		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	IBER: A. BLDG:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:			
8-0607			B. WING: 11/18/2011						
	VIDER OR SUPPLIER: PARENTHOOD KEYSTO	ONE - READING	STREET ADDRESS, CITY, STATE, ZIP CODE: 48 SOUTH FOURTH STREET READING, PA 19602						
STATE LICENS	E NUMBER: 00228701		KL/IDII(G, I	READING, 1A 17002					
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	(X5) COMPLETE DATE				
M 0000	INITIAL COMMENT			М 0000					
	This report is the result of an initial registration survey conducted on September 28, 2011, at Planned Parenthood of Northeast & Mid-Penn-Reading. It was determined that 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.								
М 9999				М 9999					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:									

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
8-0607			A. BLDG: B. WING:		11/18/2011		
NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - READING STATE LICENSE NUMBER: 00228701			STREET ADDRESS, CITY, STATE, ZIP CODE: 48 SOUTH FOURTH STREET READING, PA 19602				
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	(X5) COMPLETE DATE		
М 9999	Continued from page 1 Recommendation This REGULATION is not met as evidenced by:			М 9999	POC is optional and not required. This Plan of Correction is optional and Planned Parenthood of Northeast and Mid-Penn wants to assure the DOH that we strive to comply with all state regulations. ALL corrections were made within 24 hours of the facilty tour. 1. a) The one oxygen tank was removed and disposed of according to regulations by a local oxygen supply company. b) The two fire extinguishers were taken to ATS Security for disposal. 2. Our medical equipment		Completion Date: 09/29/2011 Status: APPROVED Date: 12/08/2011
					2. Our medical equipment maintenance company came facility the same day to servi attach the proper label. 3. We purchased a temperate gauge for the freezer and pla log on top of the freezer to dand monitor freezer temperate.	ure ced a ocument	

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Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:		
8-0607				<u></u>	11/18/2011			
NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - READING STATE LICENSE NUMBER: 00228701			STREET ADDRESS, CITY, STATE, ZIP CODE: 48 SOUTH FOURTH STREET READING, PA 19602					
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE		
M 9999	Continued from page 2		М 9999					
	A tour of the facility on September 28, 201 resulted in the following recommendations. Submission of a plan of correction is encoubut not required. Findings: Rest room - Three tanks were stored on the one unsecured oxygen tank and two expired extinguishers. Procedure Rooms 1 & 2 - Each room had a vacuum aspirator which did not have a previous maintenance label attached to indicate the edate. The freezer did not have a gauge to ensure temperatures were maintained. There was a document and monitor freezer temperatures.		e floor, d fire ventive expiration proper no log to					

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Pennsylvania Department of Health

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-0607		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 11/18/2011		
NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - READING STATE LICENSE NUMBER: 00228701			STREET ADDRESS, CITY, STATE, ZIP CODE: 48 SOUTH FOURTH STREET READING, PA 19602					
(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		(X5) COMPLETE DATE	
M 9999	Continued from page 3		м 9999					

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Certified End Page

PLANNED PARENTHOOD KEYSTONE - READING

STATE LICENSE NUMBER: 00228701 SURVEY EXIT DATE: 11/18/2011

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

Susan Cople



Rachel L. Levine, MD

Secretary of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY