Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-0202	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 01 B. WING:	(X3) DATE SURVEY COMPLETED: 12/03/2019

NAME OF PROVIDER OR SUPPLIER: **ALLEGHENY REPRODUCTIVE HEALTH CENTER** STATE LICENSE NUMBER: **00018701**	STREET ADDRESS, CITY, STATE, ZIP CODE: **5910 KIRKWOOD STREET PITTSBURGH, PA 15206**

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S 0000	INITIAL COMMENT Facility ID# 00018701 Component 01 Main Building Based on a Relicensure Survey completed on December 4, 2019, it was determined that Allegheny Reproductive Health Center was not in compliance with the following requirements of the Life Safety Code for an existing Ambulatory Healthcare Occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 28 Pa Code § 569.2. This is a three-story, Type V (000), unprotected wood-frame building, with a basement, that is not sprinklered.	S 0000		
S 0100		S 0100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:

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S 0100	Continued from page 1 General Requirements - Other General Requirements - Other List in the REMARKS section, any LSC Section 20.1 and 20.1 General Requirements that are not addressed by the provided S-tags, but are deficient. This REGULATION is not met as evidenced by:	S 0100	The life safety plan with the required information was inadvertently given to the patient DOH safety inspector the previous day. I have since got that copy back and I have emailed it to the life safety inspector who performed our survey, 12/8/19, as requested. To ensure that this floor plan is available at all times and during the Life Safety Code Survey, I have made multiple copies and have placed them throughout the facility. I do not foresee this as an issue for any further surveys, but will include adding checking for this to the monthly fire alarm checks.	Completion Date: **12/18/2019** Status: **APPROVED** Date: **12/20/2019**

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S 0100	Continued from page 2 28 Pa. Code § 201.14(a). RESPONSIBILITY OF THE LICENSEE (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents. This REGULATION has not been met. 35 P.S. § 448.808. Issuance of license. (a) STANDARDS - The Department shall issue a license to a health care provider when it is satisfied that the following standards have been met: (2) that the place to be used as a health care facility is adequately constructed, equipped, maintained and operated to safely and efficiently render the services offered. Based on observation and interview, it was determined the following item did not meet the minimum standards for the operation of a facility as	S 0100		

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S 0100	Continued from page 3 set forth by the Department and by other State and local agencies responsible for the health and welfare of residents within the component. Findings include: 1. Documentation review and interview on December 4, 2019, at 9:00 a.m., revealed the facility failed to provide a set of accurate portable floor plans. The Division of Safety Inspection requires that all facilities under our jurisdiction have a portable, accurate floor plan on site to be used during the course of the Life Safety Code Survey. The Life Safety Code Floor Plans shall include the following: a. Smoke Barrier Walls; b. Fire Barrier Walls; c. Horizontal Exits; d. Hazardous Areas; e. Required Exits should be clearly noted; f. Shafts Walls. Interview with the Clinical Director and Facilities Officer on December 4, 2019, at 9:00 a.m.,	S 0100		

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S 0100	Continued from page 4 confirmed the portable life safety floor plans were not available at the time of survey.	S 0100		
S 0131	Multiple Occupancies Multiple Occupancies - Sections of Ambulatory Health Care Facilities Multiple occupancies shall be in accordance with 6.1.14. Sections of ambulatory health care facilities shall be permitted to be classified as other occupancies, provided they meet both of the following: * The occupancy is not intended to serve ambulatory health care occupants for treatment or customary access. * They are separated from the ambulatory health care occupancy by a 1 hour fire resistance rating. Ambulatory health care facilities shall be separated from other tenants and occupancies and shall meet all of the following: * Walls have not less than 1 hour fire resistance rating and extend from floor slab to roof slab. * Doors are constructed of not less than 1-3/4 inches thick, solid-bonded wood core or equivalent and is equipped with positive latches. * Doors are self-closing and are kept in the closed position, except when in use. * Windows in the barriers are of fixed fire window assemblies per 8.3. Per regulation, ASCs are classified as Ambulatory Health Care Occupancies, regardless of the number of patients	S 0131	The unsealed penetrations noted to be deficient during the survey will be sealed by January 31, 2019 by a licensed contractor and monitored quarterly by the Facilities Manager.	Completion Date: **12/18/2019** Status: **APPROVED** Date: **12/20/2019**

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S 0131	Continued from page 5 served. 20.1.3.2, 21.1.3.3, 20.3.7.1, 21.3.7.1,42 CFR 416.44 This REGULATION is not met as evidenced by:	S 0131		

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S 0131	Continued from page 6 Based on observation and interview, it was determined the facility failed to maintain the one-hour fire-rated tenant separation wall in two instances, affecting one of two floors. Findings include: 1. Observation on December 4, 2019, revealed the following one-hour fire wall assemblies contained multiple unsealed penetrations: a) 11:00 a.m., Basement, left side of fire wall assembly by the medical records area; b) 11:10 a.m., Basement, right side of fire wall assembly by the washer/dryer. Interview with the Clinical Director and Facilities Officer on December 4, 2019, at 12:30 p.m., confirmed the unsealed penetrations of the one-hour fire rated tenant separation wall.	S 0131		

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S 0291	Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 20.2.9.1, 21.2.9.1, 7.9 This REGULATION is not met as evidenced by:	S 0291	A battery was ordered to determine if this is the cause for the illumination failure. This should arrive by Monday 23, 2019. If this is not the cause, a new emergency /exit combination light will be purchased and tested with the monthly fire alarm checks by the Facilities Manager starting Jan 1, 2019. These records will also be checked and reviewed quarterly by the Clinical Director to ensure that there are no further issues with the illumination.	Completion Date: **12/18/2019** Status: **APPROVED** Date: **12/20/2019**

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S 0291	Continued from page 8 Based on observation and interview, it was determined that the facility failed to maintain emergency lighting in one instance, affecting exiting from one of two floors. Findings include: 1. Observation on December 4, 2019, at 9:30 a.m., revealed the emergency/exit combination light at the bottom of the basement steps, by medical records, failed to illuminate upon testing. Interview with the Clinical Director and Facilities Officer on December 4, 2019, at 12:30 p.m., confirmed the emergency lighting was not functional.	S 0291		
S 0293		S 0293		

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S 0293	Continued from page 9 Exit Signage Exit Signage Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 20.2.10, 21.2.10, 7.10 This REGULATION is not met as evidenced by:	S 0293	The emergency exit signage has been removed and the only sign remaining is "not an exit".	Completion Date: **12/18/2019** Status: **APPROVED** Date: **12/20/2019**

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S 0293	Continued from page 10 Based on observation and interview, it was determined that the facility failed to maintain emergency exit signage requirements in one instance, affecting exiting from one out of two floors. Findings include: 1. Observation on December 4, 2019, at 10:10 a.m., revealed the first floor, side exit door, contained conflicting signage indicating both "Not an Exit" and "Emergency Exit Only" posted on the door. Interview with the Clinical Director and Facilities Officer on December 4, 2019, at 12:30 p.m., confirmed the exit signage deficiency.	S 0293		
S 0345		S 0345		

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S 0345	Continued from page 11 Fire Alarm System - Testing and Maintenance Fire Alarm Systems - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5 This REGULATION is not met as evidenced by:	S 0345	1) ARHC was told that there was a smart system monitoring our fire alarm and sensitivity testing was not required by SSA, our monitoring company. After inquiring with SSA after the survey, we were told that we didn't have a smart system and sensitivity testing was not completed. As of 12/18/19 we have switched fire monitoring companies from SSA to ABC Fire Extinguisher Co. and have scheduled the fire alarm sensitivity testing on 12/30/19. This will be completed every two years in December as required and/or sooner if needed for any deficiencies. 2) The unsealed penetrations noted to be deficient during the survey will be sealed by January 31, 2019 by a licensed contractor and monitored quarterly by the Facilities Manager.	Completion Date: **12/18/2019** Status: **APPROVED** Date: **12/20/2019**

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S 0345	Continued from page 12 Based on documentation review, observation and interview, it was determined the facility failed to maintain the fire alarm system in four instances, affecting the entire facility. Findings include: 1. Documentation review on December 4, 2019, at 9:00 a.m., revealed the facility failed to provide documentation showing the completion of the two-year smoke detector sensitivity testing. Interview with the Clinical Director and Facilities Officer on December 4, 2019, at 9:00 a.m., confirmed the lack of documentation available at the time of survey. 2. Observation on December 4, 2019, between 9:55 a.m. and 10:45 a.m., revealed unsealed penetrations and holes in the suspended ceiling, affecting smoke detector performance and response time, at the following locations: a) 9:55 a.m., First Floor Counseling Room, in the	S 0345		

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S 0345	Continued from page 13 Electrical Panel Closet; b) 10:00 a.m., First Floor I.T. Closet; c) 10:45 a.m., Entire basement level, including the stairway, in multiple locations. Interview with the Clinical Director and Facilities Officer on December 4, 2019, at 12:30 p.m., confirmed the fire alarm system deficiencies.	S 0345		
S 0355	Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 20.3.5.3, 21.3.5.3, 9.7.4.1, NFPA 10 This REGULATION is not met as evidenced by:	S 0355	Unfortunately I cannot not attest to why the monthly fire extinguisher log was not completed for the months of May and June because I was not in this role at this time. For future review, this testing and completion of this log will be completed by the Facilities Manager and reviewed quarterly by the Clinical Director to ensure accurate completion. In addition, review of the importance of a non-obstructed fire extinguishers will be reviewed with staff during the monthly staff meeting. The wheelchair will be placed in the back hallway corner, where no obstructions are possible.	Completion Date: **12/18/2019** Status: **APPROVED** Date: **12/20/2019**

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S 0355	Continued from page 14 Based on documentation review, observation and interview, it was determined the facility failed to maintain portable fire extinguishing equipment in two instances, affecting the entire facility. Findings include: 1. Documentation review on December 4, 2019, at 9:00 a.m., revealed the facility failed to provide documentation showing the completion of the monthly fire extinguisher inspection for the months of May and June. Interview with the Clinical Director and Facilities Officer on December 4, 2019, at 9:00 a.m., confirmed the lack of documentation available at the time of survey. 2. Observation on December 4, 2019, at 9:30 a.m., revealed a fire extinguisher, in the rear hallway by the exam rooms, obstructed by a wheelchair. Interview with the Clinical Director and Facilities Officer on December 4, 2019, at 12:30 p.m.,	S 0355		

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S 0355	Continued from page 15 confirmed the fire extinguisher deficiency.	S 0355		

Certified End Page

ALLEGHENY REPRODUCTIVE HEALTH CENTER

STATE LICENSE NUMBER: 00018701

SURVEY EXIT DATE: 12/03/2019

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Susan Coble
Deputy Secretary for Quality Assurance

Rachel L. Levine, MD
Secretary of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY