These are primarily health department inspection reports, supplemented with some media coverage and other documents.

No state inspections for these types of facility are held in: Alaska, Colorado, Hawaii, Idaho, Iowa, Maine, Minnesota, Mississippi, Montana, New Hampshire, New Mexico, Rhode Island, Vermont, and West Virginia. There are no Planned Parenthood centers in Mississippi, North Dakota or Wyoming

Inspections are held in New York, but what violations were found and at which location is heavily redacted and therefore not available to the public.

California investigates individual complaints with no full health inspections. Many of the health department documents contain nothing other than privacy complaints.

Incidents in health inspection reports that involved an ambulance to the hospital are marked with this graphic.

The website version, organized by locations, is constantly updated. It also includes documentation of malpractice suits, 911 calls, employee legal complaints, and cases involving sexual abuse, privacy violations or financial ethics:

www.problemsatplannedparentood.org

United States

	Botched Care and Tired Staff: Planned Parenthood in Crisis by Katie Benner, *The New York Times*, February 15, 2025

Excerpt:

A New York Times review of clinic documents and legal filings, as well as interviews with more than 50 current and former Planned Parenthood executives, consultants and medical staff members, found that some clinics are so short of cash that care has suffered. Many operate with aging equipment and poorly trained staff, as turnover has increased because of rock-bottom salaries . . .

Employees at various affiliates said it was common to run out of over-the-counter pain medication and I.V. flushes . . .

Clinic employees said repeatedly in interviews that patients routinely encountered long waits, undertrained staff members and trouble even booking an appointment.

“I saw clients get turned away for services because they couldn’t afford it and the process of getting aid through Planned Parenthood took too long,” said Damien Hamblin, a medical assistant who worked at health care clinics before joining Planned Parenthood Arizona in 2022; he later left. “We’re supposed to be the organization for people that don’t have resources.”

Multi-State

	Botched Care and Tired Staff: Planned Parenthood in Crisis by Katie Benner, *The New York Times*, February 15, 2025

Excerpt:

in many clinics, they also draw blood and take vital signs. Medical assistants in Ohio, Minnesota, Arizona, California, New York, Texas, Indiana and Illinois said they practiced blood draws and I.V. placements for an hour or so on a fake arm and then on a colleague before performing the procedures in clinics. But they said they sometimes ran into problems, and some said they did not know what to do when they arose. Mr. Hamblin, the medical assistant in Arizona, said that he was often asked to draw blood after other assistants had failed.

Affiliate: North Central States

Covers Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

	Botched Care and Tired Staff: Planned Parenthood in Crisis by Katie Benner, *The New York Times*, February 15, 2025

Excerpt:

For months last year at the North Central States affiliate, which oversees the Nebraska clinic, an understaffed nursing department did not upload sexually transmitted infection test results into charts, and patients wrongly believed that their results were negative when they did not hear back.

Alabama

Birmingham

The health department documents from 2009, 2013, 2014, 2016, and 2021 are at:

www.problemsatplannedparenthood.org/alabama

Highlights:

Clinic Conditions

- The clinic failed to ensure staff cleaned equipment used in surgery, nor clean chairs in the recovery room, nor wash their hands.
- An examination table was in disrepair, increasing the chance of infection.

Medical Records and Labels

- Paperwork given to women before surgery failed to include the names of medications given, what medications were to be taken home, and omitted the name of the doctor operating on them.

Incidents

- In 2014, two employees sold drugs to patients in the parking lot. The director fired all staff. To hire and train new staff, the facility was closed, but the director never informed the Health Department of the closure. None of the former employees cooperated with health inspectors.

Arizona

	Botched Care and Tired Staff: Planned Parenthood in Crisis by Katie Benner, *The New York Times*, February 15, 2025

In one incident, a young woman who received an IUD was told “it would be rough, and just ride it out,” according to a written complaint emailed to the office of the Planned Parenthood affiliate’s president. She said she suffered months of sharp pain and bleeding, but the phone system routed her mother’s calls for help to automated phone tree messages, according to the complaint. A new doctor found that Planned Parenthood had botched the procedure. The affiliate continued to bill the family, even though they had paid their balance, according to the complaint.

Arkansas

Little Rock

The health Department documents from 2016 and 2018 are under Little Rock:

www.problemsatplannedparenthood.org/arkansas

Highlights:

Clinic Conditions

- Items required for patient care weren’t stored in a clean environment. For example, white drapes used in exams were left on the floor of the storage room. The clinic was cited for allowing the contamination of patient care equipment.
- The facility “failed to ensure that equipment was kept in good repair.”
- A stool in the ultrasound room had a cloth covering which “has an absorbent nature and cannot be disinfected.” A hole in the covering extended down into the cushion.

Other

- The facility was required to make available a list of emergency phone numbers and contact information for police, the fire department, ambulance services, and other emergency responders. The list hadn’t been updated in two years. This could cause a delay in contacting emergency.

Arizona

Flagstaff

The health department document from 2016 are under Flagstaff:

www.problemsatplannedparenthood.org/arizona

Highlights:

- The facility failed to properly sterilize instruments and textiles that "may come in contact with a patients' blood and internal tissue." Using unsterilized, dirty instruments on multiple women has the potential to spread infection.

Glendale

The health department documents from 2015 and 2020 are under Glendale:

www.problemsatplannedparenthood.org/arizona

Highlights:

Clinic Conditions

- They used expired medications on patients. Some were two years past their expiration dates.
- Staff failed to perform required spore tests on the autoclaves (machines used to sterilize instruments). This could lead to "a potential risk of cross contamination and infection to their patients" according to the report.
- Staff failed to properly maintain, clean, and sterilize the autoclaves as per the manufacturer's instructions. There was no documentation that the autoclaves were cleaned on a weekly or even monthly basis.
- When blood dripped from a used speculum onto the floor, staff was observed wiping it up with paper towels and cleaning spray rather than using bleach and properly disinfecting the floor.
- Hazardous chemicals weren't properly labeled.
- Staff didn't properly clean and disinfect post-procedure specimen bottles.
- Staff failed to clean and sanitize examination tables between patients.
- There were multiple tears and punctures in the upholstered material of an examination table, exposing stuffing. This presents an infection risk as it makes the surface difficult or impossible to properly disinfect.

Incidents

- A patient had an adverse reaction to sedation administered before a procedure. She suffered severely low blood pressure. This wasn't reported to the medical director or recorded in the procedure notes. The RN who administered the sedation wasn't licensed to do so. When asked to show what protocols were in place for treating patients suffering severe hypotension (dangerously low blood pressure) the clinic was unable to provide any. The facility also had no guidelines for what blood pressure measurements indicated severe hypotension. According to the report, the center manager "verified, during an interview conducted on 2/13/15, that there are no established blood pressure parameters for severe hypotension, standing orders, and/or facility policy that identifies the care and treatment of a patient experiencing severe hypotension after adversely reacting to a medication provided for conscious sedation."

Tempe

The health department documents from 2014 are under Tempe:

www.problemsatplannedparenthood.org/arizona

Highlights:

Clinic Conditions

- Didn't have a policy for the use, cleaning, and preventive maintenance of certain equipment used on patients, such as heating pads.
- The facility appeared to be using irrigation solution (Braun 0.9% Sodium Chloride) that, by manufacturer's standards, should have been discarded.
- The autoclave, used to sterilize the instruments, was required to be cleaned weekly. However, the last documented cleaning was nearly three months prior to the inspection. Staff couldn't verify the autoclave had been cleaned more recently than that.
- The clinic staff failed to monitor how many cycles the autoclave was running. This was supposed to be done automatically by a printout attached to the machine. However, the paper in the printer had run out and hadn't been replaced.

California

California investigates individual complaints but does not do full health inspections.

Antioch

The health department document from 2016 is under Antioch:

www.problemsatplannedparenthood.org/california-a-to-f

Highlights:

Staff

- Unlicensed and untrained staff were seeing patients and giving medical care.
- Employees were counseling patients, giving medical advice, examining patients, and obtaining informed consent even though they weren't qualified to do so.
- The staff member who performed vaginal ultrasounds was untrained and unqualified, with only a high school diploma with one medical assistant class. A transvaginal ultrasound is an invasive procedure.
- The medical director stated the only requirement in hiring an ultrasound technician was a high school diploma.
- The head of ultrasound training wasn't a certified ultrasound technician.
- According to the medical director, all 20 clinics she supervised employed untrained ultrasound technicians who were merely certified as medical assistants. The director stated she felt medical assistants were qualified to do ultrasounds but was unable to give an example of a health care facility, other than her clinics, where they were doing so.

Incident

A woman suffered a severe complication, and the clinic failed to cooperate with investigators as to the incident. Surveyors were turned away twice and not permitted to inspect the facility. Clinic staff refused to allow inspectors access to the patient records, refused to allow inspectors entry into the facility, and when they did allow investigators access to electronic records, refused to let them make copies or take notes.

The patient later began bleeding heavily and passed large clots, one of which was the size of a baseball. She passed out and went to the hospital. The patient later said, "I could have died." She needed surgery and a blood transfusion.

The nurse who gave the patient medications wasn't licensed to do so and failed to follow clinic protocol. She gave the patient three extra medications.

Burbank

The 2019 Court Complaint is under Burbank:

www.problemsatplannedparenthood.org/california-a-to-f

7 . . . on October 9, 2018, Plaintiff's insured witnessed water flowing onto the premises from a toilet that had overflowed . . .

13. As a result of the negligence of Defendants and each of them, Plaintiff's insured sustained at least $296,158.54 in damages.

Orange

The health department document from 2014 is under Orange:

www.problemsatplannedparenthood.org/california-g-to-r

Highlights:

One patient suffered copious bleeding after surgery and was sent to the hospital to be treated for complications and blood loss. Staff failed to properly document the incident in their records.

- A second patient also bled heavily after surgery. She was sent home with active bleeding after passing a large blood clot. It was estimated from her hemoglobin level that she lost 720 ml of blood. The clinic failed to document the amount of blood loss in their records.

San Jose

Doctor's License Revoked – Joplin

Dr. Joplin served at Planned Parenthood, primarily at the San Jose Center, for many years and was working there at the time of his license revocation in 2011. The full license orders from 2011 and a previous one from 1997 are at:

www.problemsatplannedparenthood.org/california-san-jose

Excerpt from the 2011 license document:

8. . . . it was alleged that Respondent engaged in unprofessional conduct in that he consumed alcohol to excess and to an extent he endangered himself and others, and that he had been criminally convicted on two separate occasions of offenses

related to the use and consumption of alcohol . . . Respondent's license was revoked, stayed, with seven years probation. The terms and conditions of probation . . . required him to abstain completely from the use of products or beverages containing alcohol, submit to biological fluid testing, undergo a psychiatric evaluation, participate in psychotherapy, have a practice monitor, and not engage in the sole practice of medicine . . .

9.A. . . . Respondent failed to comply with this term of his probation in that multiple bodily fluid tests resulted in a positive test result for the presence of alcohol.

Excerpt from the 1997 license document:

First Cause for Disciplinary Action

E. Y.G. had a normal prenatal course until on or about March 28, 1990 . . .

11.G. Despite elevated blood pressure, proteinuria and other findings on examination, respondent did not consider and/or did not chart the possibility of preeclampsia, did not consider and/or did not chart the potential for early induction of labor in Y.G. and did not conduct appropriate patient surveillance. . .

11.I. Four days later, on April 9, 2990, Y.G. presented to the Emergency Room at South Valley Hospital with complaints of severe acute low back pain. . . . Y.G. was diagnosed with toxemia. Emergent medical measures were taken. After delivering a viable male infant, Y.G. died on April 10, 1990.

12 . . . he is guilty of gross negligence and/or incompetence in the practice of his profession . . .

Second Cause for Disciplinary Action

13.B. On July 17, 1993, patient M.M. presented to respondent for examination at the Planned Parenthood Clinic in Seaside, California . . . Respondent recorded in the chart that the patient was 9 and ½ weeks pregnant. Respondent preformed a pelvic examination at that time and recorded that the uterus was soft and felt approximately 11-12 weeks size . . .

13.C. On July 17, 1993, respondent undertook to perform an abortion . . .

13.D. Respondent ordered M.M. transferred to Natividad Medical Center, Where ultrasound demonstrated the fetus to be 27 weeks. Labor was induced and the female stillborn was taken for evaluation by the County Coroner.

13.E. At all relevant times, respondent knew, or in the exercise of reasonable care should have known, that M.M.'s fetus was 27 weeks and viable.

14. . . . he is guilty of gross negligence and/or incompetence .

Thousand Oaks

The health department documents from 2014 and 2018 are under Thousand Oaks:

www.problemsatplannedparenthood.org/california-s-to-z

An employee who was unfamiliar with the ultrasound machine mistakenly dated a patient's pregnancy. It was measured at 13 weeks when it was actually over 21 weeks. Prior to the procedure, the employee asked a nurse practitioner and the doctor to review the picture. Neither recognized it was incompatible with a pregnancy of 13 weeks. The doctor began surgery, but couldn't complete it, due to the advanced pregnancy. The woman was transferred to a hospital.

. .

Ventura

The health department document from 2013 is under Ventura:

www.problemsatplannedparenthood.org/california-s-to-z

A 23-year-old woman, after surgery, began to bleed heavily. The staff unsuccessfully administered medicine to stop the bleeding, then called 911. According to paramedics, the woman was "confused with slurred speech." Her blood pressure was dangerously low.

At the hospital, the woman was said to be in "severe distress" and "hemorrhagic shock." The woman was given a "massive transfusion" and taken into surgery. Surgeons found that the doctor had perforated her uterus. A hysterectomy was done, and the patient permanently lost her ability to have children at 23.

Though legally required to, the clinic failed to report the complication to the California Department of Health; it only came to light with an anonymous tip. Clinic staff claimed they were "unaware" complications needed to be reported, implying they never reported complications to the Department of Health.

Connecticut

Bridgeport

The below is taken from a video of testimony before the Connecticut House of Representatives by Connecticut state representative Treneé McGee (D), April 19, 2022. The video is under Bridgeport:

www.problemsatplannedparenthood.org/connecticut

Excerpt:

The matter of Black life began for me when I talked to a young woman . . . She got a pill [from Planned Parenthood in Bridgeport] . . . And three days later she could not walk. She landed in the hospital . . . And she then had an infection behind her uterus. She needed a blood transfusion. And she relearned how to walk which it took her a month to do . . . She didn't have the resources to pursue a case.

Hartford

The health department document from 2016 is under Hartford:

www.problemsatplannedparenthood.org/connecticut

Highlight:

The clinic failed to have needed emergency supplies.

New Haven

The health department documents from 2015 and 2018 are under New Haven:

www.problemsatplannedparenthood.org/connecticut

Highlights:

Clinic Conditions

- The autoclave, used to sterilize instruments, had not been cleaned for three months. The clinic manager was “not sure” why it hadn’t been cleaned.
- According to the inspection, “the facility failed to ensure that infection control practices were maintained.” The sterilization logs didn’t document the results of the steam indicator placed in each load of sterilized instruments.
- Medications were stored in a refrigerator with cans of ginger ale for the staff.
- Chairs in the recovery room were cloth-covered, meaning that they couldn’t be properly sterilized or cleaned.
- Prefilled syringes weren’t labeled with the dates and times filled, the initials of the staff member who filled them, and the doses.

Staff

- The staff didn’t properly clean instruments. Staff failed to mix the solution for cleaning instruments properly. Staff didn’t measure the amount of detergent to mix with water but estimated instead. They didn’t follow the manufacturer’s instructions to ensure a strong enough solution to properly clean the instruments.

Medical Records and Labels

- The times medications were given and the staff giving them weren’t recorded.
- In a subsequent inspection, records were also incorrect.

Incidents

- Before one woman’s procedure, a nurse noted no drug allergies. However, her later records showed that she was allergic to a Keflex. Fortunately, the woman didn’t suffer complications or a drug reaction, but the inconsistency in charts could’ve presented a risk.

Treatment of Patients

- Single-use intravenous fluids were used on multiple patients.
- Opened medications weren’t properly labeled and didn’t have expiration dates, leading to the use of expired medications on patients.

Norwich

The health department document from 2015 is under Norwich:

www.problemsatplannedparenthood.org/connecticut

Highlights:

Clinic Conditions

- Bags of soiled laundry, likely stained with bodily fluids, were stored in a post-anesthesia care area. Clinic staff admitted that the bags had been there for five days.
- Instruments required to be sterile were stored in the dirty decontamination area, along with multiple boxes, supplies, and equipment.
- The emergency light fixture in the staff bathroom wasn't working, nor the emergency light fixture in the waiting area. This was a violation of the fire code.
- Fire alarms and smoke detectors weren't regularly tested.

Staff

- Staff members didn't have the proper medical credentials.

Medical Records and Labels

- Sterilization logs were missing patient information. Instruments used on different women, therefore, weren't tracked to maintain proper infection control.
- Records for one patient failed to indicate that a comprehensive medical assessment was performed before surgery. Clinic staff claimed that one was performed but was not recorded due to a new computer system.

Torrington

The health department document from 2014 is under Torrington:

www.problemsatplannedparenthood.org/connecticut

Highlights:

Clinic Conditions

- According to the inspection report, "the facility staff failed to follow acceptable infection control practices."

Medical Records and Labels

- An open multi-use vial of medication wasn't marked with the date it was opened or with the discard date. Another vial was missing the discard date. This meant that clinic staff didn't know when to discard these vials and risked giving expired medicine to women.

Waterbury

The health department document from 2015 is under Waterbury:

www.problemsatplannedparenthood.org/connecticut

Highlights:

- Medications and hepatitis vaccines were stored in the dirty utility room along with used, soiled instruments. This included an open, half-empty, multi-use vial of an injectable drug stored in a refrigerator. There was no documentation on the vial of when it was opened or when it should be discarded.
- The medication refrigerator was located under the sink in the dirty utility room where dirty instruments were washed.
- Blood samples were stored with medication in the refrigerator in the dirty utility room. According to the report, these blood samples "failed to be stored in a tightly sealed container in the refrigerator."

West Hartford

The health department document from 2015, 2018, and 2020 are under West Hartford:

www.problemsatplannedparenthood.org/connecticut

Highlights:

Clinic Conditions

- Test strips are included with each load of instruments sterilized in the autoclaves. One test strip indicated a load wasn't properly sterilized. However, there was no indication in the records these instruments were subsequently sterilized again, as per proper procedure.
- The facility had cloth-covered chairs in the recovery room. These chairs couldn't be properly sterilized or cleaned.
- A cloth pillow in the procedure room wasn't cleaned between patients. The clinic failed to use disposable covers for the pillow and reused the same pillow.
- The clinic failed to test and maintain fire alarms and sprinklers.

Staff

- A staff member failed to wash her hands before preparing the procedure room for a patient.

Medical Records and Labels

- Staff repeatedly failed to document whether test strips indicated instruments were properly sterilized. (See above)
- Medical records were incomplete. The times medications were given weren't documented, nor the names of the staff members giving medications.
- There was a discrepancy in the records about the type of sedation one patient received. One set of records indicated she received intravenous moderate sedation but failed to mention the medication given. The other record indicated fentanyl and Versed were given.
- In a later inspection, one patient's records mistakenly identified the procedure she had – the procedure checked off in her informed consent paperwork wasn't the one she received. This mistake could have jeopardized the integrity of the informed consent process.
- This same patient had a complication that staff failed to document. The patient was taken to the hospital via ambulance, but documentation stated the procedure had no complications and the patient "tolerated the procedure well."
- Staff confirmed the paperwork was automatically filled out before the procedure took place and wasn't changed to reflect what happened.

Incidents

A woman at the facility suffered a complication during a medical procedure and was sent to the hospital via ambulance. She was admitted for treatment. (See under documentation above.)

Treatment of Patients

- IV fluids meant to be single-use were reused for multiple patients.

Other

- The staff failed to conduct fire drills and emergency preparedness training.
- The cabinet containing narcotics was left unlocked and unattended.
- There was a discrepancy in the records about the type of sedation one patient received. One set of records indicated she received intravenous moderate sedation but failed to mention the medication given. The other record indicated fentanyl and Versed were given.

Delaware

See several documents:

www.problemsatplannedparenthood.org/delaware

Excerpt from Testimony to the Delaware State Legislature by Nurse Mitchell-Werbrich:

On April 20, 2012, I was hired as a recovery room nurse at Planned Parenthood of Delaware. I worked a total of 27 days (approximately) at Planned Parenthood. I worked 16 days at Planned Parenthood of Delaware's Wilmington site and 11 days at Planned Parenthood of Delaware's Dover site. I was forced to resign on August 8, 2012 as the conditions at Planned Parenthood continued to be unsafe and potentially life-threatening for the . . . I feared that a patient was going to end up being harmed and that I would lose my nursing license. I also endured a hostile environment at Planned Parenthood after reporting the horrendous conditions that were occurring there . . .

I witnessed meat market style assembly line abortions. This type of care was something I had never seen before in my entire nursing career. On an average day at the Wilmington Planned Parenthood site one abortion would be completed every 8-10 minutes. The doctor would be in such a hurry to get the patients in and out that he himself would bring the patients back into the unclean procedure room where the examination table would still have bloody drainage and body fluids on it from the previous patient . . .

Another very serious concern I had at Planned Parenthood was the mishandlings of RhoGAM. RhoGAM is a product that must be given within 72 hours to every . . patient whose Rh factor is negative after having an abortion. . . I cannot help but think of all the Rh negative women that may be suffering from not having the RhoGAM they needed. It is likely that many women in Delaware may have to deal with future babies who have severe anemia, jaundice, brain damage, heart failure or even death. The sad thing is that these women may not even realized the fact that Planned Parenthood could be at fault for these medical tragedies even years after they had their abortions at Planned Parenthood . . .

I witnessed that the emergency box and equipment contained expired emergency medications as well as faulty emergency equipment such as an oxygen mask that was no longer functional. This could potentially cause death to a patient in need of emergency care . . .

I had reported to both of these state agencies the many unsafe conditions which included that there were no guidelines, no standards of care, no procedure, or protocol manuals to be found anywhere, intravenous (IV's) were being started using an unsterile technique and patients endured multiple needle sticks. I reported that Planned Parenthood's Dr. Timothy Liveright had struck a patient by inappropriately slapping her at the dilation phase during an abortion. I reported that most of the Planned Parenthood Staff members did not wear protective gear or utilize universal blood and body fluid

precautions; consents for sedation and procedures were sometimes obtained late as staff was rushed and hurried; registered nurses had to hide the patient's chart from Planned Parenthood's Dr. Timothy Liveright so the pre-procedure medications could have time to take effect because he was in such a rush to get to the next patient; lab work not being performed correctly thus the lab value results were incorrect; patients given sedation were found outside walking down Market Street dazed and confused; staff medical credentials were not verified; the emergency medications and equipment had expired; the narcotics were not being regulated; HIPPA privacy not being practiced; an intern who had been instructed by her instructor to only observe was pressured into providing abortion care; Planned Parenthood's Dr. Timothy Liveright once left sedated patients in the middle of an abortion procedure waiting for hours in order to handle a mechanical issue with his private airplane; and more . . .

Ms. Peterson also informed me that she could only take complaints from patients. I told her that this patient population was not at all likely to report to her. I explained to Ms. Peterson that abortion is a stigmatizing event that causes patients to feel too uncomfortable to advocate for themselves. I also shared with Ms. Peterson that many of the patients that receive care at Planned Parenthood are young, poor, often minorities that lack knowledge of the reporting process to Delaware Health and Social Services and that these patients generally do not have the financial means to hire legal assistance necessary to even defend themselves. I told her that I was reporting on behalf of the patients and to consider me to be the "voice of the patients." But Ms. Peterson refused again stating that she could only take complaints from a patient.

	Planned Parenthood Doctor Gave Up Delaware License by Kara Nuzback, *Cape Gazette*, June 3, 2013

Excerpt:

A former physician at Planned Parenthood is facing charges of unethical practices and sexual misconduct . . .

According to the complaint, Liveright was reprimanded March 13, 2012 for screaming and cursing in front of Planned Parenthood patients and employees; he was also rebuked for sexually harassing female employees.

Between Feb. 12 and March 13, Fortune states, Liveright over-sedated patients; performed unnecessary suction procedures; failed to assess a patient’s airway, lungs and heart prior to sedation; and did not properly document procedures.

The complaint also says Liveright caused at least one perforation during surgery, and some of his patients required emergency hospital treatment.

	Nurses Claim Wilmington Planned Parenthood Never Notified Women of STDs by Tim Furlong and David Chang, Channel 10, Philadelphia, July 30, 2013

Excerpt:

A Planned Parenthood facility in Wilmington is under fire following new accusations from three former employees.

Former manager Melody Meanor and former nurses Joyce Vasikonis and Jayne Mitchell-Werbrich spoke at a legislative hearing on Monday, claiming the Planned Parenthood clinic located on Shipley Street in Wilmington is unprofessional, under-trained and unsafe.

"Women are exposed to potential infection of any kind you can imagine that can be passed from one patient to another," Vasikonis said.

During their testimony, the women claimed the privacy of patients was jeopardized, that they were asked to falsify employee records, that medical assistants were poorly trained and that certain women in need of certain medications after abortions often didn't receive them. They also claimed that the facility failed to inform up to 200 women that they tested positive for gonorrhea and chlamydia.

Florida

Some of the health department documents only list that the facility failed to provide a phone number to report complaints or that the license wasn't posted, and those aren't included here, but are on the Florida page on the website.

Fort Myers

The health department documents from 2014, 2015, and 2022 are under Fort Myers:

www.problemsatplannedparenthood.org/florida

Highlight:

- The facility had no records documenting whether probes were sterilized between patients.

Miami – Golden Glades

The health department document from 2015 is under Miami-Golden Gates:

www.problemsatplannedparenthood.org/florida

Highlights:

Clinic Conditions

- An employee showed the inspector a room where medical procedures and patient counseling took place. The room contained empty shelves and supplies, including two paint cans. Staff later claimed the employee was in error, and that the room the employee showed the inspector was only used for storage.
- Desks were stored in the hallway. This could make the hallway difficult to navigate for emergency personnel with a stretcher and hinder evacuation during an emergency.

Privacy

- There was no curtain in the patients' changing area.
- The facility didn't provide gowns for patients to change into; they were expected to be naked from the waist down. After state inspectors complained, clinic staff said they would provide gowns to patients who requested them.

Pembroke

The health department document from 2015 is under Pembroke:

www.problemsatplannedparenthood.org/florida

Highlights:

- Staff performed surgery for which the clinic wasn't licensed.
- There were no logs or records for tracking the disposal of biological waste.

St. Petersburg

The health department documents from 2013, 2015, and 2017 are under St. Petersburg:

www.problemsatplannedparenthood.org/florida

Excerpt:

"The laboratory must define criteria for those conditions that are essential for proper storage of reagents and specimens, accurate and reliable test system operation, and test result reporting. The criteria must be consistent with the manufacturer's instructions, if provided. These conditions must be monitored and documented and, if applicable, include the following: (1) Water quality. (2) Temperature. (3) Humidity. (4) Protection of equipment and instruments from fluctuations and interruptions in electrical current that adversely affect patient test results and test reports. This standard is not met."

Sarasota

The health department documents from 2010 and 2014 are under Sarasota:

www.problemsatplannedparenthood.org/florida

Highlights:

Clinic Conditions

- The facility failed to regularly clean and test the autoclaves as per manufacturer's instructions. Autoclaves are used to sterilize instruments used on multiple women. There were no logs or other records documenting times and dates when the autoclaves were to be cleaned. Autoclaves were required to be cleaned weekly; instead, they were not cleaned for months.
- The facility failed to ensure that emergency equipment was available. There was no defibrillator on the premises.

Staff

- The facility failed to conduct annual in-service training for staff.
- The facility did not provide proper training and orientation for new staff members and volunteers.
- There were no written policies or procedures for training staff on infection control, medical complications, or safety measure

Treatment of Patients

- Written policies and procedures for patient care were inadequate and did not contain the required information.

Tampa

The health department documents from 2015 and 2019 are under Tampa:

www.problemsatplannedparenthood.org/florida

Highlights:

- Laboratory proficiency testing was found to be deficient; it was later corrected.

Incidents

A patient was sent to the hospital with complications after a procedure. Nevertheless, her records indicated her vital signs were stable at discharge, there were no complications, she was ambulatory, and she was discharged in good condition. Vital signs documented during the procedure did not show that the patient was stable and contradicted the medical record. These notes were signed by the attending physician. When questioned, the physician confirmed the statements were inaccurate. The patient had a pre-existing condition, but this was not documented in her records, which gave her medical history as normal. She was not properly evaluated for risk factors or pre-existing conditions, The attending physician classified her as low risk (level II out of a possible VI), which was incorrect based on her pre-existing condition. There was also no documentation that the attending physician had used a stethoscope or other means to listen to and evaluate the patient's heart and lungs before the procedure.

Indiana

Bloomington

The health department documents from 2017, 2018, and 2019 are under Bloomington:

www.problemsatplannedparenthood.org/indiana

Highlights:

Clinic Conditions

- According to inspectors, the facility "failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients."
- Human blood from blood tests wasn't handled in a safe and sanitary manner, risking the spread of blood-borne infections such as HIV and hepatitis. Blood was stored with medications in the refrigerator. Blood tests for Rh factors were conducted on the same countertop used to prepare medications and blood drops from these tests were in close proximity to pregnancy tests. This was noted in multiple inspections.
- Medication was stored on the same countertop where tests were done on urine and blood. This was an ongoing problem cited in two inspections.
- The clinic's backup generator wasn't given regular maintenance.
- Other equipment, such as the two autoclaves used to sterilize instruments, weren't adequately inspected and maintained. The autoclaves, exam lights, and exam tables weren't examined for electrical current leakage.
- The clinic had (and appeared to be using) expired medication.
- An oxygen tank was stored improperly and, according to the report, "could create a source of a potential hazard to patients, visitors, or employees."
- The facility failed to document (and possibly conduct) proper maintenance of equipment such as a defibrillator, emergency call system, recovery chairs, vacuum units, and procedure tables.
- Documents indicated that the telephone intercom system wasn't working, and there was no indication it was fixed.
- Staff failed to document (and possibly perform) the cleaning and disinfection of exam rooms, labs, and equipment and weren't properly trained to do so.

Staff

- The facility failed to have a policy to evaluate, test, and improve the skills of nurses, lab technicians, and other staff members. The clinic failed to review and evaluate nursing services, laundry services, medical record review services, maintenance services, or laboratory services. This was cited in multiple inspections.

- Staff failed to wash their hands after handling linens that were soiled with bodily fluids. No sink or handwashing facilities were present in the room where laundry was washed and handled.
- Staff wasn't trained to use the backup generator and no training manuals were available.
- The clinic didn't have someone "qualified by training or experience" responsible for supervising infection control and making sure proper procedures were implemented and followed.
- Staff didn't have proper training in cleaning and disinfecting instruments, equipment, and exam rooms.

Medical Records and Labels

- The clinic failed to maintain accurate medical records, neglecting to record patient condition at discharge, transfers to hospitals of injured patients, procedures performed, and other data. All three inspections found that proper medical records weren't kept, indicating an ongoing problem.
- One inspection found that laboratory results weren't documented. For example, Rh testing results were neglected to be recorded. If these tests weren't performed (and we have no way of knowing whether they were, without documentation) and the clinic, therefore, neglected to administer RhoGAM, future pregnancies of women were put at risk. Rh sensitization can cause miscarriages and damage babies in subsequent pregnancies. Also not recorded were pre-abortion pelvic exams.
- Staff repeatedly failed to sign paperwork. This was an ongoing problem, cited in two different inspections.

Treatment of Patients

- The facility failed to monitor patients' vital signs while they were in the recovery room after surgery. The clinic didn't monitor or record blood pressure, respiratory rate, and/or pulse of women post-surgery. This was true of all 22 patients whose records were examined. This was an ongoing problem; the clinic was cited for it in all three inspections.
- The clinic lacked the policy to ensure that medical histories were taken promptly and proper physical examinations were performed.

Other

- The facility didn't have a quality assurance program to oversee and evaluate emergencies, infection control, patient complaints, safety, and competence.
- There were no training manuals to teach clinic staff how to operate equipment. This was not corrected and was found to be the case in more than one inspection. There were no user manuals for the emergency call system.
- The clinic failed to regularly evaluate the care given to patients.
- Controlled substances were unsecured and could be accessed by unauthorized persons, such as patients and staff.

Indianapolis

The health department documents from 2012, 2014, 2017, 2018, and 2019 are under Indianapolis:

www.problemsatplannedparenthood.org/indiana

Highlights:

Clinic Conditions

- An oxygen tank was left unsecured standing upright in a room. According to the report "if the tank was knocked over and broke the head off the compressed cylinder, it could cause harm to people and/or property."
- Regular preventative maintenance wasn't conducted on the emergency call system, presenting a potential risk in the case of an emergency. Regular maintenance was also not conducted on a wheelchair.
- Emergency defibrillators weren't tested or properly maintained.
- Although the facility gave IV sedation, it had no cardiac monitors available.
- The facility failed to change the disinfection solution used to sanitize the procedure room as per the manufacturer's guidelines.
- The facility used expired test strips to test whether Cidex, a sterilization fluid, was of good enough quality to be effective.
- There was trash in the clinic parking lot, presenting a habitat and breeding ground for pests such as rodents and insects.
- There were expired emergency supplies, including IV bags.
- The facility failed to maintain 5 out of 7 pieces of equipment, including smoke detectors and an emergency generator. In a subsequent inspection, 11 of 12 pieces of equipment weren't properly maintained.
- The facility failed to perform regular maintenance on emergency and other equipment. This included the cardiac monitor, defibrillator, suction machine, emergency call system, sterilizer, exam light, and wheelchair. This was cited in more than one inspection.
- The facility failed to test the defibrillator to ensure it was in working order.
- Electric current leakage checks weren't performed on equipment.
- The facility failed to properly clean and sterilize the vaginal ultrasound probe.
- There were no monthly checks of medications, equipment, and supplies.
- Clinic staff failed to verify that blood specimens for Rh testing were stored at appropriate temperatures, which may compromise the integrity of the tests. Records indicated these specimens were stored at inappropriate temperatures, and this wasn't addressed or fixed promptly, rendering the tests unreliable. Failure to detect and treat Rh compatibility problems can lead to miscarriage or infant death and negative outcomes in future pregnancies.

Staff

- The clinic didn't conduct or document a proper orientation for new employees.
- Two out of four doctors (one half) and one health care assistant weren't trained in CPR and would not have been able to perform CPR in an emergency. In a subsequent inspection, a medical assistant and the medical director were found not to have CPR certification. This was an ongoing problem.
- The clinic had no designated person with prescriptive authority and no one in control of drug stocks.
- The clinic didn't verify staff immunizations and failed to provide hepatitis B vaccines to two employees who requested them. The clinic also knowingly employed several staff members who weren't vaccinated, despite having a written policy not to do so.

Medical Records and Labels

- Medical records were incomplete with missing information. Some of the things the clinic staff failed to document were whether ultrasound was used when needed for surgery, whether the patient had used drugs or alcohol before the procedure, whether the airway was maintained for patients receiving sedation, and whether there were complications. Medical histories were incomplete, with no documentation of women's health conditions that could affect the safety of procedures. In some cases, the type of anesthesia given to patients and whether they received sedation wasn't documented. Start and stop times of procedures weren't documented. Doctors failed to sign paperwork.

Incidents

- One patient who received versed and fentanyl had her oxygen saturation level drop to 76% during her surgery. Despite this dangerously low oxygen saturation level, no supplemental oxygen was given. There was no documentation in her chart of any intervention or medical treatment given for this medical crisis. The director and staff who were interviewed said they "didn't know" if any treatment was given to this patient.

Treatment of Patients

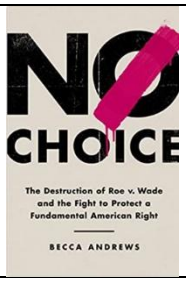
- Clinic staff gave all women the same dosage of fentanyl without regard to body weight, so the clinic overdosed 17 of 18 patients on fentanyl for sedation.
- The staff failed to check vital signs for 18 out of 30 patients while they were in the recovery room. These patients had received fentanyl and/or valium but were left unmonitored.
- The facility failed to monitor the oxygen saturation of one patient under sedation.
- The clinic failed to monitor or record vital signs for women who were under sedation.

- Physical examinations weren't conducted before sedation and medical procedures and proper medical histories weren't taken. The clinic also failed to ask patients what other medications they were taking and what medications they were allergic to before giving sedation and didn't document this.
- The staff didn't document (or possibly conduct) Rh counseling for 5 out of 5 patients who were Rh-negative. Rh sensitization presents a risk to infants born in future pregnancies and can cause miscarriages of subsequent pregnancies.
- Clinic staff didn't document (or possibly give) patients proper counseling about aftercare after their procedures.
- There was no documentation or indication that the facility was giving patients proper informed consent before medical procedures.
- The facility failed to have a policy in place to inform doctors of adverse reactions and medication errors.
- Staff failed to verify whether patients who had experienced sedation had someone to drive them home.

Other

- The facility didn't ensure that contracted services were provided safely and effectively. This was also an ongoing problem, cited in multiple inspections, with 71 different contracted services involved. The clinic also failed to keep a list of contracted services, including their scope and nature. This included pharmacy services, lab services, trash disposal, fire alarm, and sprinkler maintenance, and phone services.
- Although there was a committee tasked with implementing proper infection control procedures, that committee failed to meet regularly. When they did meet, the person designated to oversee infection control wasn't present. The medical director also failed to attend some of the meetings.
- No fire or safety inspections were conducted at the clinic.
- The clinic failed to have a plan to conduct fire drills.
- The facility failed to keep a proper log of controlled medications, presenting the possibility that some could be stolen or misplaced. Controlled substances were also left unsecured, where unauthorized persons had access to them.
- The clinic administrator failed to attend 5 of 5 meetings of the clinic governing board.
- The state license wasn't posted where patients could see it.
- The clinic had medications that were not listed in the formulary.
- There were concerns reported with a contracted waste disposal company, but no record of corrections or resolution.

Indianapolis



No Choice: The Destruction of Roe v. Wade and the Fight to Protect a Fundamental American Right

by Becca Andrews (New York: Public Affairs, 2022)

Book Excerpt:

When [Ann] began the new job, she was taken aback by the bare-bones training given to her and the dim dustiness of the clinic. She had a hazy memory of shadowing another counselor before she officially started her job, along with informal conversations with the clinic administrator that covered some of the do's and don'ts of the work . . .

An administrative office in the back smelled of cigarettes; the staff would sometimes come in on Saturdays when the clinic was closed to clean it themselves, to save money on janitorial staff . . .

Ann: "It did not have the kind of feel you expect when you walk into a doctor's office. I felt a sense of kind of shame because you want to help these women during what, for some of them, was a really difficult moment. You just realize that the standard is really not high, and there's this defeatist attitude of *there's only so much you can do*."

Once, in a procedure room, she accidentally stepped on a blood clot, and no amount of sanitizing spray could make her feel like her shoe wasn't somehow forever tainted.

The carpets were stained; the clinic doctor liked to joke that it looked like a bloody body had been dragged down the hallway. He didn't seem to notice – or care – that his quip never got a laugh . . .

[A]nother clinic worker accidentally stuck herself with a used needle. The lab room she worked in was small, and the space limitation combined with the frenetic pace of the work meant that it was only a matter of time before there was an accident… [T]he worker wound up on medication meant to ward off the [AIDS] virus.

Lafayette

The health department document from 2019 is under Lafayette:

www.problemsatplannedparenthood.org/indiana

Highlights:

Medical Records and Labels

- Doctors failed to sign medical records, and records were incomplete.

Merrillville

The health department documents from 2014, 2017, and 2019 are under Merrillville:

www.problemsatplannedparenthood.org/indiana

Highlights:

Clinic Conditions

- Potentially infectious material was stored in a cabinet, and the cabinet wasn't labeled as containing biohazardous material.
- The facility failed to document (and possibly perform) electrical leakage checks of equipment.

Staff

- The medical director hired a doctor without verifying his credentials.
- The facility failed to ensure that staff was vaccinated.

Medical Records and Labels

- Doctors failed to sign paperwork, noted in two inspections.
- The clinic failed to ensure that records were complete and accurate. This was cited in two inspections. One patient's records stated the patient was discharged at 8:55 AM, but had vital signs taken at 9:38 AM. Another chart indicated a patient was discharged at 2:05 PM but had vital signs taken at 3:06 PM. A third patient was said to have gone to the recovery room at 12:59 PM but recorded as discharged at 12:11 PM. A fourth record documented a discharge time of 11:20 AM but claimed vital signs were taken at 12:56 PM and 1:02 PM.
- Type of sedation patients received was not documented.
- Records failed to verify that patients understood discharge instructions.

Treatment of Patients

- According to the report, the facility "failed to ensure the implementation of policy and standards of care related to the checking of vital signs in the procedure and recovery rooms." There were no vital signs taken for 28 patients.
- The facility failed to conduct Rh counseling for Rh negative patients. Failure to treat Rh incompatibility can lead to miscarriage or health problems for the baby in future pregnancies.
- Patients weren't given proper instructions as to hygiene and self-care after their surgery. Paperwork given to patients omitted this information.

Other

- There was no policy in place to report adverse reactions to medication or medication errors to the doctor.
- The facility didn't have a policy to deal with health care workers' practice problems. They had no policy for dealing with providers coming in under the influence, having criminal histories, needing disciplinary actions, or other potential problems.
- The clinic had no policy for infection control. The staff member in charge of infection control wasn't qualified for that position, and had not been trained.
- The facility didn't have a plan in place for working with state and federal agencies in the event of an emergency.

Kansas

Overland Park

The health department document from 2015 and the pharmacy regulation document are under Overland Park:

www.problemsatplannedparenthood.org/kansas

Health Department Document Highlights:

- None of the staff members had received a medical exam to clear them medically for working with patients.
- There was no record of immunizations for any of the workers. Nonvaccinated people can spread diseases to patients.

Excerpt from the Summary Order on Pharmacy Regulations:

1. The Board has previously issued Responded Registration No . . . which entitles Respondent to function as a pharmacy in the State of Kansas . . .
2. On or about July 2, 2015, the Board office received notification from Respondent of Pharmacist in Charge ("PIC") . . . Shafer's resignation effective August 20, 2015 . . .

12. Respondent failed to submit the complete Change of PIC application and new PIC exam to the Board until April 27, 2016, which was 179 days beyond the 30-day window for designating a new PIC.

ORDER

. . . Respondent is ordered to pay a fine . . . Because Respondent was 179 days late, the fine accrued . . . Respondent has 30 days from the date of this order to pay the full $4,580.00 . . .

Maryland

Annapolis

The health department document from 2013 is under Annapolis:

www.problemsatplannedparenthood.org/ maryland-annapolis-baltimore

Highlights:

Clinic Conditions

- The autoclave, used to sterilize dirty instruments, wasn't properly sanitized or maintained. There was no documentation that basic maintenance was performed, and it was leaking onto shelves below.
- Routine spore testing (for mold) wasn't conducted on the autoclave.

Baltimore

The health department documents from 2013, 2015, 2016, and 2018 are under Baltimore:

www.problemsatplannedparenthood.org/maryland-annapolis-baltimore

Highlights:

Staff

- A member of the nursing staff didn't appear to have experience or documentation of training to be competent in administering and monitoring intravenous sedation yet was administering sedation.
- Staff wasn't trained in the process for emergency transfer of a patient to the hospital in case of a complication. The manager acknowledged the staff member in question hadn't been trained.
- A member of the staff had no certification or training in CPR and basic life support.

Medical Records and Labels

- All five patient medical records examined were missing information. In all cases, the patients' discharge diagnosis had been omitted.

Other

- The staff failed to conduct fire drills. This remained the case in an inspection a year later.

Michigan

Ann Arbor

The health department documents from 2014 and 2017 are under Ann Arbor:

www.problemsatplannedparenthood.org/michigan

Highlights:

- The facility mixed clean and dirty instruments, potentially causing contamination. Clean instruments were being wrapped in the same place dirty instruments were being processed.
- There was no emergency call system in the bathroom. A patient having a medical crisis couldn't press a button to inform a nurse or other staff.
- The facility failed to post its license where it could be seen by patients.
- Patients were allowed to bring personal items into the operating room, without proper containment.

Flint

The health department documents from 2015 and 2016 are under Flint:

www.problemsatplannedparenthood.org/michigan

Highlights:

- Privacy curtains prevented nurses from seeing patients in the recovery room. The curtains obstructed their view and they couldn't see if patients were in distress.
- Patients were allowed to bring personal items into the operating room, without proper containment.
- Single dose medications were used on multiple patients.

Minnesota

Minnesota doesn't do health inspections on this kind of facility.

	Botched Care and Tired Staff: Planned Parenthood in Crisis by Katie Benner, *The New York Times*, February 15, 2025

Grace Larson, a former Planned Parenthood nurse in Minnesota who was fired while trying to unionize the staff, said that clinics were operating like "a conveyor belt" for patients. She said that employees sometimes administered expired pain medication or the wrong medications as they scrambled to move people in and out. She said it was not uncommon for patients to be taken to the wrong room and prepped for the wrong procedure.

"We would catch it when a patient would say, 'Why am I in a room with an ultrasound machine and a sedation nurse for a Pap smear?' or when a nurse would come in and be like, 'Wrong room, wrong patient,'" Ms. Larson said.

Missouri

Colombia

The health department document from 2018 is under Colombia:

www.problemsatplannedparenthood.org/missouri

Highlights:

Clinic Conditions

- Suction machine cabinets were rusted and covered with adhesive tape, creating an uncleanable surface that could harbor infection-causing germs. One suction machine cabinet also had a six-inch-long dried brown stain on it. This was likely bodily fluids or blood that hadn't been cleaned.
- Tubing attached to the suction machine, intended to be used only once, wasn't disposed of between patients. The tubing was contaminated with red "bodily fluids." The bloody tubing was still there six days after the last surgery.
- Re-usable tubing was contaminated with "a blackish-gray substance," determined to be mold. Staff admitted mold had been present in the tube for four months, though using it on women.

- The re-usable glass bottle attached to the suction machine had a layer of “dried black substance” congealed on the bottom, likely dried blood and fluids.
- Exam tables were wooden with chipped paint, presenting a surface that couldn’t be disinfected.
- A cabinet under the sink hadn’t been cleaned and had a “large area of dried white residue and an area of dried yellowish-brown residue.”
- Equipment used on patients wasn’t approved for use in healthcare facilities. Heating pads were labeled “for household use only.” One of the heating pad covers was stained.
- The facility improperly used heating pads on patients who were sedated or had been given pain medication, which could lead to burns.

St. Louis

The health department documents from 2009, 2013, 2015, 2016, and 2019 are at:

www.problemsatplannedparenthood.org/missouri

Highlights:

Clinic Conditions

- The facility used worn, rusted, and deteriorating equipment with uncleanable surfaces, including a rusted surgical table. A stool for patients was covered with rust and clear tape, creating an uncleanable surface.
- An air vent was clogged with dust and debris.
- Plastic bins containing emergency supplies, IV solution, and IV supplies were covered in dust.
- An IV pole was rusted and in poor condition.
- An oxygen tank was dirty and covered with adhesive surfaces.
- The facility failed to keep the procedure rooms, supply rooms, and storage rooms free of dust and debris. The floor had visible dust and dirt. This was noted in multiple inspections.
- An exam tabletop pad was torn, with exposed foam, creating an uncleanable surface. The clinic hadn’t ordered a replacement.
- There was a dirty cloth pillow on the ultrasound table. The pillow was white but part of it was discolored gray.
- Pillows on tables in the procedure rooms had unzipped or missing plastic covers and were therefore uncleanable.
- The refrigerator was dirty and had tape and adhesive residue on the front, creating an uncleanable surface. There was hair and dust inside the refrigerator. A staff member was questioned and said he hadn’t cleaned the refrigerator or seen it cleaned in the 1 ½ years he worked at the clinic.
- The cabinet where IV catheters were stored had a thick layer of dust on the shelves.

- There was tape, adhesive residue, and peeling labels on cabinets and clipboards, creating uncleanable surfaces.
- Drawers contained dust, debris, and adhesive residue.
- Instruments were stored in a drawer that was dirty with dust and debris.
- There was a brownish residue on the floor and inside a cabinet. This may have been dried blood and/or bodily fluids.
- An ultrasound had tape on it and was extremely dusty, as was the case with a plastic tray holding protective bed pads. A wheelchair regularly used for patients also had a thick layer of dust.
- In a subsequent inspection, oxygen masks, nasal cannulas, and sterile IV tubing were found stored in bins that had “dust and loose particles” in them.
- There was expired medication, including IV fluid and ammonia (used to treat fainting), which had expired three years before. Nine vials of valium, being used on patients, had been expired for nearly a year. Other expired medications included naloxone (which is needed to give life-saving treatment to patients suffering from a narcotics overdose) and dextrose injectables. In another inspection, an expired epi-pen was found.
- Having and using expired medication was a repeat offense, cited in multiple inspections.
- The facility had expired postpartum balloons (used to stop bleeding) including one that had expired three years before. There were surgical gloves that expired six years before. In another inspection, inspectors found hand sanitizer expired by a year and expired thermometers.
- Glucose testing strips were supposed to be disposed of six months after opening. After that, they could give inaccurate results. Staff failed to note the date when the testing strips were opened, and one staff member in the lab said he had “no idea” when they were opened.
- The facility failed to inspect and maintain fire extinguishers.
- The facility failed to monitor the humidity in instrument processing areas.
- The facility failed to protect sterile items from dust and moisture by placing a solid barrier beneath them when they were on shelves.
- Staff didn’t have the manufacturer’s operating instructions for the autoclave, used to sterilize instruments. Instructions were eventually printed out from the internet. These instructions gave detailed information on how to clean and replace parts in the autoclaves. There were no records to show that the autoclave was properly cleaned and maintained. The insides of the autoclaves were discolored and had brown spots. These autoclaves were being used to sterilize instruments.
- In the sterilization room, around one of the autoclaves, there were dust and white flecks which left a mark when a finger was pulled through it.
- Staff failed to follow the manufacturer’s instructions to test the autoclaves, which are to be done after each instrument load. The tests were performed only once a week.
- The clinic failed to have a procedure in place to prevent cross-contamination of clean instruments by dirty ones.
- Instruments weren’t properly sterilized.

- Peel packs were covered in off-white flakes that fell off when they were lifted. When clinic staff was asked about this a staff member admitted she didn't know where the white flakes came from.
- Staff failed to store refrigerated medication at appropriate temperatures. RhoGAM, used to treat RH sensitization, had a required temperature range to remain usable. Frequently, ranges of temperature weren't tested, but tests showed temperatures out of range for over a week. This wasn't addressed. RhoGAM was allowed to remain at inappropriate temperatures for an extended period.
- Open medications were left in the procedure room and not kept in a centralized location.
- Unsterile corrugated boxes were in the sterile supply room.

Staff

- Two surgical assistants (out of four) weren't trained to assist in surgery, nor did they have certified surgical technologist credentials.
- The facility failed to perform Employee Disqualification List (EDL) checks on any of its employees before hiring them. Medical facilities are forbidden to hire staff whose names appear on the EDL.
- The facility failed to run criminal background checks before hiring. They also failed to perform background checks on volunteers, including one volunteer who had been there for over 30 years. This was an ongoing problem, cited in more than one inspection report.
- The staff didn't wear appropriate personal protective equipment. Inspectors observed one staff member cleaning instruments without wearing a mask or face shield.
- The facility failed to provide ongoing training for staff in infection control. One staff member had been working at the clinic for nearly 10 years and had no infection control training.
- The facility didn't conduct proper orientation for staff.

Medical Records and Labels

- The clinic failed to document medication given to patients. Names of medications, times they were given, and dosages were omitted from records. Some records were inaccurate – one patient's chart said that she received medication at 4:46 PM but was discharged at 12:55 PM.
- The facility failed to ensure medication orders were timed, dated, and signed by a physician.
- The staff didn't document ongoing issues with quality control.

Incidents

- The Missouri Department of Health investigated the clinic for complications in five cases, and all five doctors involved refused to cooperate. A letter from the Department states “RHS's non-cooperation on this point is unprecedented and untenable.”

Treatment of Patients

- Single-use medications weren’t discarded after one use, but were used on multiple patients. Clinic staff admitted that fentanyl vials were used on multiple patients because of a “shortage.” Using single-use medication on multiple patients was cited in multiple inspections.
- The facility didn’t give accurate information to patients concerning who to contact to file a complaint against the clinic or the process for doing so.
- The facility failed to monitor patients’ vital signs, including those of patients under sedation. The facility failed to monitor level of consciousness, blood pressure, pulse, oxygen saturation level, and respiratory rate frequently enough throughout the time patients were under sedation. This put patients at risk.
- Residents performing surgery weren’t properly supervised.

Other

- Staff wasn’t knowledgeable about evacuation plans in the event of a fire, and fire drills weren’t conducted.
- The facility didn’t submit pathology specimen reports to the Missouri Department of Health and Senior Services, as they were required to do.

Nebraska

	Botched Care and Tired Staff: Planned Parenthood in Crisis by Katie Benner, *The New York Times*, February 15, 2025

Many clinics are in dire need of upgrades and repairs. In Omaha last year, sewage from a backed-up toilet seeped into the abortion recovery room for two days, according to interviews with staff members and photographs and text messages shared with The Times. Employees shoved exam table pads under the bathroom door to block the leak. Patients vomited from the stench.

New York

The health department in New York won't specify which facility the report applies to, which precludes us from knowing which apply to Planned Parenthood centers. The two lawsuits below aren't quite health violations, but that's the category they best fit.

Simmons

The full 2024 Affidavit are under Rochester:

www.problemsatplannedparenthood.org/new-york

Excerpt:

5. I decided that I couldn't wait several weeks for an ultrasound, so I called Planned Parenthood . . . I was asked if I was considering an abortion. I figured that's what I had to say to get an ultrasound quickly, so I told them yes and I got a scheduled appointment much faster than I could get one with my regular doctor.

6. On December 21, 2023, I went to the Planned Parenthood . . . in Rochester. . . I filled out my information . . . including the fact that I have a history of seizures and high blood pressure, as well as the fact that I had pre-eclampsia with one of my babies. No one at the facility offered me any testing for HIV or other STDs. They didn't even take my blood pressure, after I had put down that I have a history of high blood pressure . . .

7. During the ultrasound, the woman wouldn't let me see the ultrasound screen. She kept tilting the screen so that I couldn't see what was going on, even when I asked her if she could turn it so that I could see it . . .

8. After asking me when I thought I had my last period and I said that I wasn't sure, she told me that she thought I was "4 months and some change" along in the pregnancy. I asked her if it was a boy or a girl and she said she couldn't tell me. . .I asked her if she saw any defects with the baby because my other child has a club foot, and she told me that she wouldn't be able to tell that from "this kind of ultrasound" . . .

9. I then went to leave and asked her for the ultrasound picture. She got all weird and kept saying it's not really going to show anything . . . but I had come to get an ultrasound and I wanted the picture so I pushed for it . . .

10. When I looked at it, it was so blurry I couldn't even see anything on it . . .

11. As I left the Planned Parenthood office, I saw some people standing on the sidewalk outside . . . I told them . . . how I had gone into Planned Parenthood and had an ultrasound, and showed them my ultrasound picture. I asked them what they thought of it. They told me that I could have a free ultrasound right then in the mobile van . . .

12. The woman sonographer in the mobile van was very nice and she had it set up so that I could see the screen at the same time that she was looking at it, which made me feel better right from the start. As soon as I saw the screen come up, I saw a very clear picture of my baby and heard the heartbeat. I also learned that I was about 17 weeks along, and that the baby was a girl! . . .

13. I just couldn't, and still can't, believe the difference in two ultrasounds, done so close in time on the same day.

Thompson

The 2024 Pre-Action Petition are at

www.problemsatplannedparenthood.org/new-york-city

On September 27, 2024, our paralegal . . . faxed a copy of our letter and executed authorization for release of the records to the medical records department at Planned Parenthood . . .

On November 5, 2024, [the paralegal] followed up with the medical records department by leaving voicemail messages and a second request was faxed . . . [the paralegal] followed up with the respondent via telephone on numerous occasions, faxed and mailed a third and final request via express mail (FedEx) on November 19, 2024 . . . To date, the respondent has not responded to [the paralegal's] messages or provided the medical records.

North Carolina

Chapel Hill

The health department documents from 2014, 2015, 2016, and 2017 are under Chapel Hill:

www.problemsatplannedparenthood.org/north-carolina

Highlights:

Clinic Conditions

- Staff failed to clean and disinfect the floor in the procedure room. Inspectors found dirt and rust on the floor. There were dirt stains on the floor at the foot and head of the exam table.

Staff

- Medications were administered by unlicensed, unqualified staff members. This included intramuscular injections of RhoGAM and birth control injections.

Medical Records and Labels

- The facility failed to document medication administration properly in its records. They didn't record at what times medications were given. Multiple inspections documented this.

Treatment of Patients

- The facility failed to conduct proper informed consent, as cited in multiple inspections.
- In seven out of seven cases, the facility failed to give women instructions about what to do and who to contact in the event of medical emergencies.
- Staff failed to sterilize a vaginal ultrasound probe between uses. They used the ultrasound probe on multiple women without properly cleaning and disinfecting it. This has the potential to spread infections.

Fayetteville

The health department documents from 2015 and 2016 are under Fayetteville:

www.problemsatplannedparenthood.org/north-carolina

Highlights:

Clinic Conditions

- The facility had expired medications and supplies. An oxygen mask required for emergencies had expired eight years before. Needles and curettes were expired by over two years, and other supplies were also expired.

Treatment of Patients

- The facility was required to keep women in the recovery room for at least an hour after surgery to make sure there were no complications. Staff failed to do this. Women were discharged 35 – 37 minutes after surgery and were not observed long enough to rule out complications.

Wilmington

The health department document from 2015 is under Wilmington:

www.problemsatplannedparenthood.org/north-carolina

Highlights:

Clinic Conditions

- Blood samples and human tissue were stored in the same refrigerator as medications. This brings a risk of cross-contamination.

Medical Records and Label

- Doctors failed to sign consent forms.

Winston-Salem

The health department documents from 2015, 2016, and 2020 are under Winston-Salem:

www.problemsatplannedparenthood.org/north-carolina

Highlights:

Clinic Conditions

- Biohazardous waste, including used needles, was stored close to employees' personal belongings and extra supplies.
- A syringe filled with lidocaine was left unattended and unsecured, leaving open the possibility of contamination or tampering.
- A disposable lab coat and masks were used repeatedly, and there was not enough personal protective equipment for the staff.

Staff

- There was no evaluation of competency for staff preparing and administering medication. One of the doctors administering medication was not registered with the North Carolina Board of Pharmacy. The clinic failed to ensure that a healthcare assistant preparing medication was competent to do so.
- The staff didn't properly disinfect instruments. The staff failed to "follow safe practices to prevent the spread of infection," according to the report. There was possible cross-contamination between dirty and clean instruments as dirty instruments were lifted and passed over clean ones. Staff kept dirty and clean instruments in the same sink.
- Staff failed to wear sufficient personal protective equipment when handling dirty instruments.
- According to the clinic's regional director, "a lot of our docs don't use masks during procedures."
- Staff did not practice good hand hygiene while handling potentially infectious material. Because of this, they were required to go through more training.

Medical Records and Labels

- Documents verifying informed consent weren't signed by doctors. This was the case for every patient whose paperwork was examined. This was an ongoing problem, also cited in a second inspection two years later.
- In this second inspection, it was also found that the time of the procedure wasn't given for any of the patients whose records were examined. By way of excuse, the clinic's regional director said that the clinic's health service manager "did not receive the proper training and it was just poor training on my part."

Other

- The facility failed to conduct periodic checks of emergency equipment including the emergency defibrillator. The clinic's regional director and vice president said, "I know we aren't checking it, and to be honest, we haven't looked at the manufacturer recommendations or developed a protocol. We are going to have to determine how often checks should be done . . . Maybe every six months or maybe we need to do it every month." This lack of testing of equipment needed in an emergency could put patients' lives at risk.

Ohio

Bedford Heights

The health department documents from 2011, 2013, 2014, 2015, 2016, and 2019, along with a letter assessing a fine, are under Bedford Heights:

www.problemsatplannedparenthood.org/ohio

Highlights:

Clinic Conditions

- According to an inspection report, the facility "failed to ensure a safe and sanitary environment" for patients, visitors, and staff.
- Walls in the waiting room were darkened, dirty, and discolored. A review of the contracted cleaning staff's duties revealed that the walls weren't cleaned.
- The clinic failed to ensure appropriate ventilation and humidity levels in the operating rooms and recover rooms, increasing the risk of infection to patients.
- The facility had expired supplies, including test strips to determine whether the proper concentration of disinfectant was used to sterilize instruments. This was a repeat offense. In a later inspection, the facility had and was using expired products for skin dressings, hand hygiene, and disinfectant.
- The waiting room door's automatic release wasn't working, possibly preventing patients and staff from exiting the building in the event of a fire or other emergency.
- Fire extinguishers, which were supposed to be inspected monthly, had not been inspected for several years.
- Several tests had labels indicating they should only be used within three months after opening, but products were opened and undated.
- Saline, only good for 60 days after opening, had been opened two years ago and was being used.
- Cardboard boxes were stored in an unsafe manner, creating a fire hazard.

- Band-Aids had been removed from the manufacturer's protective packaging. Staff claimed that the Band-Aids were open and exposed to save time.
- Condoms were used to cover the ultrasound probe which was placed inside women. These condoms were stored unwrapped before use, an unsanitary situation.
- A full urine specimen cup was left sitting in the bathroom for four days, untested and not disposed of.
- The facility wasn't monitoring temperature in the refrigerator where fetal remains were kept. Too low temperatures could allow decomposition and create a health risk. The refrigerator also wasn't given proper maintenance and testing.
- The facility failed to post the complaint hotline where patients could see it.
- There were unlabeled filled syringes with no indication of what medication was in them. A staff member admitted, "we don't know what's in them."

Staff

- None of the nurses on staff had surgical experience and none was qualified to be the director of nursing.
- Doctors didn't have proper privileges to perform surgery, and there was no documentation of competence from the governing body of the clinic. The facility did not conduct evaluations based on medical records and references on their doctors. According to the inspection report, "this could affect all patients receiving surgical services in the facility."
- The facility failed to conduct tuberculosis testing on newly hired staff.
- The facility failed to perform a yearly evaluation of staff.

Medical Records and Labels

- Medical records for patients were incomplete and missing information in all the records inspectors looked at. Vital signs were not recorded and may not have been taken. This was a repeat offense, with another inspection also finding omissions in patient records.
- Records weren't signed, and the times medications were given weren't recorded.
- There were also mistakes. One claimed the patient was given pain medication 1.5 hourse after she was said to have left the facility.

Incidents

A surgery patient suffered hemorrhaging and was taken by ambulance to the hospital. The clinic didn't send her medical records to the hospital or notify the hospital's emergency department.

A second patient was also transferred to the ER having suffered a uterine perforation, which is potentially life-threatening. She needed laparoscopic surgery
.

- The facility didn't have "legible and complete" records on either of these women, omitting various pieces of information including medical outcomes. The writing in the records was illegible and couldn't be deciphered by staff or inspectors.

Other

- The facility allowed unauthorized persons to have access to controlled substances. The facility also failed to properly repackage narcotic painkillers.

Cincinnati

The health department documents from 2012, 2013, 2014, 2015, 2016, 2018, and 2019 are under Cincinnati:

www.problemsatplannedparenthood.org/ohio

Highlights:

Clinic Conditions

- Two operating tables had tears in their vinyl covers.
- There was no emergency call system in the recovery room.
- Intravenous catheters in the operating room were found to be expired.

Incidents

- A minor patient having surgery suffered an allergic reaction and an asthma attack and had to be taken to the hospital.
- Fifteen patients suffered incomplete procedures. Another three women hemorrhaged, and one needed a blood transfusion.

Treatment of Patients

- facility failed to have a transfer agreement with the local hospital, putting patients at risk in the event of complications from surgery.
- Surgical devices being used on patients were improperly sterilized.
- The manufacturer's instructions say aspiration devices need to be disassembled in a steam sterilizer for 30 minutes. Staff were only sterilizing them for three minutes. These devices were used on 15-20 patients a week.
- The manufacturer's instructions say aspiration devices used in surgery could be reused "up to 25 times." Staff didn't keep track of how many times each device was used and didn't dispose of them unless they malfunctioned. A staff member stated one aspiration device had been used "for many years."

Columbus (East)

The health department documents from 2011, 2012, 2013, 2014, 2015, and 2018 are under Columbus – East:

www.problemsatplannedparenthood.org/ohio

Highlights:

Clinic Conditions

- A suction machine and its table, still in use, were coated with a heavy layer of dust and dirt.
- Patient care supplies were stored in an unsanitary manner, cardboard boxes directly on the concrete floor.
- One exam table had a large tear in its vinyl cover, exposing foam and making it impossible be sterilized. A staff member said the tear was brought to the attention of clinic administration a month before, but had not been repaired.

Medical Records and Labels

- The facility didn't properly label filled syringes and open vials of medication. Filled syringes didn't have the dosages on them, which led one staff member to say he would be afraid to administer the medication to patients. Open vials of medication weren't all labeled with the date they were opened.
- The facility failed to document the times medications were given to patients.

Treatment of Patients

- The facility was only supposed to discharge patients who were accompanied by someone. The facility sent patients away alone, and without documentation they were well enough.
- The facility failed to post the complaint hotline where patients could see it.

Other

- Controlled substances weren't in a double-locked storage area, so they could be accessed by unauthorized persons.

Pennsylvania

Allentown

The health department documents from 2011-2024 are under Allentown:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Clinic Conditions

- Over thirty medical instruments were covered with a reddish-brown substance, even though they were supposed to be sterile. This was an ongoing problem. In a subsequent inspection, multiple instruments still had reddish-brown stains.
- The facility had no provisions for disposing of liquid waste. They washed it down the drain.
- There were expired medications in the emergency kit. This was an ongoing problem, cited in multiple inspections. Intravenous fluid, used in emergencies, was also expired.
- Lollipops and crackers, meant to be given to patients, were stored in close proximity to biohazardous material and medical waste in a dirty area. In a later inspection, lollipops and crackers were stored in a dirty area where blood was drawn and urine tests analyzed.
- In the examination room, there was a container of cotton swabs with blood in it. This presented the risk of infection when used on patients.

- There were open, partially used, undated bottles of medication. With no record of when they were opened, staff couldn't confirm whether they were expired. This was an ongoing problem, cited in more than one inspection. Staff confirmed the facility had no policy of monitoring expiration dates for partially used medications or disposing of them.
- An open container labeled “saline” was found to have white and black debris floating in it.
- There was expired surgical equipment.
- The facility didn’t have needed emergency supplies. Items such as sterile hemostats (an instrument used to compress or treat bleeding vessels) were missing. This was an ongoing problem, cited repeatedly in multiple inspections between 2011 and 2019.
- The facility had no policies or procedures for monitoring supplies needed in emergencies.
- The garbage can in the procedure room had no bag and had bloody gauze and a used catheter in it.
- The refrigerator where medical waste was stored didn't have a biohazard sticker warning of its contents as required.

- Medication and cleaning solutions were stored together, in violation of regulations. This was an ongoing problem, cited in more than one inspection.
- Unsterilized, unwrapped metal speculums were stored in drawers on the examination table.
- Signage required by the Department of Health, including a complaint number, wasn't posted in the waiting room.
- Pads, sheets, curettes, sponges, and other medical equipment that were supposed to be clean were stored on the floor.
- Biohazard buckets that held medical waste had no lids or covers.
- Needles and other sharps weren't secured. This was an ongoing problem, cited in more than one inspection, and included used needles.
- Staff confirmed that heating pads and chair coverings in the recovery room weren't cleaned between patients. This was an ongoing problem and wasn't corrected.
- An oxygen tank was found difficult to open. The facility didn't have proper tools to open it.
- Medications were kept in an unlocked cabinet.
- The facility failed to monitor the temperature of medications that required refrigeration and had no policy for doing so.
- Syringes full of medication were not labeled as to dosage, medication strength, expiration date, or date opened. The facility had no policy on labeling syringes.
- Scrubs that were considered clean were stored on top of the dryer where dirty linens were washed. The dryer lid wasn't cleaned, raising the possibility of cross-contamination.
- The vent of the facility's dryer had an amount of lint comparable to the size of a golf ball.
- Ceiling tiles were stained and damaged. Paint was scraped off the wall.
- Drapes used to cover the procedure table, and pillows were kept in the procedure room during surgeries, making them vulnerable to blood splatters.
- The facility had no generator to provide power in the case of a power outage during a procedure.
- There were no call buttons either in the operating rooms or in the patient bathrooms, making it difficult for patients to summon staff in an emergency.
- A colposcopy machine (used to illuminate and magnify the view of the cervix) was stored in an unclean area, and four ultrasound machines were stored in an examination room. Staff admitted that the facility didn't have adequate clean storage spaces for these machines.
- The facility didn't have oxygen available for an emergency.

Staff

- The facility failed to perform criminal background checks on some of its employees. This was an ongoing problem, cited in more than one inspection.
- Staff were untrained and uncertified in advanced cardiac support and CPR.

- The facility failed to have guidelines for the proper dosing and administration of emergency medicine to pediatric patients requiring emergency care, and staff were untrained in this area.
- The facility did not have a Director of Nursing on staff.
- Staff didn't regularly check medication storage and had no policy for doing so.
- Staff didn't properly clean the examination room, "wiping down" only horizontal surfaces.
- The facility did not maintain health status files for staff.
- Staff failed to conduct preventative maintenance on an ultrasonic cleaner used to sterilize instruments.
- Staff failed to conduct preventative maintenance on an ultrasound machine.
- Staff didn't log the presence and amounts of medications.
- The facility failed to have a policy requiring staff to wear proper attire during surgical procedures.

Medical Records and Labels

- Boxes of patient records were stored under water-stained ceiling tiles. The boxes weren't stored in a manner that prevented water damage. This was an ongoing problem, cited in more than one inspection.
- Physicians failed to write or dictate post-operative surgical reports immediately after procedures.

Privacy

- The facility failed to keep medical records with patient information private. Medical records were stored in a manner where patients' names were visible.
- There were no curtains between the recliners in the recovery room, limiting patient privacy. This was an ongoing problem that wasn't fixed after first being cited.
- The medical records of seventeen patients that were supposed to be confidential were left open and in full view of other patients at an unattended desk in the waiting room. The computer was also left on and unattended, meaning patients could access private medical records.
- The computer's password was written on a piece of paper taped to the wall next to the computer in full view of those in the waiting room. An unauthorized person could therefore access records on the computer while the desk was unattended.

Incidents

A woman's uterus was perforated during surgery, and she was transferred to a hospital. The facility failed to notify the woman of her complication in writing, as required.

A second woman hemorrhaged after surgery, suffering from “excessive bleeding with noticeable large clots.” Staff called 911 and she was taken to the hospital by ambulance. The facility didn’t conduct an internal investigation into the incident and failed to report the complication to the Department of Patient Safety Authority as required. It also failed to evaluate and discuss the case at its Patient Safety Committee Meeting and made no recommendations to prevent such events in the future.

Treatment of Patients

- The facility failed to ensure that there was a licensed nurse on duty in the recovery room. Patients were therefore not properly monitored for complications after surgery.
- The facility failed to ensure only nonflammable agents were used for pre-surgical preparations. The facility was using an improper surgical prep (chlorhexidine gluconate solution 4.0%) to prepare patients’ cervixes for surgery.
- In one inspection, the facility was found to have failed to test patients for Rh sensitization.
- In other inspections, patients who were known to be Rh-negative were found not to have received RhoGAM shots. Without a RhoGAM shot, a Rh-negative patient can develop Rh sensitization after surgery. Rh sensitization can lead to stillbirth, infant death, or medical complications for the infant and mother in a subsequent pregnancy.
- Physicians at the facility did not evaluate patients before administering anesthesia.
- Medical practitioners did not obtain informed consent before initiating procedures.
- Staff were cleaning instruments with unlabeled, possibly expired, cleaning solutions and were unaware the solution had an expiration date.

Other

- Prescription pads were left in an unlocked cabinet, where they could be accessed by unauthorized personnel.
- According to inspectors, the facility’s Child Abuse Policy failed to include required information and did not meet the standards of the Child Protective Services Law as mandated by the Department of Public Welfare.
- The facility failed to arrange an annual fire inspection with the fire department, as required by regulations.

Harrisburg

The health department documents from 2012, 2017, and 2018 are under Harrisburg:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Clinic Conditions

- One of the patient restrooms was found to be dirty.
- One of the exam tables was ripped. The tear was held together with duct tape.
- They had expired supplies; namely, packages of surgical gloves and a Nanosonics Trophon Chemical Indicator, which verifies the proper concentrations of solutions to sterilize instruments.

Staff

- An employee had long fingernails with acrylic nail polish, which inspectors felt was unsanitary.
- The facility failed to conduct performance reviews for four out of five employees.

Medical Records and Labels

- The facility didn't keep copies of reports that were submitted to the Health Department

Lancaster

The health department document from 2023 is under Lancaster:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Staff

- The facility had no Certification of Clinical Privileges form on file for one of its doctors. He may not have been properly credentialed.
- A physician didn't have an up-to-date Drug Enforcement Administration (DEA) registration certificate.

Norristown

The health department document from 2012 and 2023 are under Norristown:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Clinic Conditions

- The facility "failed to provide a functional and sanitary environment for the provision of surgical services" and didn't "adhere to professionally acceptable standards of practice for the sterilization and disinfection of equipment."
- Machines for sterilizing equipment only got spore tests (mold tests) monthly. The manufacturer's instructions required weekly tests.
- Surgical instruments were covered with rust. This included suture scissors and speculums. These instruments were being used on patients.
- There was no emergency call system in the operating room or recovery room. There was no intercom in the exam room.
- They had no cardiac monitors or defibrillators. They also didn't have any tracheostomy supplies, which might be needed in an emergency.
- They failed to ensure there was a "properly conditioned air supply in critical areas of the facility."
- They failed to monitor the temperature and humidity in operating rooms or the recovery room.
- There was no nurse's station in direct view of the recovery room.
- There was no scrub station located near the operating room.
- The facility's Soiled Storage Room, where biohazardous waste was stored, was a small closet. They had no provision for disposing of fluid waste.
- There was no area where staff could change their clothes or put on scrubs.
- Dirty instruments, linens, and other items are supposed to be kept separate from clean ones and kept in different areas. Instead, sinks and counters were used for both dirty and clean items. Wrapped sterile supplies were stored in the same area as dirty items. Syringes and needles were also stored close to dirty items.
- There were no temperature, humidity, or ventilation monitors where sterile supplies were stored.
- Medical waste wasn't kept in a designated area but scattered throughout the facility.
- A plastic gallon container used to collect used urine strips and other items that may have come in contact with bodily fluids was kept next to the sink where staff washed their hands.
- Bathrooms were not equipped with hardware that allowed staff to enter them if a patient was having a medical emergency.
- There were no grab bars in the bathrooms, so they weren't handicapped accessible.

- Doorways, including entrances and exits from the facility, were too narrow to accommodate a gurney in case of an emergency.
- The facility had no oxygen or vacuum available for emergencies.
- Clean and sterile items were kept in the same area as blood and urine samples.
- They had no room dedicated to laboratory tests.
- Staff used dirty, unsterilized brushes to clean instruments.
- Bottles of Tylenol with codeine, which is a controlled substance, weren't stored in a double-locked cabinet and were therefore accessible to unauthorized persons.
- A thermometer in the laboratory had expired.

Staff

- There were no employees trained in Pediatric Advanced Life Support (PALS) for surgical procedures performed on children under 18. None of the doctors, nurses, or other employees were trained to conduct CPR on minors. Yet the facility had performed surgery on 77 minors in the past 11 months.
- They didn't have processes in place to perform criminal background checks on employees before hiring.
- The facility failed to conduct annual performance evaluations on half of its employees.
- None of the facility's doctors were licensed to administer anesthesia, but they were administering anesthesia anyway.

Privacy

There were no cubicle curtains for patient privacy in the recovery room.

Incidents

- One patient's medical record revealed medication failed to work, but there was no evidence the incident was reported or documented for tracking.

Treatment of Patients

- They didn't have a contract or agreement with an ambulance service, putting patients in danger in case of emergencies.
- Staff failed to monitor patients' oxygen saturation while they were under anesthesia. The facility had no equipment capable of monitoring oxygen saturation. This created a risk for patients.
- They were giving expired medications to patients.

Philadelphia (Locust Street)

The health department documents from 2011-2019 are under Philadelphia - Locust Street:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Clinic Conditions

- To quote: “the facility failed to provide a safe and sanitary environment.”
- The cushion of a bench patients were expected to sit on was covered with multiple dark stains – likely blood or bodily fluids.
- There were multiple dark stains on the carpeted floor in the recovery room.
- Used needles had spilled out of containers and were scattered on the floor in the biohazard room. The containers were stored directly on the floor.
- A container of used needles was also on the floor in the recovery room.
- In the storage room, toilet paper, paper cups, latex gloves, and exam table rolls, all of which should have been kept clean, were sitting on the floor. Bottles of solution were also on the floor.
- There were no hands-free scrub sinks outside the operating rooms.
- The facility failed to properly store human tissue, creating unsanitary conditions. Biohazardous waste was stored in an unlocked refrigerator in an unlocked closet. Biohazard bags were undated. In another inspection, cardboard boxes of biohazardous waste were found on the floor.
- The area where drugs, including narcotics, were stored wasn’t periodically checked by a pharmacist or practitioner, and no log was kept.
- The facility failed to maintain temperatures per established guidelines in the Recovery Area. It was too cold. In another inspection, staff were found not to be monitoring temperature or humidity in the operating rooms or recovery room.
- Twenty Gauze Sponge packets used in surgery were stored under a sink in the procedure room.
- The facility’s lab refrigerator/freezer, for storing control tests, had a buildup of ice.
- All of the wraps and pouches of sterilized instruments had wet stains on them.
- A metal container in the sterile processing room wasn’t properly sterilized.
- They had no policy on how long to soak instruments in sterilizing solution as per the manufacturer’s instructions. This could lead to instruments being used on patients that weren’t properly sterilized.
- The facility was cited for numerous health code violations, and the facility’s administration submitted a plan of correction. When the inspectors came back the next year, this plan hadn’t been implemented. According to the report: “the facility failed to correct deficient practice and failed to follow the Plan of Correction submitted to, and accepted by, the Department of a full State Licensure survey… for one of six deficiencies cited.”

- Two bags of Sodium Chloride solution, meant for intravenous use, and located in a heating cabinet, were undated. There was no way to determine if they had expired or were safe to use.
- The facility failed to ensure that stored drugs were periodically checked by a doctor or pharmacist.
- There was no record of the facility conducting maintenance on the ventilation system.
- Fusible link components of fire dampers were never tested. Fire alarms and fire extinguishers weren't inspected regularly.
- Electrical receptacles at patient bed locations and in locations where deep sedation or general anesthesia were administered weren't tested regularly.

Staff

- The facility failed to request and consider reports from the National Practitioner Data Bank for employees, which is a tool to prevent medical professionals from moving from state to state without disclosing previous medical malpractice.
- The facility failed to conduct background checks on employees working with minors.

Medical Records and Labels

- The facility had no written policy concerning the retention of medical records or specifying who had access to them. They also had no written policy dictating under what circumstances medical records could be removed or released.
- The facility's fire safety plan had no provisions for evacuating or securing patients' medical records.
- Staff failed to correctly complete paperwork on patients being discharged, neglecting to classify them according to physical status.

Privacy

- There were no curtains between reclining chairs in the recovery room, compromising patient privacy.

Treatment of Patients

- The facility wasn't reporting statutory rape or sexual assault of minors. They had no policy in place to do so.
- In 6 of 6 cases of pregnant minors under 16, the facility failed to ascertain whether the girls were victims of abuse by an adult and failed to report the incidents. These were four 13-year-olds and two 14-year-olds who were pregnant. No questions were asked, and no reports were made. Two of the minors reported that their first sexual intercourse occurred when they were twelve or younger. This wasn't reported.

- The facility failed to do physical examinations and assess patients' physical status before administering anesthesia and doing surgery.
- The facility failed to have a doctor supervise the nurse who gave anesthesia, nor were any doctors certified to give this supervision. The nurse giving anesthesia was not registered with the National Practitioner Data Bank.
- The facility didn't not have a policy that addressed the discharge of an incompetent patient.
- Patients having surgery weren't properly assessed before being discharged. Staff failed to check and document patients' respirations, activity level, pain, or nausea and vomiting.

Incidents

- A patient suffered a "serious event," i.e., a complication, and the facility failed to notify her in writing of the complication within seven days, as required.

Other

- When the entity that owns the facility (Planned Parenthood Southeastern Pennsylvania) held a Risk and Quality Management meeting for all its affiliates, no one from the facility attended.
- The facility did not request an annual inspection by the local fire department. Fire inspections weren't being done.

Philadelphia (Far Northeast)

The 18 health department inspections documents from 2012 to 2019 are under Philadelphia – Far Northeast:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Clinic Conditions

- Potentially infectious pathological waste was improperly stored. The facility had no freezer or refrigerator for storing human tissue, so they stored it at room temperature. Staff didn't use preservatives but simply boxed the tissue to be picked up by a waste disposal company. This presented a health hazard due to potentially decomposing human tissue.
- The treatment bed in one of the operating rooms was stained brown, allegedly by a cleaning solution. The armrest of the bed had tape on it, creating a surface impossible to properly sterilize.
- An IV pole in the operating room was rusty, and an air vent in the operating room was dirty and covered in rust.

- Medication in pre-filled syringes was kept in the procedure room, raising the risk of contamination by surgical products, dirty instruments, and biohazardous waste. The staff were drawing up medication into syringes in potentially contaminated areas.
- Packets of purportedly sterile instruments had wet stains on them, meaning they weren't sterile. The facility was planning to use the instruments during surgery.
- They had no official policies in place to determine that surgical instruments were properly sterilized.
- Staff didn't monitor or document the total time, pressure, or temperature for each load of instruments being sterilized in the autoclave to ensure sterilization was done correctly.
- Staff failed to use test strips on an open bottle of medication as required to ensure the effectiveness and safety of the medication.
- They had no emergency call system in the operating rooms or recovery room. This could lead to delays in summoning help in emergencies.
- They failed to establish policies for the timely cleaning of equipment and were unable to provide cleaning schedules. Staff had no records to show inspectors when and how often equipment was cleaned.
- Soiled and clean work areas were located in the same room and close to one another, raising the risk of cross-contamination.
- There were no hands-free scrub sinks outside the operating rooms.
- They had no devices for monitoring temperature and humidity anywhere in the building. This included the operating room, post-anesthesia area, and elsewhere.
- The ventilation system wasn't regularly checked and maintained. There was no policy to do so.
- They failed to ensure drugs were checked periodically by a pharmacist or practitioner. This was an ongoing problem, mentioned in more than one inspection.
- They failed to conduct routine maintenance of electrical receptacles, plugs, wires, and connectors, or ensure that they were safe.
- Formalin containers, which are required to be in a secure area, were stored in a place accessible to unauthorized staff.
- The facility was out of compliance with regulations for ambulatory surgical centers. The operating rooms were too small, the ceiling was not monolithic, and the floor didn't have sealed seams.
- They didn't have proper emergency illumination at the exits, a violation of the fire code. In two subsequent inspections, the exits were still not illuminated.
- They were also out of compliance with the fire code because fire barriers didn’t meet requirements. In a subsequent inspection, they were still found to be out of compliance with the fire code.
- They failed to ensure that automatic fire extinguishing systems and fire alarms were inspected by qualified personnel every three months, as required. There was no documentation for when they were last inspected.

Staff

- The facility failed to conduct background checks on its employees who were working with minors, as required by law.
- Staff weren't trained in the operation of the fire warning system, the proper use of firefighting equipment, and the procedure to follow if electric power was impaired. None had ever attended a fire safety workshop.
- They were unable to provide inspectors with any records on the education of nurses nor to substantiate they had proper training.
- They failed to designate a physician to serve as the director of anesthesia services. Therefore, no doctor was overseeing the nurses who delivered anesthesia or ensuring it was safely administered.
- The facility had no established policies and procedures for the supervision of the nurses administering anesthesia. There were no policies and procedures in place to ensure the education, training, and responsibilities of non-physician anesthetists.

Medical Records and Labels

- They had no official policy for specifying which employees had access to medical records and under what conditions medical records could be released or removed.
- In another inspection, inspectors found that unauthorized staff had access to confidential medical records.
- Records were stored in cardboard boxes alongside paint, ladders, light bulbs, and cleaning chemicals in a room that contained no fire extinguishers or fire-extinguishing system.
- The facility failed to have a proper plan for preserving medical records in the event of closure, as per state requirements.

Privacy

- There were no curtains for privacy between recliners in the recovery room.

Incidents

- Records showed that staff failed to report the possible sexual abuse of two minors under 16 who came to the facility pregnant. In such cases, staff are required by law to determine if the minor's sexual partner is four or more years older than she is. If so, a report must be filed. Staff failed to ask the minors the ages of their partners and filed no reports. Further questioning revealed that the facility had no policy for dealing with the sexual abuse of minors.
- Records showed five patients who had surgical procedures at the facility were not physically assessed before discharge.

- In a subsequent inspection, records show eight patients had been released without being assessed for nausea and vomiting, which could be symptoms of a complication.

Treatment of Patients

- They failed to have a written policy concerning the discharge of minors and incompetent patients.
- They had no policy for assessing patients for nausea and vomiting before discharge.
- They had no quality assurance and improvement program. They weren't trying to monitor and evaluate the quality of patient care.
- In a later inspection, it was noted that the facility did have a Risk and Quality Management Committee. But there was no documentation that they were performing their duties. The committee didn't appear to be evaluating medical staff functions, anesthesia services, nursing services, pharmaceutical services, pathology services, infection control procedures, and reports of accidents, injuries, and safety hazards. The facility's governing body failed to review reports from the Quality Assurance and Improvement, Infection Control, and Patient Safety Committees, and problems mentioned in these reports were not addressed or corrected. This was an ongoing problem, cited in more than one inspection.
- In a later inspection, it was found that the facility no longer had a facility-specific Infection Control Committee at all.

Other

- They failed to review contracted services to ensure they were provided safely and effectively. These services included housekeeping, linen, 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 alarm services.
- They failed to establish a workable plan with the nearest fire department.
- They failed to conduct fire drills. This was an ongoing problem, cited in multiple inspections. They also failed to arrange annual fire inspections, which was also an ongoing, uncorrected problem.
- They failed to maintain proper paperwork regarding staffing schedules and had no list of approved operative procedures performed at the facility.

Pittsburgh

The health department documents from 2011-2024 are under Pittsburgh:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Clinic Conditions

- To quote: “the facility failed to keep the premises and equipment clean.”
- There were multiple large stains on the carpet in the patient waiting room.
- In the ultrasound room, there was heavy dust on the sharps container, paper towel dispenser, and picture frames.
- In the operating rooms, there was excessive dust on picture frames, paper towel dispensers, cabinet tops, and door frames. This was an ongoing problem, cited in more than one inspection.
- In the utility room, there was a buildup of dried sanitizing material adhering to the bottom and sides of the wash station. This was where instruments were cleaned.
- A washer and dryer were covered with “a heavy coat” of dust, and the dryer had a broken lint filter and was full of lint.
- A trashcan with a biohazard bag, used for medical waste, was stored in the back hall by the staff entrance.
- One of the recovery chairs had a cracked, split seat cover, making it difficult to sanitize.
- The clean and soiled work areas were shared. The clean and soiled work counters were connected, raising the risk of cross-contamination.
- There were multiple cracked tiles on the floors of three operating rooms.
- Doors to the operating rooms were too narrow to admit stretchers, possibly causing delays and difficulties in emergencies.
- They failed to maintain medications within the recommended temperature ranges on the manufacturer's packaging for four out of four medications.
- They had multiple medications and surgical products that had expired years ago.
- Sterile strips had expired nineteen years before the inspection. The facility also had expired Chlamydia culture tubes and one container of cytology fixative spray that had expired six years before. Other fixative sprays had expired seven years before.
- The facility had medication that was expired by seven years and surgical masks expired by three years. Birth control injections had expired three years before.
- More than fifty curettes, used in surgery, had expired three years before. Another had expired two years before. Dilators used in surgery were also expired. A bottle of solution was three years past its expiration date.
- A box contained over forty medical instruments, such as forceps, that were also expired. This box did have a label marking the instruments as expired. This was not so with other expired items in the facility.

- Supposedly clean surgical tools were left in a drawer under the exam table.
- The facility failed to have a cardiac monitor and defibrillator available in each operating room and the recovery area. They were also missing other emergency supplies and devices, which would compromise the staff's ability to assist patients experiencing complications.
- According to inspectors, "the facility failed to provide adequate space to perform the volume of work with optimal accuracy, precision, efficiency, and safety." This concerned the exam room, which inspectors felt was too small.
- Staff didn't monitor temperature and humidity in the surgical and recovery areas.
- There were no humidity or ventilation monitors in the area where sterile instruments were stored.
- Ceiling tiles in three operating rooms weren't "monolithic, scrubbable, and capable of withstanding chemicals," as was required.

Staff

- None of the staff was certified in Advanced Life Support. They would be unprepared in an emergency. This was an ongoing problem, cited in more than one inspection.
- An unqualified nurse wrote prescriptions using prescription pads that were pre-signed by a doctor.
- They hired untrained staff to perform medical tasks, including assisting in medical procedures and surgeries. They required only a high school diploma and two years' educational/work experience after high school.
- When hiring staff, they didn't verify prospective employees' certifications and work experience, nor did they ask for references.
- Nursing staff had no experience in the postoperative care of pediatric patients.
- The facility had no anesthesiologist or certified registered nurse anesthetist on staff and yet was providing sedation to patients. This was an ongoing problem, cited in more than one inspection.
- When hiring doctors, the facility failed to examine and document evidence of their education, training, and assignment or curtailment of clinical privileges. They had no policies to do so.
- Nine out of ten doctors didn't have the paperwork regarding their DEA licenses in order, but all were dispensing a controlled substance.
- They granted privileges to doctors without doing proper background checks, in that they failed to request and consider reports from the National Practitioner Data Bank for each practitioner who requested privileges.
- They failed to specify which members of staff were allowed to dispense medications. Administration failed to ensure that only qualified staff dispensed them.
- They had no registered nurse, and no registered nurse was on the Quality Assurance and Improvement Committee.

Medical Records and Labels

- Medical records didn't have the names of staff members who dispensed medication and administered anesthesia, raising the concern that unqualified staff were performing these medical tasks.
- Preoperative tests and their results weren't properly documented in the medical records. There was no documentation for evaluation, annotation, or signature of the person evaluating the test.
- Medical records did not contain pertinent information regarding the choice of anesthesia.
- The facility had no policy for the removal of medical records.
- Some entries in the medical records weren't dated or signed.

Privacy

- There were no curtains between chairs in the recovery room, compromising patient privacy.

Treatment of Patients

- They failed to properly monitor the vital signs of patients who had received anesthesia before surgery. EKG monitoring wasn't done during procedures.
- They failed to conduct proper informed consent before surgery. Consent forms were incomplete as to the comparative risks, benefits, and alternatives associated with performing a procedure.
- The staff failed to properly evaluate patients who had surgery before discharging them. Staff didn't monitor, document, or check if patients had nausea or vomiting before clearing them to leave.
- They failed to notify patients receiving sedation that they needed to have a responsible person escort them home. The preoperative instructions didn't include this requirement, nor did they state that a patient might need to go to the hospital in the event of complications.
- They failed to verify the identities of patients before administering anesthesia and had no policy for doing so.
- They failed to send tissue removed during surgical abortions to a laboratory for examination by a pathologist. This could lead to a missed diagnosis of retained tissue, endangering the patient.
- They didn't have a written transfer agreement with an ambulance service. This could cause a delay in transporting a patient to the hospital in the event of a surgical complication or other emergency.
- They failed to have medically qualified staff observe patients who received sedation or anesthesia for a period of time to ensure they didn't experience complications.
- Written post-operative instructions given to patients lacked important medical information, such as instructions to avoid certain physical activities.
- Staff didn't take patients' temperatures before discharging them.

Other

- Prescription pads that had been pre-signed by a doctor were left in an unlocked cabinet in an unlocked room.
- Controlled substances were left unlocked and unattended in the crash cart. In a later inspection, controlled substances were not properly secured.
- They failed to track infections among patients and had no policy to do so.

Reading

The health department documents from 2011. 2012, 2017, 2018, 2019, 2022, and 2023 are under Reading:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Clinic Conditions

- The facility failed to separate the “clean” work area from the “soiled” one. They stored sterile instruments in the same area where dirty instruments were processed.
- The facility had an unsecured oxygen tank on the floor of one of the restrooms.
- The facility had two expired fire extinguishers on the floor of a restroom.
- Both procedure rooms had surgical equipment without preventative maintenance labels so there was no way to determine when the equipment expired.
- The freezer didn't have a temperature gauge to ensure items inside were kept at the right temperature.
- There were no temperature, humidity, or ventilation monitors where sterile instruments were stored.
- Sinks in the procedure rooms weren't hands-free. There were no scrub sinks located outside the rooms.
- The facility was unable to provide documentation that the autoclave, which sterilizes medical instruments, was properly tested for biologics that could contaminate instruments during the sterilization process.

Staff

- No staff members were trained in advanced cardiac life support.
- The governing body failed to properly screen their physicians.
- The facility had no registered nurse on staff.
- The facility failed to train staff on infection control.
- The facility failed to conduct annual performance evaluations for its doctors. This was an ongoing problem, cited in more than one inspection.

Medical Records and Labels

- The facility had no written policy regarding the preservation of medical records.
- The facility had no specific policy regarding which staff members had access to confidential medical records, under what conditions medical records could be removed, and under what circumstances medical information could be released.
- Physicians failed to sign pre-operative admission order sets and inter-operative notes.

Privacy

- There were no curtains separating patients in the recovery room.

Treatment of Patients

- Doctors at the facility failed to obtain informed consent and failed to notify patients of the risks of anesthesia and medical procedures.
- Staff failed to obtain proper informed consent for six out of six patients whose records were examined. The patients weren't given information on the comparative risks, benefits, and alternatives associated with performing a procedure in the ambulatory surgery facility instead of in a hospital.
- According to medical records, staff failed to assess patients for nausea and vomiting before discharge.
- Patients weren't provided with written pre-operative instructions before medical procedures, nor were they provided with post-operative instructions afterward.
- Staff failed to conduct necessary blood tests for patients prior to performing medical procedures. These tests, including hemoglobin or hematocrit measures, were meant to indicate whether a patient had risk factors that could complicate surgery.

Other

- The facility failed to conduct fire drills.
- Staff didn't conduct periodic checks of the area where medication was stored, and didn't maintain logs of medications.
- The facility had no written policies for prevention, control, and investigation of infection.

West Chester

The health department documents from 2011, 2012, 2014, and 2017 are under West Chester:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Clinic Conditions

- A foul odor was noted and was present throughout the facility.
- The suction machines used in surgery didn't have a preventive maintenance label to indicate the inspection date. There was no indication they'd been inspected.
- Medical supplies were expired, including a box of masks that had been expired for five years and two packages of gowns that had been expired for four.
- Human tissue from surgery was stored in a paper bag that was leaking blood in the refrigerator.
- The facility failed to ensure that linen was handled in a manner to minimize contamination. Linens weren't washed long enough, and the clinic staff didn't monitor the temperature of water to determine if it was hot enough to properly sterilize the linens.
- The facility failed to inspect and properly maintain the ventilation system.
- The facility failed to monitor the temperature and humidity levels in the operating rooms and post-anesthesia care area.
- Automatic fire extinguishing systems and fire alarms weren't inspected and tested.
- Grab bars were missing in the patient bathroom, meaning it was not handicapped accessible.
- There were no cubicle curtains for privacy in the recovery room.
- The soiled work area and clean work area were located together in the same room, raising the risk of cross-contamination.
- The facility didn't meet structural requirements – the floor didn't have sealed seams and the operating rooms were too small.
- There were no hands-free scrub sinks located outside the operating rooms.
- The facility failed to ensure controlled substances were properly secured. For example, 26 containers of Tylenol with Codeine were left in an open cardboard container on the countertop in the recovery room.
- According to an inspection report, "the facility failed to adhere to professionally acceptable standards of practice to assure a functional and sanitary environment."

Staff

- One of the doctors who maintained a supply of controlled substances, dispensed, and prescribed controlled substances didn't have the proper certification from the DEA.
- The facility failed to conduct background checks on its employees and didn't have a policy for doing so.
- There was no documentation that a doctor had privileges to administer anesthesia. There was no delineation of privileges regarding doctors administering anesthesia.

Medical Records and Labels

- The facility failed to have a written policy regarding the retention of medical records. It also failed to have a policy specifying which employees had access to medical records and under what conditions they could be released.
- There was no plan to evacuate medical records in case of an emergency.

Treatment of Patients

- The facility had a policy in place to monitor patients' blood pressure after surgery by taking vital signs every 15 minutes. However, this wasn't done for 11 out of 25 patients.
- The facility failed to provide a written policy for the discharge of an incompetent patient, i.e., a patient who couldn't consent to medical care because of age or mental condition.

Other

- Managers had erroneously instructed employees that they could turn away health inspectors if the inspectors arrived on a day that surgeries were being done.

Wilkes-Barre

The health department document from 2023 is under Wilkes-Barre:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Treatment of Patients

- According to medical records and staff interview, staff failed to offer required documents from the Department of Health to a minor patient and her parent to review before the minor's medical procedure. The facility failed to document that the educational materials were offered and failed to document whether the patient and/or parent chose to view them.

York

The health department documents from 2011-2025 are under York:

www.problemsatplannedparenthood.org/pennsylvania

Highlights:

Clinic Conditions

- The facility had no emergency call system in the bathrooms, operating rooms, and recovery area.
- They failed to ensure the ventilation system was inspected and maintained. They therefore failed to ensure air quality was kept at proper filtration, humidity, and temperature requirements in operating rooms and the recovery room.
- They had no fire extinguishing systems or fire alarms.
- Ceilings consisted of textured tiles that were not scrubbable or gasketed.
- There were no scrub sinks located outside of the procedure rooms.
- Doors were too narrow to admit a gurney in case a patient needed to be transferred to the hospital in an emergency.
- The facility failed to have emergency equipment readily available for resuscitation for procedures using local anesthesia.
- They failed to conduct regular testing of their automated external defibrillator to ensure it was in working order. This equipment could be critical in an emergency.
- The only oxygen tanks in the facility were empty.

Staff

- They failed to request and consider reports from the National Practitioner Data Bank for both of its doctors. The National Practitioner Data Bank is a tool that prevents medical professionals from moving from state to state without disclosing previous medical malpractice.
- They failed to ensure a Registered Nurse was on the Quality Assurance and Improvement Committee.
- Staff didn't have training or education in infection control.
- They failed to provide a committee for the prevention, control, and investigation of infection.
- They failed to complete annual performance evaluations for three of their four physicians.

Medical Records and Labels

- None of the medical records contained documentation the patients were assessed for nausea and vomiting before discharge.
- No post-operative surgical reports were written for six of six patients.

- Entries in medical records weren't dated and authenticated by the person making the entries. Paperwork wasn't signed or dated in 100% of cases.
- The facility didn't have a policy regarding the preservation of medical records.

Incidents

- The facility failed to administer a RhoGAM shot to a woman who was Rh-Negative. This could lead to Rh sensitization, which can cause serious complications and infant death or disability in future pregnancies.
- A patient suffered a medical complication, and they failed to notify the patient in writing of the event within seven days because, at the time, they had no patient safety officer.
- In 2023, the facility was cited for "failing to report a serious event." This was likely a complication, but no more information is available.

Treatment of Patients

- They failed to ensure practitioners documented informed consent.
- They failed to conduct a physical exam and evaluation before performing surgery or giving anesthesia for six of six patients whose records were examined.
- The facility failed to ensure patients were properly identified by the operating surgeon before the start of surgery for six of six medical records reviewed. In every case, the surgeon didn't identify the patient prior to the start of the procedure.
- The facility failed to document whether a Rh-negative patient was given or refused a RhoGAM shot.

Other

- They didn't have written policies and procedures that only authorized people in the proper attire could be in the surgical area.
- They failed to establish a workable plan with the nearest fire department.
- They failed to conduct fire drills.

South Carolina

Charleston

Highlights:

Clinic Conditions

- Eighteen disposable syringes, used on patients, were found to be expired.

Incidents

- The facility failed to conduct proper informed consent before a surgical procedure on one patient. There was no documentation of informed consent, and the patient hadn't signed the required form attesting to receiving it.

Treatment of Patients

- There were no emergency call buttons in any of the bathrooms, meaning patients couldn't summon staff in the event of an emergency.

Other

- A doctor on staff failed to report procedures to Vital Records and Public Health Statistics at the Department of Health, as was required.

Columbia

The 2015 health department document are under Columbia:

www.problemsatplannedparenthood.org/south-carolina

Modern Healthcare
Associated Press, September 12, 2015

Excerpt:

The Department of Health and Environmental Control issued suspension orders for Planned Parenthood's Columbia clinic and the Greenville Women's Clinic, citing violations found during recent inspections . . . The Columbia clinic was cited for 21 violations . . . Planned Parenthood's additional citations include having expired medicine and storing sterile and nonsterile gloves together.

South Dakota

Sioux Falls

The health department document from 2014 is under Sioux Falls:

www.problemsatplannedparenthood.org/south-dakota

Highlights:

Clinic Conditions

- According to the inspection reports, the facility failed to maintain an environment "in such a manner that the safety and well-being of the patients are assured."
- There were holes in three of the four walls in the elevator equipment room. There were four holes in the ceiling of the generator room. There were eight holes in the ceiling of the second floor mechanical room. There were holes in the walls in the boiler room. These problems were cited in multiple inspections, and were not fixed.
- The exhaust fan in the soiled storage room wasn't functioning.

The facility had the following fire hazards:

- A hand sanitizer dispenser was installed above a light switch.
- Electrical receptacles in a corridor had a damaged cover.
- Light fixtures in many of the rooms did not have bulb protection.
- The facility had not had its fire dampers inspected in four years.
- Access to a fire extinguisher was obstructed by an advertisement sign.
- Another fire extinguisher was taped to the wall and wasn't available to be used in an emergency.
- None of the fire extinguishers were being inspected or tested.
- Doors were blocked with rubber wedges, possibly preventing patients and staff from escaping in the event of a fire.
- Signs were stored in the hallways, interfering with evacuation in case of an emergency.
- In a different inspection, cases of water were blocking hallways and bottles of beer were blocking stairs leading out.
- There were unsecured oxygen cylinders in the surgery room.
- There were no hazard signs located in areas where oxygen and other flammable gases were stored.

This problem was not corrected and was cited in two different inspections.

Tennessee

Nashville

The health department/board of medical examiners document is under Nashville:

www.problemsatplannedparenthood.org/tennessee

Highlights:

At the Planned Parenthood facility, the doctor gave a prescription to an employee without proper examination, and later gave the employee a signed blank prescription. The doctor was required to complete a course on proper medical oversight of prescriptions.

Texas

Austin (South)

The health department document from 2015 is under Austin - South:

www.problemsatplannedparenthood.org/texas-austin

Highlights:

Clinic Conditions

- The facility "failed to ensure a safe and sanitary environment for all surgical patients."
- There were pieces of debris around patient beds in the operating rooms. There were used alcohol pads on the floor of one OR and on the table in another.
- The bed rests on tables in both OR's were covered with socks, and the socks weren't changed between patients.
- There was tape on multiple surfaces in both operating rooms. Tape creates a sticky surface that can't be properly disinfected.
- There was a "thick, visible layer of dust" on surfaces in both operating rooms. Inspectors said this indicated "ineffective cleaning."
- The facility was improperly sterilizing instruments. Sterile instruments were left open or sealed in a way that would prevent them from being fully sterilized.
- Packages of patient tubing and curettes were stored improperly, in potentially unsanitary conditions.
- Multi-dose vials of Lidocaine were stored improperly.
- Patient care items weren't taken out of shipping containers, and were stored within them, leading to possible unsanitary conditions.

Treatment of Patients

- The facility was only supposed to discharge patients if they were accompanied by a responsible adult. The facility didn't follow this policy and sent patients away alone. There was no documentation that these patients were well enough to leave the facility and travel home alone.

Dallas (South)

The health department document from 2015 is under Dallas - South:

www.problemsatplannedparenthood.org/texas-dallas-ft-worth

Highlights:

Clinic Conditions

- A cabinet beneath the sink in the waiting room had a large circle of dark brown dried substance on it.
- The emergency call button in one of the patient bathrooms was too high off the floor for a patient to reach if they had fallen.
- Patient bags were stored on the sitting bench in the bathroom across from the toilet.
- Other patient bags and belongings were stored in a cardboard shipping box on the floor of the pre-op storage area.
- In one of the patient bathrooms, three ceiling tiles had large brown water stains.
- There was no gauge on the only available oxygen tank that was available for patient emergencies, so the oxygen couldn't be turned on.
- The vital sign machine was three months past the date when it should have received preventative maintenance and an electrical safety check.
- The cabinet covering where sterile instruments were wrapped was peeling and cracked. Under the cabinet, empty cardboard boxes were stored on the floor in the same area where sterile instruments were wrapped. According to the report, "this had the likelihood to contaminate supplies which could cause an infection."
- Cardboard shipping boxes were stored with open patient supplies on the shelves. Cardboard boxes were on the shelf above the open sterile supplies.
- Open sterile supplies were stored near the floor where dust particles could contaminate them. Cardboard shipping boxes containing patient belongings were stored on the floor where open sterile supplies were kept.
- Two suction machines had no preventative maintenance safety check stickers, so they weren't being inspected or properly maintained. Staff told inspectors these machines weren't being used, but they didn'tt have a "do not use" label.
- Cardboard shipping boxes with biohazard needles were stored on the floor in the same area where sterile supplies were kept.

- There were trash and dust particles in the area where open sterile supplies were stored.
- Clean linen was observed on the floor of the laundry room.
- The biohazard waste storage room, where human tissue was kept, had an unsealed cement floor. This created a situation for blood to leak from the biohazard bags onto the unsealed cement floor, creating a surface that was impossible to clean and increasing the risk of transmitting infection.
- Temperature and humidity weren't monitored in areas where sterile instruments were stored. According to the inspection report, this could cause a fire hazard, the buildup of dust, and/or the growth of microbes.
- Sterile instrument packages were incorrectly sealed. According to the report, this had the potential to cause contamination and microbial growth. According to one staff member, "the girls assisting me did not have the knowledge to recognize that the peel pouches were not sealed or labeled correctly and that they would need further training."

Staff

- A staff member reached into a washing machine and handled dirty linen, potentially stained with blood and bodily fluids, without personal protective equipment.
- Staff failed to wear proper operating room attire during surgeries.
- The facility didn't know the hepatitis B status of half of its employees.

Medical Records and Labels

- Sealed packages of instruments weren't labeled correctly and were also improperly sealed.

Treatment of Patients

- Doctors didn't perform physical exams on patients prior to surgery. There was no documentation of exams for half of the patients whose charts were examined and inspectors were "unable to find evidence" that exams were done.
- Patients weren't evaluated by a physician or advanced practice registered nurse prior to being dismissed from the facility after surgery. An employee stated, "the physician completes their procedure and does not see them in recovery unless there is a complication." However, without an exam, it could be hard to determine if there was in fact a complication. Other employees confirmed patients weren't seen in recovery prior to going home.

Other

- The facility failed to store medication in a safe and secure area. Lidocaine vials were located in an unlocked storage area, where they could be accessed by unauthorized persons.

Fort Worth (Southwest)

The health department document from 2016 is under Fort Worth - Southwest:

www.problemsatplannedparenthood.org/texas-dallas-ft-worth

Highlights:

Clinic Conditions

- The facility "failed to ensure a safe and sanitary environment for surgical patients."
- The facility wasn't conducting proper maintenance on three suction machines. The facility was nevertheless performing surgery with these machines.
- Supplies in the emergency crash cart were expired.
- There were no oxygen tanks available in case of emergencies.
- Cardboard shipping boxes were stored with sterile patient supplies, creating a risk of contamination. A dirty feather duster was lying beside sterile supplies.
- A cardboard box containing biohazardous waste was also stored right next to the sterile supplies. According to the report, "this had the likelihood to contaminate the clean and sterile supplies from the waste products brought into the room and placed in the biohazard box."
- Trash and dust particles were on the floor of the room where sterile supplies were stored.
- There were exposed wires from an uncovered electrical outlet in the laundry room, creating a fire hazard. These wires were close to where water ran into the washing machine.
- The wall in the laundry room had areas where plaster was missing. This made it so employees couldn't clean the wall and created the risk of contamination of clean linens.
- Snacks for patients were kept in a cardboard box placed on a dusty and dirty cart.
- There was equipment that wasn't labeled or sorted to determine if it was clean or dirty.
- In the pharmacy, there were several carts covered with dust.
- Packages of instruments weren't sealed correctly, leaving the possibility of contamination.
- Staff didn't maintain the autoclave, which was used to sterilize dirty instruments. They failed to monitor pressure and temperatures. According to the report, this "had the likelihood to cause contamination and microbial growth in the sterile instrument packages." The printer on the autoclave hadn't been working for six months, so there was no way for staff to know if the autoclave had reached the proper pressure and temperature to sterilize the instruments.
- The facility failed to conduct a monthly examination of one of its two fire extinguishers.

Staff

- None of the nurses who were administering conscious sedation to patients had proper training.
- Staff didn't wear proper operating room attire in surgery.
- The facility didn't know the Hepatitis B status for half of its employees.

Treatment of Patients

- Doctors at the facility didn't conduct physical exams on patients before their surgery in every patient case reviewed. Staff could find no documentation or evidence that physical exams had been performed and couldn't provide evidence that they were.
- The facility had expired laminaria (sticks put inside women's bodies before abortions to open the cervix) and seemed to be using them on women.

Other

The facility had no policy of surveillance techniques to minimize sources of infections. They didn't track infections of patients.

Houston

The health department documents from 2015, 2017 and 2020 are at:

www.problemsatplannedparenthood.org/texas-houston-stafford

Highlights:

Clinic Conditions

- The biological indicator used on the autoclave wasn't properly tested. The autoclave was used to sterilize instruments. Inspectors determined that the biological indicator tests being conducted weren't valid.
- Medical equipment in the operating room was covered with rust and couldn't be disinfected.
- Packages of dilators marked as sterile had dime-sized brown spots on them. When questioned about the stains, a staff member admitted that the instruments weren't sterile and shouldn't have been labeled as such or stored with the sterile instruments.
- Instruments were improperly sterilized. Instruments were improperly packaged, preventing them from being properly sterilized.

Staff

- The doctor was operating on women without washing his hands. Staff members failed to wash their hands after handling dirty instruments.
- When a doctor was observed not washing her hands after surgery, she told inspectors, “Yes, I should do that, but because maybe sometimes if people are watching you, it’s kind of overwhelming.”
- Staff didn’t have training on how to properly sterilize instruments. Three of the staff working in sterile processing had no documentation of training or competency.
- Staff didn’t properly measure the amount of detergent per water used to clean instruments.
- None of the nurses administering sedation were officially trained to do so or had documentation of competency to do so. The Director of Nurses claimed that nurses administering sedation learned on the job, by observing others in a mentorship-type situation, but none of the employees administering sedation were formally trained.

Treatment of Patients

- Contaminated, unsterile instruments were used in surgery.
- Staff didn’t clean the IV port prior to injecting medications into women

San Antonio – San Pedro

The health department documents from 2020 and 2021 :are at

www.problemsatplannedparenthood.org/texas-san-antonio

Highlights:

Clinic Conditions

- Instruments were washed and sterilized in the same area where dirty, biologically contaminated surgical instruments and medical waste were processed.
- The facility failed to keep medical waste and dirty instruments separated from clean ones, creating cross-contamination.
- There was only one sink and eyewash station. It was located in the same area as the dirty instruments and medical waste.
- sterile instruments intended for surgery were stored in a manner that they were no longer sterile. This created a risk of infection when those instruments were used on patients.
- There were no protective barriers on heating pads. The pads weren't properly cleaned between patients.
- The solution used to decontaminate vaginal ultrasound probes had dust and “unidentifiable debris” in it. The facility was using this solution to sterilize the

vaginal probes between uses. This was not corrected and was found to be the case in another inspection a year later.
- In this later inspection, the ultrasound and ultrasound probes were found to be dusty and had pinkish-red stains on them.
- There were red stains (presumably blood) on the walls and floors of all the operating rooms.

Staff

- Staff had no set schedule to clean the operating rooms between patients, and did not appear to be doing so.

San Antonio – South Texas

The health department documents from 2012, 2015 and 2019 are at:

www.problemsatplannedparenthood.org/texas-san-antonio

Highlights:

Clinic Conditions

- According to the report, "the facility failed to follow its own procedures to maintain separation of contaminated and sterile supplies."
- Biological indicators used for monitoring the effectiveness of steam sterilizers were in the same refrigerator as medications. Biological indicators contain bacteria spores and, according to the inspection report, should be regarded as contaminated and should be stored apart from medication and sterile supplies.
- The medication refrigerator was kept in the dirty utility room.
- The facility failed to have signs posted which offered sex trafficking victims a hotline they could call for help. It was a legal requirement for them to be posted in patient bathrooms and consulting areas.

Other

- The facility allowed unlicensed staff to have access to the cabinet where controlled substances were kept. An unlicensed staff member had the keys to the cabinet and unlimited access to the narcotics.

Stafford

The health department documents from 2019 is under Stafford:

www.problemsatplannedparenthood.org/texas-houston-stafford

Highlights:

Clinic Conditions

- Hazardous chemicals and cleaning products weren't stored securely.
- There were expired supplies, including needles and surgical equipment.

Treatment of Patients

- The facility didn't have written discharge instructions. None of the patients got a list of potential complications to be aware of. They weren't instructed on what symptoms indicated an emergency and necessitated calling the facility or going to an emergency room. They weren't given an emergency number to call to reach a doctor in the event of a complication or if they had questions.
- The facility wasn't having women return for a follow-up appointment after taking a medication that might put them in danger of suffering infection or hemorrhaging.

Utah

Salt Lake City - Metro

The health department documents from 2012, 2015 and 2017 are under Salt Lake City:

www.problemsatplannedparenthood.org/utah

Highlights:

- Hot water in patient areas was measured at temperatures that were too high, risking burns.
- There were no grab bars in the bathrooms for patients.
- The facility's communication room ceiling had two loose or missing tiles, creating a fire hazard.
- The facility didn't have emergency exit lighting. There was no back-up emergency light over the stairs, creating a hazard if the building needed to be evacuated.
- In another inspection, exit signs weren't lit, presenting a risk in case of an emergency.
- The facility failed to have smoke detectors in the required locations.

Virginia

Charlottesville

The health department document from 2012, 2014, 2016, and 2018 are under Charlottesville:

www.problemsatplannedparenthood.org/virginia

Highlights:

Clinic Conditions

- The exam table was torn at the corners. Half the reclining chairs also had tears. This created porous surfaces impossible to sterilize, risking infection.
- There were open packages of medication that staff were administering to patients. However, staff failed to document the dates they were opened. Since open medications must be discarded a certain number of days after being opened, this oversight created the risk of using expired medication on patients.
- Medication that had been removed from its original packaging and stored elsewhere was improperly labeled.
- Used needles and sharp instruments weren't stored safely. Sharp containers were on the floor and unsecured.
- Two sinks in the procedure room didn't meet the requirements of hand-washing stations.
- The facility didn't have medications on hand to treat cardiac emergencies that may arise during surgery.
- The building failed to comply with state and local codes regulating surgical facilities.

Staff

- Unqualified staff were dispensing medication (including controlled substances), administering vaccines, and doing birth control injections without sufficient training.
- Inspectors observed a staff member perform a pelvic exam without washing their hands. They then went on to complete surgery, conduct an ultrasound, and handle medical waste without washing their hands between tasks or afterwards.
- The governing body of the facility failed to document the appointment of a clinic administrator and staff couldn't provide the name of one.
- All but one employee were providing direct care to patients without proof of licensure on file.
- The facility failed to conduct criminal background checks on staff who had access to controlled substances in violation of Virginia law.

- The staff member in charge of infection control was not a licensed medical professional and had not received adequate training.
- indicated two staff members tested positive for tuberculosis, but there wasn't any follow-up from a physician.

Privacy

- The facility staff failed to ensure that medical records were stored in a secure area. Records containing personal information were observed lying on top of a shelf just inside a door, accessible to anyone who opened the unlocked door.

Other

- Unsigned prescriptions for controlled substances were stored behind an unlocked door, where they could be accessed by unauthorized persons.
- Narcotics weren't kept locked up but were unsecured.

Richmond

The health department document from 2014 is under Richmond:

www.problemsatplannedparenthood.org/virginia

Highlights:

- Surfaces weren't disinfected between patients.
- Staff failed to maintain procedures which prevented cross-contamination and transmission of infections.
- There was a sticky residue from tape on one of the exam tables that prevented the table from being properly disinfected between patients.
- Four of the seven recliners in the recovery room were dirty, with particles of food in crevices between the seat cushions and the sides. Staff admitted the recliners hadn't been disinfected between patients.
- Disposable absorbent padding wasn't changed between cases. Instruments and surgical supplies were placed on this padding, raising the risk of infection.
- Staff failed to wash their hands after changing out of contaminated gloves before putting on new gloves. They also failed to use hand sanitizer and didn't clean their hands after touching blood, bodily fluids, and dirty instruments.
- Inspectors witnessed a staff member place a dirty container that had been sitting on top of a biohazard box onto an exam table a woman was about to lie on.

Roanoke

The health department document from 2012, 2014 and three from 2016 are under Roanoke:

www.problemsatplannedparenthood.org/virginia

Highlights:

Clinic Conditions

- A brownish-red stain one inch long was found on an operating table. Staff claimed the stain was "possibly [the medication] betadine." Staff attempted unsuccessfully to clean the table, then lifted the cushion, revealing extensive bloodstains beneath the cushion.
- The report says: "The undercarriage of the support cushion had multiple areas where blood had dripped and ran down the undercarriage. The accumulation of dried blood varied in coloration and thickness. Staff #10 acknowledged the substance was dried blood and not betadine."
- One of the procedure tables was torn with exposed foam, creating a surface that couldn't be properly sterilized.
- Five of five chairs in the recovery room were torn and couldn't be properly sterilized. Three chairs were also dirty, with food particles and "unidentifiable" substances between the seat cushions and arms. Staff admitted they weren't being cleaned.
- The facility had outdated supplies available for patient use. Tracheal tubes, used to maintain a patient's airway in the event of an emergency, had expired eight years earlier. Sutures in the facility were 2-4 years past their expiration dates.
- Indicator strips being used to test sterilization equipment were past their expiration dates.
- Expired supplies were an ongoing problem. In a subsequent inspection, defibrillator pads, needed in an emergency, were found to be expired. There were no pads in the facility that hadn't expired.
- Emergency medication, available to be administered to patients, was also expired.
- The surgery facility was out of compliance with requirements regarding airflow and air filtration.
- There was no inspection report on one of the vacuum suction machines used for surgery. The same problem was found in a subsequent inspection.
- There was no record that a pulse oximeter used for emergencies had been inspected.
- In a subsequent inspection several years later, the facility's pulse oximeter hadn't been inspected by staff as required or given proper maintenance.
- Inspectors found "dried yellow debris circled in brown" on a heating pad stored in a drawer labeled "gloves."
- Controlled substances weren't stored securely. Although they were kept in a lockbox in a locked cabinet, the keys were kept in an unsecured location - an

unlocked drawer in an unlocked office. Staff admitted every employee therefore had access to the medication.

- Controlled substances in the crash card weren't monitored, regularly counted, or kept secure.
- A bottle of Ativan in the facility's lockbox was open, and staff didn't know whether the medicine had been accessed, or if any was unaccounted for.
- The crash cart was missing vital emergency supplies. There were no foley catheters or Vasopressin, needed in emergencies.
- There was no paperwork to indicate a completed inventory check of the emergency supplies for two months.
- Regular inspections weren't conducted of the emergency defibrillator.
- There were open bottles of medication in the refrigerator with no labels as to when they'd been opened. One of those medications was supposed to be discarded 28-30 days after opening. Without a date on the bottle, staff were unable to determine how long it had been open, or when it should be discarded.
- Emergency medications were listed as being in the crash cart, but weren't there, and staff were unable to find them anywhere in the facility.

Staff

- The facility failed to conduct criminal background checks on staff who were handling controlled substances, as required by Virginia law. This was an ongoing problem, also found in two other inspections, years later.
- Staff failed to conduct pill counts and properly monitor controlled substances.
- Staff failed to properly put on and take off personal protective equipment.
- After handling materials in the medical waste lab, one staff member neglected to change gloves.
- When mixing the solution used to sterilize instruments, a staff member failed to measure the components of the mixture or follow guidelines on how to prepare it. This created the risk that instruments weren't properly sterilized.
- A staff member was observed placing instruments that had just been cleaned on a surface covered in blood and tissue. These re-contaminated, dirty instruments were intended to be used on patients.
- The facility failed to screen staff for vaccination status or communicable diseases to prevent staff from spreading diseases to patients, in violation of requirements from the US Occupational & Health Administration.
- The facility had no policy for reporting "inappropriate behaviors" or violations among staff to the Board of Medicine or the Board of Nursing.
- There were three doctors listed as employees of the facility. Inspectors asked a staff member if they were the only doctors performing surgery, and the staff member said that they were. However, inspectors found that multiple residents, who weren't listed on the paperwork as employees, were also performing surgery. The facility had no written records as to the competency, privileges or credentials of these doctors, nor any records of their training.
- Required drills on active shooter situations and patient complications were held, but attendance sheets showed some staff didn't attend them.

- Paperwork on drills for complications such as hemorrhage and anaphylaxis stated all nurses were present and demonstrated correct knowledge. However, when investigators looked at the sign-in sheets for these drills, they saw the nurses weren't present. When questioned, staff admitted the nurses hadn't attended the drills, and the paperwork was false.
- Paperwork admitted that one nurse, who worked four hours a week in the recovery room, "has not been fully trained on medical standards and guidelines."
- An unlicensed staff member was administering Depo-Provera injections. There was no documentation indicating that this staff member had proficiency in the administration of intramuscular injections.
- Two staff members didn't have documentation on file that they underwent CPR training or were certified in CPR.
- Internal paperwork reported that administrators had concerns about staffing (lack of nurses) in 2015 and 2016 that weren't resolved at the time of the inspection. Staff said they intended to attract and hire more nurses, but there was no documented plan on how to do so. There was also no documentation on steps taken to resolve the issue.
- observed a staff member conducting a urine pregnancy test without wearing gloves.
- Staff handled medication and dispensed it to patients without wearing gloves.
- Staff left medication in an unlabeled, open container unattended in a room frequented by patients and staff.
- Staff failed to document, log, or maintain any records of infections, as required.
- Staff claimed that patient records were evaluated for completeness and accuracy but could provide no documentation that this was done.

Medical Records and Labels

- Paperwork on individual surgeries didn't list the names of the doctors who performed them. When asked how many surgeries were performed by each resident, staff couldn't answer because no records were kept.
- Records on employees were incomplete and lacked job descriptions as well as information about performance evaluations.
- The facility had conducted audits of staff on personal protective equipment and hand hygiene but failed to record the results.
- When staff took inventories of medication, they were required to document the expiration date (listed on the paperwork as "exp") and the location of the medication in the facility ("loc"). When inspectors examined the records, they saw these boxes had been left blank. When questioned, the staff member tasked with doing the inventories stated that they had left them blank because they didn't know what "exp" and "loc" meant.
- One set of paperwork had checkmarks beside names of medications. Inspectors asked what the checkmarks meant, and staff didn't know.

Incidents

- Inspectors discovered that a patient had called the regional call center and reported that she was experiencing a complication and couldn't get through to staff at the Roanoke facility. According to the notes, "Patient was very upset, stating that she thinks that she has a possible infection and can't get in touch with anyone, and nobody will help her." The patient said she'd been trying to contact the Roanoke clinic and the doctor "refuses to see her." Even though the call was logged in the patient's medical records, it was never documented as an official complaint or addressed as such by Planned Parenthood. When questioned, staff members at the Roanoke facility weren't aware of the call or the situation. They didn't recognize the name of the call center employee listed in the records. It is unknown whether and where the patient received medical assistance.

Treatment of Patients

- Paperwork given to patients about the process for filing complaints didn't include a statement that all complaints would be responded to within 30 days.
- Staff were performing surgery with vacuum curettes that had expired two years before. Surgical supplies used for IVs were 12 years past their expiration date.
- When preparing to give a patient an injection from a multi-dose bottle of lidocaine, a staff member failed to clean the top of the bottle with an alcohol swab before inserting the needle into the bottle. This created a risk of infection for the patient.
- Staff admitted that the operating tables (one of which had bloodstains) had not been sterilized between patients.
- Staff had no system to report or respond to patient complaints, and complaints that had been made weren't investigated or resolved.
- The facility didn't offer testing for sexually transmitted diseases to patients coming in for surgery, nor did they ask patients about symptoms or STD history. Patients who have surgery while infected with an untreated STD have a higher risk of developing pelvic inflammatory disease.

Other

- The facility had no policy for reporting disease outbreaks or infection rates to the health department in accordance with requirements and weren't doing so.
- The facility had no policies or procedures for reporting potential patient deaths to the Office of Licensure and Certification.
- The facility had no policies or procedures for infection control and performed no annual review related to infection prevention policy.

Wisconsin

Milwaukee (Water Street)

The health department document from 2011 and 2017 are under Milwaukee – Water Street:

www.problemsatplannedparenthood.org/wisconsin

Highlights:

Staff

- The laboratory staff failed to monitor temperatures in the laboratory. Specimens and reagents need to be kept at a certain temperature to prevent them from being compromised. Fluctuating or too warm temperatures can prevent proper results.
- The laboratory staff didn't follow the proper procedures for testing samples. Lab technicians didn't follow manufacturer's instructions while conducting tests with laboratory equipment.
- The laboratory director failed to sign off on documentation of test results.
- In another inspection, the facility was found not to have procedures for evaluating the competence of laboratory staff who were conducting tests.

Patients

- Four patients who were tested for Rh incompatibility were listed as Rh negative in one set of paperwork and Rh positive in another. Rh negative patients need a RhoGAM shot to protect future pregnancies. Confusion over Rh status can lead to patients who need the shot not receiving it.
- The laboratory director failed to review or evaluate the documentation about corrective action for this incident.