STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	8-5144	A. BLDG: 00 B. WING:	10/11/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
M 0000	INITIAL COMMENT This report is the result of an Annual Registration survey conducted on October 11, 2019, at PPSP Far Northeast. It was determined the facility was in compliance with the requirements of the Pennsylvania Department of Health Regulations § 28 Pa Code, Chapter 29, Subchapter D, Ambulatory Gynecological Surgery in Hospitals and Clinics.	M 0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 0000	INITIAL COMMENT This report is the result of a full State Licensure survey conducted on October 11, 2019, at PPSP Far Northeast. It was determined that the facility was not in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Ambulatory Care Facilities, Annex A, Title 28, Part IV, Subparts A and F, Chapters 551-573, November 1999.	S 0000		
S 0102		S 0102		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 0102	Continued from page 1 551.3 DEFINITIONS 551.3 Definitions This REGULATION is not met as evidenced by:	S 0102	By 12/15/19, the Medical Standards and Guidelines, Abortion Services [02_01] will be updated to more clearly specify when Physical Status (PS) classification is required and the Physical Status (PS) Classification Policy will be updated to clarify that no PS classification is needed if the patient is to undergo a medication abortion. It is our medical protocol that Physicians review patient medical and surgical history to determine if patient is an appropriate candidate for their chosen procedure and patients with medical conditions that are contraindicated (that may cause medical complications) would be counseled on their options and referred out as needed. If a medication abortion patient were to change to a surgical abortion (with or without anesthesia), their PS classification would be evaluated and documented prior to the procedure. By 12/15/19, the facility medical staff will receive the updated policies and instructions on how to document	Completion Date: **12/15/2019** Status: **APPROVED** Date: **11/26/2019**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 0102	Continued from page 2	S 0102	Physical Status in the patient medical record. Training will be provided as needed. In one month, the RQM Coordinator will audit medical records for patients receiving medication abortion to monitor compliance to updated policies. The Director of Patient Services will ensure all above corrective actions are completed and evidence of actions are available for Department review.	

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S 0102	Continued from page 3 Based on a review of policies and procedures and medical records (MR), and interview with staff (EMP), it was determined the failed to document the physical status (PS) classification of patients for five of 15 medical records reviewed (MR1, MR2, MR3, MR4, and MR5). Findings include: State Regulation "551.3 Definitions...The following words and terms, when used in this subpart, have the following meanings, unless the context clearly indicates otherwise:...Physical status classifications-The evaluation of the patient's overall health as it would influence the conduct and outcome of anesthesia or surgery, or both. Physical status shall be defined within one of five assigned classes which are: (i) Class 1 patients have no organic, physiologic, biochemical, metabolic or psychiatric disturbance. The operation to be performed is for a local pathologic process and has no systemic effect.	S 0102		

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S 0102	Continued from page 4 (ii) Class 2 patients have a systemic disturbance which may be of a mild to moderate degree but which is either controlled or has not changed in its severity for some time. (iii) Class 3 patients suffer from significant systemic disturbance, although the degree to which it limits the patient ' s functioning or causes disability may not be quantifiable. (iv) Class 4 patients suffer from severe systemic diseases that are already life-threatening and may or may not be correctable by surgery. (v) Class 5 patients are moribund and not expected to survive without surgery..." Request was made to EMP1 on October 11, 2019, for a policy that required the facility to assess the patients' physical status and document it. No policy was provided. Review on October 11, 2019, of MR1, MR2, MR3, MR4, and MR5, revealed the patients had procedures performed at the facility between July 19, 2019, and September 27, 2019. Further	S 0102		

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S 0102	Continued from page 5 review revealed there was no documention that the physical status (PS) classification of these patients were assessed. Interview with EMP1 on October 11, 2019, at 12:42 PM, confirmed the above patients had no assigned PS classifications.	S 0102		

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S 033A	553.3 (1) Governing Body Responsibilities 553.3 Governing Body responsibilities include: (1) Conforming to all applicable Federal, State, and local laws. This REGULATION is not met as evidenced by:	S 033A	Beginning November 2019, PPSP (Planned Parenthood Southeastern Pennsylvania) will conduct facility-specific Infection Control Committee meetings. Surgical Far Northeast Health Center's Infection Control Committee will review facility-specific infection control related reports, activities, and quality measures. Surgical Far Northeast's facility-specific content will be reflected in meeting minutes and these minutes will be available for Department review. The Director of Clinical Services will implement the facility-specific meetings and ensure meeting minutes accurately reflect facility-specific content and committee members. Following the next quarterly meeting, PPSP's Risk and Quality Management Coordinator will monitor compliance via review and audit of meeting minutes. Implementation (and compliance) of this Plan of Correction is the responsibility of PPSP's Director of Clinical Services.	Completion Date: **11/15/2019** Status: **APPROVED** Date: **11/12/2019**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 033A	Continued from page 7 Based on review of facility documents and interview with staff (EMP), it was determined the facility failed to conform to all applicable State laws. PPSP Far Northeast Health Center was not in compliance with the following State law: "Act 52 of 2007, Medical Care Availability and Reduction of Error (MCARE) Act Chapter 4. Health Care-Associated Infections 40 P.S.§ 1303.403. Infection control plan (a) Development and Compliance. - Within 120 days of the effective date of this section, a health care facility and an ambulatory surgical facility shall develop and implement an internal infection control plan that shall be established for the purpose of improving the health and safety of patients and health care workers and shall include: (1) A multidisciplinary committee ..." This is not met as evidenced by:	S 033A		

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S 033A	Continued from page 8 Based on review of facility documents and interview with staff (EMP), it was determined the facility did not have a specific infection control committee for PPSP Far Northeast Health Center. Findings include: Review on October 11, 2019, of the "Infection Control Committee" meeting minutes, dated November 2018, February, May, and August 2019, revealed the facility's infection control committee was combined with three additional health care facilities. Further review of the minutes, revealed there were no specific infection control meeting minutes for PPSP Far Northeast Health Center. Interview on October 11, 2019, at 11:37 AM, with EMP1 confirmed the facility's infection control committee was combined with three additional health care facilities. Further interview with EMP1 confirmed there were no specific infection control meeting minutes for PPSP Far Northeast Health	S 033A		

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S 033A	Continued from page 9 Center.	S 033A		
S 033F		S 033F		

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S 033F	Continued from page 10 553.3 (6) Governing Body Responsibilities Governing Body responsibilities include: (6) Adopting policies or procedures necessary for the orderly conduct of the ASF. This REGULATION is not met as evidenced by:	S 033F	By 11/30/19, PPSP's Director of Patient Services will update the facility's policies, including Quality policies, Abortion policy manual, Pharmaceutical Services policies, medical Staff policies, Laboratory policies, medical record policies, and patient bill of rights policies with a cover sheet and/or header that is center-specific. PPSP's Board of Directors (governing body) reviews and approves the policies and procedures for all of PPSP's health centers. Adding a cover sheet and/or header will clarify that each of these policies is specific to PPSP's Far Northeast health center. The cover sheet and/or header will be updated every time there is a new or updated policy for PPSP Far Northeast health center.	Completion Date: **11/30/2019** Status: **APPROVED** Date: **11/12/2019**

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S 033F	Continued from page 11 Based on review of facility policies and procedures and interviews with staff (EMP), it was determined that the facility failed to ensure that the policies and procedures were consistent in reflecting the identification and the orderly conduct of the facility. Findings include: Review on October 11, 2019, of the facility's policies and procedures including Quality policies, Abortion policy manual, Pharmaceutical Services policies, medical Staff policies, Laboratory policies, medical record policies, and patient bill of rights policy, revealed these policies were not specific to PPSP Far Northeast Health Center. Further review revealed these policies were identified as "Planned Parenthood Southeastern Pennsylvania" and not PPSP Far Northeast Health Center. Interview with EMP1 on October 11, 2019, at 1:35 PM, confirmed the facility's policies and procedures including Quality policies, Abortion policy manual,	S 033F		

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S 033F	Continued from page 12 Pharmaceutical Services policies, medical Staff policies, Laboratory policies, medical record policies, and patient bill of rights policy,were not specific to PPSP Far Northeast Health Center. Further interview confirmed these policies were identified as "Planned Parenthood Southeastern Pennsylvania" and not PPSP Far Northeast Health Center.	S 033F		

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S 3250	553.25 (1-6) Discharge Criteria 553.25 Discharge Criteria A patient may only be discharged from an ASF if the following physical status criteria are met: (1) Vital signs. Blood pressure, heart rate, temperature and respiratory rate are within the normal range for the patient's age or at preoperative levels for that patient. (2) Activity. The patient has regained preoperative mobility without assistance or syncope, or function at his usual level considering limitations imposed by the surgical procedure. (3) Mental status. The patient is awake, alert or functions at his preoperative mental status. (4) Pain. The patient's pain can be effectively controlled with medication. (5) Bleeding. Bleeding is controlled and consistent with that expected from the surgical procedure. (6) Nausea/vomiting. Minimal nausea or vomiting is controlled and consistent with that expected from the surgical procedure. This REGULATION is not met as evidenced by:	S 3250	PPSP policies, Medical Standards and Guidelines 02_18 Recovery Area Care and Abortion Policy Manual, have been updated to include the requirement to evaluate (and document) status of nausea and vomiting for all surgical patients prior to discharge (effective 11/1/19). The Director of Clinical Services updated the policies and communicated the required changes. They will provide training to recovery room nurses as needed. At one month, PPSP's RQM Coordinator will audit patient records for PPSP Far Northeast's patients to evaluate for documentation of nausea/vomiting assessment prior to discharge. PPSP's Director of Patient Services will ensure Plan of Correction is implemented and compliance is maintained.	Completion Date: **11/05/2019** Status: **APPROVED** Date: **11/12/2019**

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S 3250	Continued from page 14 Based on a review of facility policy, medical records (MR), and interview with staff (EMP), it was determined the facility failed to ensure that patients met the required discharge criteria prior to discharge for eight of 15 medical records reviewed (MR6, MR7, MR8, MR9, MR11, MR12, MR13, and MR 14) Findings include: A request was made to EMP1 on October 11, 2019 for a policy that addressed assessing patients for nausea and vomiting. No policy was provided. Review on October 11, 2019, of MR6, MR7, MR8, MR9, MR11, MR12, MR13, and MR 14, revealed these patients had procedures at the facility between April 24, 2019, and September 18, 2019. Further review revealed there was no documentation that the patients' nausea and vomiting were assessed prior to discharge.	S 3250		

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S 3250	Continued from page 15 Interview on October 11, 2019, at 12:54 PM with EMP1 confirmed that there was no documentation in MR6, MR7, MR8, MR9, MR11, MR12, MR13, and MR 14 that the patients' nausea and vomiting were assessed prior to discharge.	S 3250		

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S 3250	Continued from page 16	S 3250		
S 5200		S 5200		

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S 5200	Continued from page 17 555.2 Medical staff membership 555.2 Medical Staff Membership A member of the medical staff shall be qualified for membership and the exercise of clinical privileges granted to him. The governing body of the ASF, after considering the recommendations of the medical staff, may grant clinical privileges to qualified, licensed practitioners in accordance with their training, experience and demonstrated competence and judgement. Members of the medicals staff and others granted clinical privileges shall currently hold licenses to practice in this Commonwealth. This REGULATION is not met as evidenced by:	S 5200	By November 30, 2019, PPSP's Governing Body Responsibilities Policy Abortion Policy Manual will be updated to include certified registered nurse anesthetists (CRNA) to the list of medical staff that require Board of Directors-granted clinical privileges and appointment to the facility's medical staff. The Director of Patient Services and Director of Human Services will update our Abortion Provider Privileging Policy to include the additional licensed practitioners (CRNA staff). All current CRNA staff will be presented to the governing body for consideration at the next PPSP Board of Directors meeting, scheduled for 12/19/19. Privileging and Appointment documents will be maintained in credential files and available for Department review.	Completion Date: **11/30/2019** Status: **APPROVED** Date: **11/12/2019**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	8-5144	A. BLDG: 00 B. WING:	10/11/2019

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S 5200	Continued from page 18 Based on review of allied health credential files (CF), and interview with staff (EMP), it was determined the facility failed to grant clinical privileges and appoint allied health practitioners to the facility's medical staff for three of three allied health credential files reviewed. (CF3, CF4, and CF5) Findings include: Request was made to EMP1 on October 11, 2019, to provide a policy or bylaws that required the certified registered nurse anesthetists to be granted clinical privileges and be appointed to the facility's medical staff. None was provided. Review on October 11, 2019, of CF3, CF4, and CF5 revealed there was no documented evidence in these files that these certified registered nurse anesthetists were granted clinical privileges and appointed to the facility's medical staff.	S 5200		

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S 5200	Continued from page 19 Interview with EMP2, on October 11, 2019, at 11:24 AM, confirmed CF3, CF4, and CF5 provide anesthesia services to patients at the facility. EMP2 further confirmed there was no documented evidence in these files that these certified registered nurse anesthetists were granted clinical privileges and appointed to the facility's medical staff.	S 5200		
S 6701		S 6701		

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S 6701	Continued from page 20 567.1 Principle CHAPTER 567 - ENVIRONMENTAL SERVICES 567.1 Principle The ASF shall have a sanitary environment, properly constructed, equipped and maintained to protect surgical patients and ASF personnel from cross-infection and to protect the health and safety of patients. This REGULATION is not met as evidenced by:	S 6701	By November 15, 2019, the facility's "Infection Control Plan" will be updated to reflect procedural techniques for sterilization of instruments used in the ASF that will allow us to identify instruments used for patient procedures and maintain a tracking system for investigation of infection. Logs used for monitoring quality (autoclave monitoring log, procedure log) will be updated to allow for tracking loads/instruments to patients and the Autoclave Monitoring Log will include total time and condition (temperature, pressure) for each load. The Director of Clinical Services will update and communicate changes to the Infection Control Plan, and provide training and support to the facility team as needed. The ASF person-in-charge is responsible for implementation and monitoring of new procedures (and logs) in the facility. Quality logs (autoclave monitoring	Completion Date: **11/15/2019** Status: **APPROVED** Date: **11/15/2019**

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S 6701	Continued from page 21	S 6701	log and procedure log) will be audited regularly by PPSP's RQM Coordinator for compliance. PPSP's Director of Patient Services will ensure all corrective actions are completed and evidence of actions are available for Department review.	

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S 6701	Continued from page 22 Based on review of policies and procedures and facility documents, observations, and interviews with staff (EMP), it was determined the facility failed to provide a safe and sanitary environment for the provisions of surgical services. Findings include: " Review on October 11, 2019 of the facility ' s policy and procedure manual revealed there was no policy for monitoring each sterilization load with mechanical indicators including total time, temperature, and pressure, and the facility did not provide evidence of any other policy or procedures showing it ensured a sanitary environment was established and maintained. " Observation of the Sterile Processing area on October 11, 2019, at 10:45 AM revealed the facility had 2 steam autoclaves that did not provide automated cycle information (mechanical indicators)	S 6701		

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S 6701	Continued from page 23 printouts for each sterilization load. Review on October 11, 2019, of facility document "Autoclave Monitoring Log," dated October 1, 2019, through October 11, 2019, revealed two autoclave checklists. Further review of the "Autoclave Monitoring Logs," revealed no documentation of the total time for each load being sterilized, the temperature for each load being sterilized and the pressure recorded for each sterilization load. Interview on October 11, 2019, with EMP1 at approximately 11:00 AM confirmed there is no policy for monitoring each sterilization load with mechanical indicators including total time, temperature, and pressure. Further interview confirmed the facility was not documenting the total time, temperature and pressure for each sterilization load. Further confirmed the steam autoclave used by the facility was not capable of providing a printout of cycle information for each load of instruments being sterilized that included the total	S 6701		

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S 6701	Continued from page 24 time, the temperature and pressure of the sterilization cycle for each load of the instruments. Further interview with EMP1 confirmed there was no documented evidence of the sterilized instruments used for each patient to maintain a tracking system for the investigation of infection.	S 6701		

Certified End Page

PPSP FAR NORTHEAST HEALTH CENTER

STATE LICENSE NUMBER: 9HEG8701

SURVEY EXIT DATE: 10/11/2019

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

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY