIATE DAT			
S 6701	Continued from page 10 facility utilizes. EMP2 infection control plan o wraps on top of each o	does not state to stac	-	S 6701			

ZJT912

IF CONTINUATION SHEET Page 11 of 11



# **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 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