STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	8-5130	A. BLDG: 00 B. WING:	08/30/2019

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PPSP SURGICAL LOCUST STREET HEALTH CENTER STATE LICENSE NUMBER: **00238701**	**1144 LOCUST STREET** **PHILADELPHIA, PA 19107**

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M 0000	INITIAL COMMENT This report is the result of an Annual Registration survey conducted on August 29, and 30, 2019, at Ppsp Surgical Locust Street Health Center. 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:

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S 0000	INITIAL COMMENT This report is the result of a State licensure survey conducted on August 29, and 30, 2019, at Ppsp Surgical Locust Street Health Center. It was determined 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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S 0102	Continued from page 1 551.3 DEFINITIONS 551.3 Definitions This REGULATION is not met as evidenced by:	S 0102	By October 31, 2019, PPSP's Director of Clinical Services will update PPSP's Medical Standards and Guidelines, Abortion Services 02_01 to include the requirement of physical status (PS) classification for all patients based on State regulation 551.3. The updated policy along with physician specific instructions that all patients, including those seeking medication abortion must have PS classification documented will be sent out by PPSP's Medical Director to all physicians working at the Class B ASF. By November 30, 2019, PPSP's RQM Coordinator will audit medical records for patients receiving medication abortion to monitor compliance and based on findings will address any concerns. The Director of Patient Services will ensure all above corrective actions are completed and evidence of actions are available for Department review.	Completion Date: **10/31/2019** Status: **APPROVED** Date: **10/06/2019**

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 Based on a review of policies and procedures and medical records (MR), and interview with facility staff (EMP), it was determined this Class B Ambulatory Surgical Facility failed to document the physical status (PS) classification of patients for eight of 15 medical records reviewed (MR3, MR6, MR9, MR10, MR11, MR12, MR14, and MR15). 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 3 (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 August 27, 2019, for a policy that required the facility to assess the patients' physical status and document it. None was provided. Review on August 27, 2019, of MR3, MR6, MR9, MR10, MR11, MR12, MR14, and MR15 revealed these patients had procedures performed at the facility between March 2, 2019, and July 3, 2019.	S 0102		

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S 0102	Continued from page 4 Further review revealed there was no documention that the physical status (PS) classification of the patients were assessed. Interview with EMP1 on August 27, 2019, at 10:48 AM, 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 October 2019, PPSP will conduct facility-specific Infection Control Committee meetings. Surgical Locust Street Health Center's Infection Control Committee will review facility-specific infection control related reports, activities, and quality measures. Surgical Locust'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: **10/31/2019** Status: **APPROVED** Date: **10/11/2019**

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S 033A	Continued from page 6 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 Surgical Locust Street 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 7 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 Surgical Locust Street Health Center. Findings include: Review on August 26, 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 Surgical Locust Street Health Center. Interview on August 26, 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 Surgical Locust Street	S 033A		

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S 033A	Continued from page 8 Health Center.	S 033A		
S 3250		S 3250		

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S 3250	Continued from page 9 553.25 (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	By October 31, 2019, PPSP's policy (Medical Standards and Guidelines, 02_18 Recovery Area Care) will be updated to include the requirement to evaluate (and document) status of nausea and vomiting for all surgical patients prior to discharge. The Director of Clinical Services is responsible for updating and communicating the policy changes and providing training to recovery room nurses as needed. At one month, PPSP's RQM Coordinator will audit patient records specifically to evaluate for evidence of 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: **10/31/2019** Status: **APPROVED** Date: **09/25/2019**

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S 3250	Continued from page 10 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 nine of 15 medical records reviewed (MR2, MR4, MR5, MR7, MR8, MR12, MR13, MR14, and MR15). Findings include: A request was made to EMP1 on August 27, 2019 for a policy that addressed assessing patients for nausea and vomiting. None was provided. Review on August 27, 2019, of MR2, MR4, MR5, MR7, MR8, MR12, MR13, MR14, and MR15, revealed these patients had procedures at the facility between March 2, 2019 and July 3, 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 11 Interview on August 27, 2019, at 11:35 AM, with EMP1 confirmed that there was no documentation in MR2, MR4, MR5, MR7, MR8, MR12, MR13, MR14, and MR15 that the patients' nausea and vomiting were assessed prior to discharge.	S 3250		

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S 3250	Continued from page 12	S 3250		
S 6702		S 6702		

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S 6702	Continued from page 13 567.2 (1) INFECTION CONTROL - Committee Responsibility 567.2 Committee responsibilities The quality assurance committee shall be responsible for: (1) The prevention, control and investigation of infection in the ASF and for assuring the effectiveness of current procedural techniques in all departments. This REGULATION is not met as evidenced by:	S 6702	By October 31, 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 will include total time and temperature for each load. The Director of Clinical Services will update the Infection Control Plan, provide training and support to the facility team, and monitor compliance. The ASF person-in-charge is responsible for implementation and monitoring of new procedures (and logs) in the facility. Quality logs (autoclave monitoring log and procedure log) will be audited by PPSP's RQM Coordinator for compliance. PPSP's Director of Patient Services will	Completion Date: **10/31/2019** Status: **APPROVED** Date: **09/25/2019**

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S 6702	Continued from page 14	S 6702	ensure all corrective actions are completed and evidence of actions are available for Department review.	

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S 6702	Continued from page 15 Based on observation of the sterilization area, review of facility documents and interview with staff (EMP), it was determined the facility failed to ensure procedural techniques were maintained for sterilization of instruments used in the ASF for the prevention and control of infection and failed to identify instruments used for patient procedures to maintain a tracking system for investigation of infection. Findings include: Review on August 26, 2019, of facility policy "Infection Control Plan," last updated November 27, 2017, revealed, " ... Clinical instruments which require sterilization ... An entry is made in the Quality Assurance Record indicating: ... time and temperature condition of sterilization ... Outbreak Investigation ... The Medical Director will review the charts of the involved staff or clients and determined that an epidemic exists ... Infection control Committee will gather and compile data related to	S 6702		

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S 6702	Continued from page 16 the infection (s) as follows: ... Review client/staff charts ... review various infection prevention techniques (... sterilization techniques ...)". Observation of the Sterile Processing area on August 29, 2019, at 11:00 AM revealed the facility had two steam autoclaves that did not provide automated cycle information printouts for each sterilization load. Review on August 29, 2019, of facility document "Autoclave Monitoring Log," dated June 1, 2019, through July 31, 2019, revealed two autoclave checklists. Further review of the "Autoclave Monitoring Logs," revealed no documentation of the total time for each load being sterilized or the temperature for each load being sterilized. Interview with EMP1 on August 29, 2019, at 11:45 AM confirmed the two steam autoclaves used by the facility were not capable of providing a printout of cycle information for each load of instruments being sterilized that included the total time and the	S 6702		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PPSP SURGICAL LOCUST STREET HEALTH CENTER STATE LICENSE NUMBER: **00238701**	**1144 LOCUST STREET PHILADELPHIA, PA 19107**

(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
S 6702	Continued from page 17 temperature 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 6702		

Certified End Page

PPSP SURGICAL LOCUST STREET HEALTH CENTER

STATE LICENSE NUMBER: 00238701

SURVEY EXIT DATE: 08/30/2019

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