Report of the Problems at Planned Parenthood Committee
PDF book version of the Colorado page of the constantly-updated website:

Problems at Planned Parenthood - **www.problemsatplannedparenthood.org**

Pennsylvania page:
www.problemsatplannedparenthood.org/pennsylvania

This report organizes problems with a section for each kind of problem. The website instead reports problems by individual centers or groups of centers.

PDF version dated July 26, 2026

Section 1

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Incidents in health inspection reports that involved an ambulance to the hospital have the highlight explaining it marked with this graphic.

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.
- 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. They could be accessed by unauthorized personnel.
- Controlled substances were left unlocked and unattended in the crash cart. In a later inspection, controlled substances were not properly secured.
- The governing body of the facility failed to approve proper medical standards and techniques for administering anesthesia.
- They failed to track infections among patients and had no policy to do so.
- They failed to arrange regular fire inspections.

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, also on the floor of one of the restrooms.
- 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. This could lead to medications and tests being improperly maintained.

- The facility failed to monitor the temperature and humidity in the operating rooms and the recovery room.
- There were no temperature, humidity, or ventilation monitors in the area where the sterile instruments were stored. The temperature and humidity weren't being monitored.
- 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 facility failed to reappraise and reappoint physicians and certified registered nurse practitioners every two years as required.
- The governing body failed to request and review reports from the National Practitioner Data Bank before granting doctors privileges. They didn't properly screen their physicians.
- The facility had no registered nurse on staff.
- The facility had no staff member(s) responsible for developing and monitoring the infection control program and maintaining records of infections among patients.
- 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.

Warminster

This clinic is permanently closed, so the health department documents from 2012, 2016, 2017, and 2018 are at:

www.problemsatplannedparenthood.org/closed-centers

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 at:

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.

Section 2

We include only cases since 2000, and only those where details of the allegations are known.

We use the plaintiff's last name to distinguish the cases, but the plaintiff's full name and the name of individual defendants are redacted in the excerpts on our pages. They are of course available in the official court documents on the Problems at Planned Parenthood website (problemsatplantedparenthood.org).

Philadelphia – Castor Street

Matalski

The 2016 Complaint is under Philadelphia – Castor Street:

www.problemsatplannedparenthood.org/pennsylvania

Excerpt:

1. In November of 2004, Pfizer the manufacturer of Depo-Provera Contraceptive Injection (hereinafter “Depo-Provera”) released a 22 page report containing detailed information related to Depo-Provera . . .

3. The report contains a detailed “black boxed warning,” about loss of bone density on the first page, which should be relayed to the patient . . .

43. According to the chart, Ms. Mastalski, then 29 years old, had already been taking Depo-Provera (a/k/a “depo shot”) as a form of birth control for more than 2 years . . .

46. On August 16, 2010, Defendants knew or should have known that Ms. Mastalski had been receiving the Depo-Provera injection beyond the time recommended by the manufacturer.

161. She received her sixteenth injection of Depo-Provera on March 22, 2014 . . .

167. On June 19 2014, Ms. Mastalski underwent a DEXA scan . . .
170. The interpretation states: “Abnormal DEXA study. The lowest T-score in the central DEXA is -2.8. There is severe osteoporosis with highly increased risk of fracture.” . . .
179. On December 9, 2014, Ms. Mastalski had an x-ray of her right foot which revealed a fracture of the right fourth proximal phalynx . . .
184. Defendants’ failure to timely consider, diagnose and treat Ms. Mastalski caused her to develop severe osteoporosis and fractures.

Philadelphia – Locust Street

Allen

The 2009 Complaint is under Philadelphia – Locust Street:

www.problemsatplannedparenthood.org/pennsylvania

Excerpt:

7. On or about May 26, 2007, Defendant Planned Parenthood by and through its agents . . . evaluated the Plaintiff and partially performed the abortion.

8. Thereafter . . . Defendants discharged Plaintiff, despite the fact that the abortion was not complete . . .

10. At all times relevant hereto, Plaintiff was improperly and inappropriately treated by the Defendants despite the availability of Plaintiff’s test results and screening . . .

16. As a direct and/or proximate result of Defendant’s negligence, Plaintiff has experienced excruciated pain . . . a necessity for extended care and/or treatment, embarrassment, mental anguish and/or humiliation as well as out of pocket expenses.

Reading

Matos

The 2021 Complaint is under Reading at:

www.problemsatplannedparenthood.org/pennsylvania

Excerpt:

7. On or about September 10, 2018, plaintiff was treated at defendant Planned Parenthood for the insertion of an IUD . . .

11. Planned Parenthood, as a national purveyor of birth control advice and treatment, knew, or should have known of the defects in the MIRENA® device . . .

14. Plaintiff was not provided with the risks of the procedure prior to the insertion of the IUD.

15. Subsequently plaintiff developed intense headaches and severe abdominal pain and accordingly sought treatment at Reading Hospital.

16. On January 10, 2019, a pelvic ultrasound was preformed which revealed the IUD was mal-positioned. It lay in the posterior uterine myometrium and extended close to but not definitely through the posterior serosa in the body of the uterus . . .

18. On March 4, 2019, plaintiff underwent IUD removal.

19. Plaintiff continued to suffer from severe abdominal pain.

20. However, following the procedure, plaintiff continued to suffer from pain including chest pain . . .

22. On April 23, 2019, plaintiff presented to Reading Hospital complaining of shortness of breath and nausea and vomiting. Initial evaluation was suggestive of congestive heart failure and possible community acquired pneumonia.,

23. While at Reading Hospital plaintiff's condition worsened with a concern for myocarditis. As a result on April 25, 2019, plaintiff was transferred to Jefferson Hospital in Philadelphia.

24. Plaintiff was an inpatient at Jefferson from April 25, 2019 until May 4, 2019 having been discharged with congestive heart failure.

Section 3

We only report what can be documented by sources who are not Planned Parenthood opponents. Dispatch audio recordings and paper documents were received through official agencies and are available on the Problems at Planned Parenthood website:

problemsatplannedparenthood.org/pennsylvania

Allentown:

Two incidents involving ambulance calls are listed in health inspection documents under Pennsylvania Allentown above in Section 1.

February 16, 2010
March 19, 2010
June 10, 2011
October 14, 2011
February 28, 2014
November 13, 2015
November 3, 2017
December 21, 2018

West Chester

Used a private ambulance service**;** these dates are when police assisted paramedics.

October 12, 2001
December 19, 2003
August 20, 2004
March 18, 2005
April 13, 2005
February 17, 2006
February 15, 2007
May 12, 2007
September 7, 2007
October 26, 2007
February 23, 2008
September 11, 2010
May 25, 2013
August 15, 2013
September 4, 2014
September 8, 2014”

And an audio dispatch: October 21, 2022

York

November 21, 2013
December 26, 2013
April 22, 2014
July 11, 2014
April 8, 2015
August 5, 2015
October 7, 2015
October 14, 2015
February 22, 2017
March 8, 2017
January 9, 2019
May 22, 2019

Section 4

Open Letter: Save PPPA

	On November 24, 2020, employees of Planned Parenthood released an open letter alleging racism and poor management of severe budget cuts. It was signed by the entire staff. The letter demanded the resignation of Executive Directo. She resigned on December 1, 2020.

	Planned Parenthood's Pennsylvania Chapter Director Resigns After Racism Claims by Emily Shugerman, *The Daily Beast*, December 2, 2020.

Section 5

Philadelphia (Locust Street)

The inspection document is under Philadelphia – Locust Street:

www.problemsatplannedparenthood.org/pennsylvania

No policy for sex abuse reporting

Excerpt:

Based on feedback from surveyor during the August 29, 2013 survey, the surgical center manager reviewed Pennsylvania State law and PPSP protocols specific to mandatory reporting at center staff meeting on September 17, 2013. PPSP Chief Operating Officer and Manager of Center Quality with legal consultation will revise current protocol to include language on when to ascertain if the child had sexual intercourse with an individual who was four or more years older than the child. The revised protocol will be in place by January 15, 2014 . . .

Lack of documentation when reporting child sexual abuse as revealed in survey 8/29/13 was reviewed at the 9/17/13 center staff meeting. Detailed instructions on required documentation was reviewed.

Section 6

Indeed.com is a site that among other things provides a place for employees to give reviews of their employers. For Planned Parenthood, these reviews would appear under the specific centers the employees worked for.

We collected a set of hundreds of reviews revealing problems. Screenshots are under each PP center that has them on the website. We offer a sampling of some of the worst reviews.

For an accurate understanding of employees' experiences as a whole, those who choose to post reviews will be inadequate and a full survey or stratified random sample study would be needed. We're unaware of any such study.

PA Reading Indeed

1.0

★☆☆☆☆

Avoid at all cost terrible employer

Medical Assistant (Former Employee) - Reading, PA - October 6, 2021

Worst company I've ever worked for. Not a good company for anyone that wants to advance and get treated with respect. Employer will use you to train new employees with no change in position

✓ **Pros**

Coworkers

✕ **Cons**

Low pay, not employee friendly company

PA Philadelphia Indeed

1.0

★☆☆☆☆

Went in hopeful, left appalled.

Manager (Former Employee) - Philadelphia, PA - November 2, 2016

Planned Parenthood has a valiant mission that should be supported by women in the United States. Not having a choice is NOT an option. However, I wish this company wasn't the one representing choice. Horrible management and mostly horrible staff. Most of them do NOT know what they are doing. They started back in the 70s and 80s when non profits were easier. That kind of approach just doesn't cut it anymore and you have people in power who don't understand how to move with the times. They are wasting donation dollars hand over fist and it's an absolute tragedy. It's not just with the Philadelphia office, it's a nationwide epidemic. It's time to clean house.

✓ **Pros**

None

✕ **Cons**

uneducated and untrained workforce

Articles of special interest for all states:

	Botched Care and Tired Staff: Planned Parenthood in Crisis by Katie Benner, *The New York Times*, February 15, 2025
	You scheduled an abortion. Planned Parenthood's website could tell Facebook. The organization left marketing trackers running on its scheduling pages by Tatum Hunter, *The Washington Post*, June 29, 2022

Compilation of reviews on specific topics:

	**Reviews Report - Medical Dangers**
	**Reviews Report - Racism**
	**Reviews Report - Employee Rights**
	**Reviews Report - Financial Ethics**