Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5144	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 08/10/2016

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

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M 0000	INITIAL COMMENT This report is the result of an annual Registration survey conducted on August 10, 2016, 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 a full State Licensure survey conducted on August 10, 2016, at Planned Parenthood Far Northeast. 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 033G		S 033G		

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S 033G	Continued from page 1 553.3 (7) Governing Body Responsibilities Governing Body responsibilities include: (7) Assuring that the quality of care is evaluated and that identified problems are appropriately addressed. This REGULATION is not met as evidenced by:	S 033G	The ASF's (Planned Parenthood Southeastern Pennsylvania) Board Policy, approved by its governing body on June 19, 2012, indicates, "the board will receive quarterly updates on the risk and quality management of abortion services, therefore assuring that the quality of care is evaluated and identified problems are appropriately addressed." These updates, including reports of findings/actions from PPSP's Far Northeast Health Center when applicable, are provided via the agency's Senior Management Team report to the governing body. The Chief Operating Officer is responsible for ensuring the risk and quality management of abortion services is included in the quarterly reports. The COO serves as chair of the agency's Risk and Quality Management (RQM)Committee (quality assurance and improvement) and active member of the Patient Safety and Infection Control	Completion Date: **10/01/2016** Status: **APPROVED** Date: **10/03/2016**

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S 033G	Continued from page 2	S 033G	Committees. In this role, the COO participates in the review of identified problems and corrective actions to ensure that quality improvements are implemented and sustained. The COO includes findings discussed in these meetings in the quarterly Senior Management Team report. The required process of updating the governing body of quality care is included in the agency's "Risk and Quality Management (RQM) Overview and Workplan for Fiscal Year 2017". The Chief Operating Officer (COO) is responsible for review and revision of the annual RQM Workplan . The annual RQM Workplan is approved at the first board meeting of each Fiscal Year. To further ensure compliance, the approval of the fiscal year RQM Workplan and the annual approval of the governing bodies policy have been added to PPSP Board's annual work plan, and this Board work plan is available for Department review.	

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S 033G	Continued from page 3	S 033G	On 9/29/16, the 2017 RQM Workplan and the most recent Senior Management Team report will be presented and approved by the ASF's governing body. The ASF person-in-charge will be advised of and provided any updates, including the annual RQM Workplan and will have access to the governing body meeting minutes for Department review.	

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S 033G	Continued from page 4 Based on review of facility documentation and staff interview (EMP), it was determined that the facility failed to ensure that reports of findings of "PPSP Far Northeast Health Center" Quality Assurance and Improvement, Infection Control, and Patient Safety Committees were evaluated by the Governing Body and that identified problems were appropriately addressed. Findings include: Review on August 10, 2016, of facility's "Planned Parenthood Southeastern Pennsylvania By-laws," undated, revealed no requirement to ensure that findings of the Quality Assurance and Improvement, Infection Control, and Patient Safety Committees were evaluated by the Governing Body and that identified problems were appropriately addressed. Review on August 10, 2016, of "PPSP Medical Committee meeting minutes," dated May 12, 2016, revealed no documentation that findings of the Quality Assurance and Improvement, Infection	S 033G		

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S 033G	Continued from page 5 Control, and Patient Safety Committees were evaluated by the Governing Body and that identified problems were appropriately addressed for the PPSP Far Northeast Health Center. Interview on August 10, 2016, at 2:20 PM with EMP1 confirmed the above findings.	S 033G		
S 033S		S 033S		

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S 033S	Continued from page 6 553.3 (13)(i-iv) Govern Body Responsibilities Governing Body responsibilities include: (13) Approving major contracts or arrangements affecting the medical care provided under its auspices, including, those concerning; (i) The employment for contractual arrangements with practitioners and others providing direct patient care. (ii) The provision of all treatment related services including, radiology, medical laboratory, pathology , anesthesia and pharmaceutical services. (iii) The provision of care by other health care organizations. (iv) The provision of education to students and post graduate trainees. This REGULATION is not met as evidenced by:	S 033S	To ensure that contracted resources are provided in a safe and effective manner, the Chief Operating Officer (COO) will revise the ASF's (Planned Parenthood Southeastern Pennsylvania) Board Policy to include additional language, "the governing body will approve major contracts or arrangements affecting the medical care provided under its auspices." In addition, the COO will update the Risk and Quality Management (RQM) Workplan for FY2017 to include annual review of Governing Body responsibilities and related policies including ensuring governing body review of contracts. The revised policy and the 2017 RQM Workplan will be put forth for board review and approval at its next meeting on September 29, 2016. These documents will be available for Department review October 1, 2016. Beginning 10/1/16, the Chief Operating Officer (COO) is responsible for ensuring implementation and compliance	Completion Date: **10/01/2016** Status: **APPROVED** Date: **10/06/2016**

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S 033S	Continued from page 7	S 033S	monitoring of the updated Board policy. Board meeting minutes will reflect compliance to the requirement of contract review/approval and will be available for Department review. The ASF's RQM Committee and the COO will monitor and ensure compliance to the updated 2017 RQM Workplan.	

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S 033S	Continued from page 8 Based on review of facility documents, and interview with staff (EMP), it was determined the facility failed to review the facility's contracted services to ensure they were provided in a safe and effective manner. Findings include: Review of facility's "Planned Parenthood Southeastern Pennsylvania By-laws, "undated, revealed no requirement to ensure that contracted services were provided in a safe and effective manner. Review on August 10, 2016, of the facility's document "Risk and Quality Management Fiscal Year 2016 ... Plan, "undated, revealed no requirement for the governing body to ensure that contracted resources were provided in a safe and effective manner. Review of facility documents revealed the contracted services included housekeeping, linen,	S 033S		

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S 033S	Continued from page 9 heating and ventilation systems services, electrical system services, anesthesia services, infectious waste removal, ambulance services, pest control, hospital transfer agreement, laboratory services, equipment preventative maintenance, water service, environmental systems, and fire alarms services. Review on August 10, 2016, of the facility's "Quality Improvement Meeting Minutes," dated February 5, 2016, April 20, 2016, and June 15, 2016, revealed no documentation the quality assurance program reviewed the facility's contracted services. Interview on August 10, 2016, at 2:20 PM with EMP1 confirmed there was no documentation of quality analysis conducted for contracted resources.	S 033S		

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S 034G		S 034G		

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S 034G	Continued from page 11 553.4 (g) Other Functions 553.4 OTHER FUNCTIONS (g) The governing body shall ensure the licensee provides to the Department, the documents under 551.53 (relating to presurvey preparation). This REGULATION is not met as evidenced by:	S 034G	By 10/1/16, the Director of Risk and Quality Management (RQM) and Training will educate the Center Manager (ASF person-in-charge) on the requirement to have available all required documents onsite and ready for review the day of scheduled surveys. The Director of RQM and Training will ensure the Center Manager has all requested materials as applicable for Department review. Materials will be available onsite and the Director of RQM and Training will conduct a pre-survey site visit to review (including materials, staff schedules, and personnel files) to ensure compliance. 1) The ASF's Human Resources Manager ensures the maintenance of personnel files that include evidence of nursing staff current licensure and certification. Maintaining current licensure shows that nursing staff have met the state-required continuing education requirements (30 hours of continuing education including 2-3 hours of Department of	Completion Date: **10/06/2016** Status: **APPROVED** Date: **10/11/2016**

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S 034G	Continued from page 12	S 034G	Public Welfare (DPW) approved continuing education in child abuse recognition and reporting requirements). HR regularly monitors certification and licensure dates to ensure compliance and communicates issues to Center Manager as indicated. Additionally, we maintain training records for all agency (Planned Parenthood Southeastern Pennsylvania) required training in our Human Resources Department and these records are available for Department surveyor review. 2) The ASF's staffing schedule includes our nursing staff and the ASF person-in-charge will make these available for Department review. The Director of RQM and Training will instruct the Center Manager on this requirement and will include schedule review during periodic site visit (next visit in November). 3) By 10/1/16, the ASF's (PPSP's) Board Policy, approved by its	

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S 034G	Continued from page 13	S 034G	governing body on June 19, 2012, will be revised to include a list of approved operative procedures performed at its two Class B ASFs. The Chief Operating Officer (COO) will revise the Board policy and ensure it is put forth for board review and approval at its next meeting on September 29, 2016. The updated policy including the list of approved operative procedures performed at the facility will be available for Department review on 10/1/16.The COO is responsible for oversight and compliance with this regulation, and the Director of RQM and Training will ensure the Center Manager has the updated policy as part of the required documents for Department review. The Director of RQM and Training is responsible for implementation and ongoing monitoring for compliance of the Plan of Correction.	

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S 034G	Continued from page 14 Based on review of facility documentation and interview with staff (EMP), it was determined that the facility failed to provide records of continuing education for the nursing staff, staffing schedules, and a list of approved operative procedures performed at the facility. Findings include: Multiple requests were made to EMP1 on August 10, 2016, at 11:30 AM, 2:30 PM and 3:35 PM, for continuing education records of nursing staff, staffing schedules, and a list of approved operative procedures performed at the facility. None of the before mentioned documents were provided. Review on August 10, 2016, of the Department's material list for an annual licensure survey provided to the facility on July 11, 2016 via email, revealed "Please send a copy of the following material which is highlighted ... The remainder (material list) is to be made available on the first day of survey ... g. Continuing Education Program, h. List of	S 034G		

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S 034G	Continued from page 15 procedures performed at the facility ... 7. ...c. Staffing Schedules ...". Interview on August 10, 2016, at 10:00 AM, with EMP1 confirmed EMP1 received an email on July 11, 2016, that contained the list of documents required to be available on the day of the survey, to be reviewed onsite for licensure compliance.	S 034G		
S 6126		S 6126		

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S 6126	Continued from page 16 561.13 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 required by the ASF's policy "Periodic Provider Drugs Checks", dated June 12, 2012, the ASF maintains a log titled "Record of Periodic Physician Review of ASF Drug Storage" which is current and has a last date of review 8/26/16. This record was in a locked drug cabinet during the Annual Survey, and is available for Department review. Immediately following the Survey on 8/10/16, the ASF person-in-charge (Center Manager) located and reviewed the current log and policy. By 10/1/16, the "Record of Periodic Physician Review of ASF Storage" will be moved outside of the locked cabinet to ensure the Center Manager has easy access and can monitor compliance. The Director of Risk and Quality Management will ensure the ASF person-in-charge understands the requirement and the use of the log, and their responsibility to ensure compliance to regulation 561.13. The	Completion Date: **09/16/2016** Status: **APPROVED** Date: **10/06/2016**

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S 6126	Continued from page 17	S 6126	Director of Risk and Quality Management and Training will monitor for compliance during periodic site visits to the ASF.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5144	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 08/10/2016
NAME OF PROVIDER OR SUPPLIER: **PPSP FAR NORTHEAST HEALTH CENTER** STATE LICENSE NUMBER: **9HEG8701**	STREET ADDRESS, CITY, STATE, ZIP CODE: **2751 COMLY ROAD PHILADELPHIA, PA 19154**		

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S 6126	Continued from page 18 Based on a review of facility policy and staff interviews (EMP), it was determined that the facility failed to ensure all medication storage areas were periodically checked by a responsible pharmacist or practitioner. Findings include: Review on August 10, 2016, of facility's policy "Periodic Provider Drug Checks," dated June 12, 2012, revealed "The area in the ASF where drugs are stored shall be periodically checked by a responsible pharmacist or practitioner and proper logs maintained". Request was made to EMP1 on August 10, 2016, for documentation to indicate that the facility's areas containing medications were checked by a responsible pharmacist or practitioner. No documentation was provided. Interview on August 10, 2016, at 3:30 PM, with EMP1 confirmed that the facility has no documentation to show the area was checked by a	S 6126		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5144	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 08/10/2016

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S 6126	Continued from page 19 responsible pharmacist or practitioner.	S 6126		
S 6350		S 6350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	8-5144	A. BLDG: 00 B. WING:	08/10/2016

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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S 6350	Continued from page 20 563.5 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	1. As of 9/16/16, the Manager of Facilities and Purchasing cleared all building maintenance supplies from the locked medical record storage area. To ensure limited access "authorized personnel only" signage will be immediately posted to the storage area door by the Center Manager (ASF person-in-charge)and all facility staff will be educated on the appropriate storage of confidential patient information. To increase protection against loss or damage when the building is occupied, a manual fire extinguisher was installed (9/13/16) and by 9/16/16 the Center Manager ensured that all staff have been instructed on the location and the use of the extinguisher. By 10/10/16, the Center Manager will arrange for the secure offsite storage of the identified medical records with a vendor that guarantees protection against loss and damage. The Center Manager is responsible for ensuring ongoing offsite storage through regular archiving of medical records	Completion Date: **10/10/2016** Status: **APPROVED** Date: **10/06/2016**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5144	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 08/10/2016
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S 6350	Continued from page 21	S 6350	per guidelines detailed in the Retention of Files section of "Medical Records" policy (dated 6/19/2012), which was recently presented to the ASF's governing body on 9/29/16. The Manager of Facilities and Purchasing is responsible for ensuring proper storage of maintenance equipment and will regularly monitor the facility for compliance. The Director of Risk Quality Management (RQM) and Training is responsible for ensuring this Plan of Correction is implemented and will monitor compliance of the proper storage of medical records in November and during periodic site visits. 2. During the 8/10/16 survey visit, the Procedure Log books were immediately removed from the Lab Room closet and all facility staff members were reminded that no storage is allowed in this area. The Center Manager (ASF	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5144	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 08/10/2016

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S 6350	Continued from page 22	S 6350	person-in-charge) is responsible for educating all staff (current and new) on the appropriate storage of confidential patient information. The Center Manager will periodically check the closet to ensure compliance and the Director of RQM and Training will monitor compliance during site visits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5144	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 08/10/2016

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S 6350	Continued from page 23 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 prevent loss, damage and unauthorized access. Findings include: Review on August 10, 2016, of facility policy "Medical Records," no review date, revealed "Retention of Files ... 4. Safeguards against loss and use by unauthorized persons must be maintained." 1. Observation on August 10, 2016, at 12:10 PM of the facility's medical record storage area revealed a locked storage area that contained 29 cardboard boxes of medical records and building maintenance supplies that included paint, ladders, light bulbs, cleaning chemicals. Further observation revealed the boxes were stored on open metal shelving and the room contained one smoke detector and no manual or automatic fire extinguishing equipment.	S 6350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5144	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 08/10/2016

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S 6350	Continued from page 24 Interview with EMP1 August 10, 2016, at the time of the observation confirmed the card board boxes stored in the area contained patient information from 2007 to 2014, that included medical records from procedures completed at the facility, pregnancy testing results, family planning and fetal ultrasound documents. Further interview confirmed equipment and supplies for the maintenance of the facility are also stored in the medical record storage area. Interview with EMP1 on August 10, 2016, at 12:38 PM confirmed the facility's maintenance staff have access to the medical record storage area, aresulting in unauthorized access to confidential patient information. Further interview confirmed medical records stored in cardboard boxes would not be protected from smoke, fire and water damage if there was fire in the location. 2. Observation on August 10, 2016, at 12:20 PM of the Lab room sump pump closet revealed patient medical records "AB (abortion) Procedure Logs, dated from January 1, 2011 to December 31, 2011,	S 6350		

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S 6350	Continued from page 25 and January 1, 2012, to January 31, 2012, stored on a shelf in the closet. Interview with EMP1 August 10, 2016, at the time of the observation confirmed the log books were placed in the closet for storage prior to shredding the documents. Interview with EMP1 on August 10, 2016, at 12:38 PM confirmed the facility's maintenance staff and unauthorized staff have access to the sump pump closet.	S 6350		
S 636C		S 636C		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5144	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 08/10/2016
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S 636C	Continued from page 26 563.6 (c) Preservation of Medical Records 563.6 Preservation of medical records (c) If an ASF discontinues operation, it shall make known to the Department where its records are stored. Records are to be stored in a facility offering retrieval services for at least 5 years after the closure date. Prior to destruction, public notice shall be made to permit former patients or their representatives to claim their own records. Public notice shall be in at least two forms, legal notice and display advertisement in a local newspaper of general circulation. This REGULATION is not met as evidenced by:	S 636C	The "Medical Records" as described below was presented and approved by the governing body on 9/29/16. By 9/29/16, the Director of Risk/Quality Management and Training will update the ASF's policy "Medical Records" to include, "the plan to notify the Department where medical records would be stored if operations where discontinued" and "the plan to publicly notify patients or their representative to claim their own records prior to destruction" in compliance with 563.6. The updated "Medical Records" policy will be presented to the ASF's governing body (Board) on September 29,2016. The Director of Risk/Quality Management and Training will ensure the approve updated policy is published and available to the ASF person-in-charge for review by the Department by 10/1/16. The Director of Risk/Quality Management and Training is responsible for the education of the new policy to the ASF	Completion Date: **10/06/2016** Status: **APPROVED** Date: **10/11/2016**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5144	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 08/10/2016

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S 636C	Continued from page 27	S 636C	person-in-charge.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5144	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 08/10/2016

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S 636C	Continued from page 28 Based on a review of facility policy and staff interview (EMP), it was determined the facility failed to incorporate all requirements for the preservation of medical records in the event the facility should discontinue operations. Findings include: A review on August 10, 2016, of the facility"s policy "Medical Records" no review date, revealed no documented evidence the facility had a plan in place to notify the Department where medical records would be stored if operations would be discontinued and no provisions to publicaly notify patients or their representatives to claim their own records prior to destruction. An interview conducted on August 10, 2016, at 11:00 am AM with EMP1 confirmed that the facility policy did not incorporate all required state requirements for the preservation of medical records.	S 636C		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5144	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 08/10/2016

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S 636C	Continued from page 29	S 636C		
S 6744		S 6744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5144	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 08/10/2016

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S 6744	Continued from page 30 567.41 MAINTENANCE SERVICE - Principle 567.41 Principle The ASF shall be equipped, operated and maintained to sustain its safe and sanitary characteristics and to minimize health hazards in the ASF for the protection of patients and employes. This REGULATION is not met as evidenced by:	S 6744	By 9/29/16, the Director of Clinical Services will update the ASF's Infection Control Plan to include specific guidance on locked storage of Formalin as indicated in the MSDS for 10% Neutral Buffered Formalin, dated January 2013. By 10/10/16, the Director of Clinical Services will ensure facility staff are educated on the proper storage of Formalin and informed of the updated policy. Once updated, Infection Control Plan will be presented to the governing body for review and approval at their next meeting (9/29/16). By 9/1/16, the ASF person-in-charge had informed all staff (verbally and via email) that the cabinet containing Formalin must be locked at all times to prevent unauthorized access and to minimize health hazards in the ASF for the protection of patients and employees. Additionally, the cabinet has been labeled with a biohazard material sticker. The Center Manager (ASF	Completion Date: **10/10/2016** Status: **APPROVED** Date: **10/06/2016**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5144	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 08/10/2016
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S 6744	Continued from page 31	S 6744	person-in-charge) is responsible for the proper storage of formalin and will regularly (daily for now, monthly ongoing) monitor compliance immediately addressing any issues found. The Director of Risk and Quality Management and Training will monitor compliance on the storage of Formalin at next site visit (November) and during periodic site visits, reporting findings to the Center Manager and Director of Clinical Services via site visit report. The Director of Clinical Services is responsible for the successful implementation of this Plan of Correction and reporting to the ASF's Infection Control Committee.	

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S 6744	Continued from page 32 On August 10, 2016, a request was made for a policy regarding the storage of Formalin and none was provided. Review on August 10, 2016, of the MSDS (Material Safety Data Sheet) for 10% Neutral Buffered Formalin, dated January 2013," revealed "Section 2: Hazards Identification ... P405- Store locked up." Observation on August 10, 2016, at 1:00 PM revealed 60 clear plastic containers of 10% Neutral Buffered Formalin in an unlocked cabinet located in an area adjacent to the procedure rooms. Interview on August 10, 2016, with EMP1 confirmed [they] did not know Formalin was to be locked up, and confirmed the Formalin containers were stored in an area accessible by unauthorized staff.	S 6744		

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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	By September 30, 2016, the Manager of Facilities will submit a request for inspection to the local fire department. The Manager of Facilities is responsible for making this request annually and providing record of the request to the ASF person-in-charge. Records of fire inspections and/or request for inspections will be available for Department review.	Completion Date: **10/01/2016** Status: **APPROVED** Date: **09/20/2016**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5144	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 08/10/2016

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S 6916	Continued from page 34 Based on a review of facility documents and staff interview (EMP), it was determined the facility failed to request an annual inspection by the local fire department for the year 2015. Findings include: Review on August 10, 2016, of policy "Fire Safety Program," dated June 19, 2012, revealed "... PPSP's Director of Facilities is responsible for the ongoing compliance of annual fire inspection and requesting our annual inspections from the local fire departments." Request was made to EMP1 on August 10, 2016, for documentation to indicate that the facility requested an annual inspection from its local fire department for the year 2015. No documentation was provided. Interview on August 10, 2016, at 1:30 PM, with EMP1 confirmed the facility did not request an inspection by the local fire department for 2015.	S 6916		

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5144	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 08/10/2016
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S 6916	Continued from page 35	S 6916		

Certified End Page

PPSP FAR NORTHEAST HEALTH CENTER

STATE LICENSE NUMBER: 9HEG8701

SURVEY EXIT DATE: 08/10/2016

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

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY