

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>22D0076972</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/14/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1055 COMMONWEALTH AVENUE, ROOM 1055B BOSTON, MA 02215</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE	
D 000	INITIAL COMMENTS	D 000			
D5805	<p>TEST REPORT CFR(s): 493.1291(c)</p> <p>The test report must indicate the following: (c)(1) For positive patient identification, either the patient's name and identification number, or a unique patient identifier and identification number. (c)(2) The name and address of the laboratory location where the test was performed. (c)(3) The test report date. (c)(4) The test performed. (c)(5) Specimen source, when appropriate. (c)(6) The test result and, if applicable, the units of measurement or interpretation, or both. (c)(7) Any information regarding the condition and disposition of specimens that do not meet the laboratory's criteria for acceptability. This STANDARD is not met as evidenced by: . Based on record review and interview with the Laboratory Director (LD) and the Technical Supervisor (TS) on 8/14/2024, the laboratory failed to indicate on the patient final test report the name and address of the laboratory where the test was performed as evidenced by the following:  The surveyor reviewed sixteen (16) patient final test reports between November 2022 and June 2024. The review revealed:</p>	D5805		9/30/24	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

08/20/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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D5805	<p>Continued From page 1</p> <p>The laboratory failed to indicate the name and address of the laboratory location where the test was performed on four (4) out of four (4) patient final test reports for Rh Type and two (2) out of two (2) patient final test reports for Wet Preps.</p> <p>The LD and TS confirmed through interview on 8/14/2024 at 2:12 PM that the patient final test reports did not indicate the name and address of the laboratory where the test was performed for Rh Type and Wet Preps.</p> <p>The laboratory performs 630 Rh Type tests and 5 Wet Preps tests annually.</p>	D5805			