Pennsylvania Department of Health

	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-3910		A. BLDG:0	LE CONSTRUCTION: 0	(X3) DATE SURVEY COMPLETED: 08/23/2017	
PLANNED ALLENTC	VIDER OR SUPPLIER: • PARENTHOOD KEYST(• WN • SE NUMBER: 00218701) DNE -	STREET ADDRESS 29 NORTH 97 ALLENTOW	TH STREET	P CODE:	1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEED	f OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
M 0000	This report is the result of a Special Mor			M 0000			
M 0007	This report is the resul survey conducted on A Parenthood Keystone - (PPKey-Allentown). I was not in compliance Pennsylvania Departm 28 Pa Code, Chapter 2 Ambulatory Gynecolo Clinics.	August 23, 2017, at P - Allentown it was determined the with the requirement ent of Health Regula 9, Subchapter D,	Planned e facility hts of the ations §	M 0007			
LABORATORY	DIRECTOR'S OR PROVIDER/SUPPL	IER REPRESENTATIVE'S SIGN	ATURE		TITLE:	(X6) DATE:	
State Form		1DNK1	1			IF CONTINUATIO	ON SHEET Page 1 of 18

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Pennsylvania Department of Health

	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-3910	:	A. BLDG: B. WING:	PLE CONSTRUCTION: 	(X3) DATE SURVEY COMPLETED: 08/23/2017	
	OVIDER OR SUPPLIER:) PARENTHOOD KEYST() WN	DNE -	STREET ADDRESS, 29 NORTH 97 ALLENTOW	TH STREET			
STATE LICEN (X4) ID PREFIX TAG	MUST BE PRECEED	F OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
M 0007	Continued from page 1 29.33(7) Requirements for Rho (D) immune globin each Rh-negative patient at contraindicated. Evidence - paragraph shall appear in th If for any reason the patient Rh immune globulin when be noted in the clinical reco This REGULATION is not	(human) shall be admin the time of any abortion of compliance with this he medical record of the t refuses the administrati recommended, this refus ord of the patient.	n, unless patient. on of	M 0007	Action Plan: Center Manger and all staff, including clinician are respon for ensuring RhoGam is give same day as service. Policy and Procedure: 1. Rh typing must be perform unless reliable written documentation of Rh type is available. Otherwise, Rh tea done on-site on the day of procedure. (Patients may present a block card or lab report of their Rh in lieu of testing) If testing v done during a previous visit, result may also be used. 2. If Rh-negative, The staff the chart by using a different folder - a red folder - and ma results on forms 3. If Rh-negative, Rh0 (D) i	en the med, sting is d donor status vas this will flag c color urk	Completion Date: 09/07/2017 Status: APPROVED Date: 10/06/2017

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Pennsylvania Department of Health

	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-3910		A. BLDG:	PLE CONSTRUCTION: 00	(X3) DATE SURVEY COMPLETED: 08/23/2017	
	VIDER OR SUPPLIER: PARENTHOOD KEYST(WN	DNE -	STREET ADDRESS, 29 NORTH 9T ALLENTOWN	TH STREET	- -		
STATE LICENS	SE NUMBER: 00218701						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D PREFIX MUST BE PRECEEDED BY FULL REGULATORY (TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE /	OULD BE	(X5) COMPLETE DATE	
M 0007	A 0007 Continued from page 2			M 0007			
					 globulin (RhoGam) will be p according to the Medical Sta and guidelines. 4. Information regarding Rh immune globulin must be give the patient in writing and must documented in her medical r The staff is responsible to ha patient convey understanding answer all questions, using the clinician as a resource as need. 5. If the patient refuses after receiving the education by cl the patient is required to sign appropriate release (Release Test Not Obtained). The refut also documented. 6. When patient agrees to re the Rh0 (D) immune globuli (RhoGam), this occurs in the Procedure Room and is require be documented. 7) Because the patient will b checking out by proving the in the red folder, The patient 	(D) ven to ist be ecord. ive the g and he eded. inician, in the When isal is ceive n e Post ired to e details	

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Pennsylvania Department of Health

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-3910		A. BLDG:	PLE CONSTRUCTION: 00	(X3) DATE SURVEY COMPLETED: 08/23/2017	
	VIDER OR SUPPLIER: PARENTHOOD KEYST(WN	DNE -	STREET ADDRESS, 29 NORTH 9T ALLENTOWN	TH STREET	- -		
STATE LICENS	e number: 00218701						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D PREFIX MUST BE PRECEEDED BY FULL REGULATORY (TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE /	OULD BE	(X5) COMPLETE DATE	
M 0007	M 0007 Continued from page 3			M 0007			
					 asked by the check-out staff has received a Rhogam shot. 8) The check out team will a patient to please wait and chestatus with the clinician. 9)If the Rhogam shot was ginot documented in the red for the Center Manager will follwith clinician. 10) If the Rhogam shot was rigiven, the check out team with the Center Manager who will the patient to the clinician. 11) It is important that the R shot be given the same day a inconvenience the patient to to the center another day for procedure that should have be done the same day as RH negresults were identified. 12) It is also important that the team apologize for the delay check out team identifies that should was not initially adminitiant. 	sk the eck the ven but older, ow up not ill notify l refer hogam is to not return a peen gative he PP if the it the	

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Pennsylvania Department of Health

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-3910		A. BLDG:	PLE CONSTRUCTION: 00	(X3) DATE SURVEY COMPLETED: 08/23/2017	
	VIDER OR SUPPLIER: PARENTHOOD KEYST(WN	DNE -	STREET ADDRESS, 29 NORTH 9T ALLENTOWN	TH STREET	л		
STATE LICENS	STATE LICENSE NUMBER: 00218701						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D PREFIX MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
M 0007	Continued from page 4			M 0007	 13) The RQM Director will in each facility daily and provide feedback and coaching as need that, when appropriate, the patient receil Rhogam shot the same day. Managers cannot rely on run reports the next day and callipatients back to the center for shot. This shot must be give same day to those patients we need the shot, unless the shot refused. All responses and do results for patient must be documented that day. 15) The RQM Director will reports of all facilities and in staff immediately to contact which somehow did not recersion and there was no documentation to reveal a report will be filed same day of notificar Center Manager will be coact re-educated. 	le eded. ves the Center ning ing r a n the ho t is end un daily form the a patient ive a ason for ill also tion. The	

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Pennsylvania Department of Health

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-3910		A. BLDG:	PLE CONSTRUCTION: 00	(X3) DATE SURVEY COMPLETED: 08/23/2017	
	VIDER OR SUPPLIER: PARENTHOOD KEYST(WN	DNE -	STREET ADDRESS, 29 NORTH 9T ALLENTOWN	TH STREET			
STATE LICENS	STATE LICENSE NUMBER: 00218701						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH I PREFIX MUST BE PRECEEDED BY FULL REGULATORY TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE /	OULD BE	(X5) COMPLETE DATE	
M 0007	M 0007 Continued from page 5			M 0007			
					16) Policy will be reviewed Managers during the 2 separ monthly visits to their center RQM Director. Meetings to 10/9/17 and will be complete 10/31/17. Daily reports will the interim by the RQM Director	ate t by the start ed by be run in	

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PLAN OF COR NAME OF PRO PLANNED ALLENTO STATE LICENS	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-3910 NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: 00218701 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE		STREET ADDRESS, 29 NORTH 97 ALLENTOWN	A. BLDG: _ B. WING: _ CITY, STATE, 2 YH STREET N, PA 1810	C 1	(X3) DATE SURVI COMPLETED: 08/23/2017	
(X4) ID PREFIX TAG	MUST BE PRECEED	ſ OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O IFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
M 0007	Continued from page 6			M 0007	 Center Manager or designer responsible for running an R Report from the Electronic F Record at the end of day of sto to ensure all Rh Negative pareceived MiCROGam or Rh indicated. Any patients who receive Rhogam as indicated contacted and offered correct to be administered within 72 For Medication Abortion F Physician administers and documents Rhogam at time of Mifeprex. The Chief Medic (CMO) will communicate the requirement to all physicians For Surgical Patients - Lic or APC or MD staffing Post Procedure room administers 	h Health services tients oGam as did not d, will be t dose hours. Patients - of al Officer is s.	

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Pennsylvania Department of Health

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-3910		A. BLDG:	IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 08/23/2017	
	VIDER OR SUPPLIER: • PARENTHOOD KEYST(• WN	DNE -	STREET ADDRESS, 29 NORTH 97 ALLENTOWN	TH STREET			
STATE LICENS	e number: 00218701						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE 4	OULD BE	(X5) COMPLETE DATE	
M 0007	Continued from page 7			M 0007			
					 documents Rhogam. Lead C will confirm this is included of Post Procedure responsibile CMO will communicate this instruction at APC meeting of 9/11/2017. 4. All Rh Negative Charts with audited. 5. Rh Policy and Procedures updated. 6. Dir. of RQM is responsible effectiveness check of this p the final POC summary will reported to the CEO of PP K The updated policy will be communicated to the Center Managers on 9/11/2017. Implementation is set for 09. 	as part lities. on Il be will be le for the lan and be reystone.	

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Pennsylvania Department of Health

	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-3910					EY			
	WIDER OR SUPPLIER:) PARENTHOOD KEYST() WN	DNE -	STREET ADDRESS, CITY, STATE, ZIP CODE: 29 NORTH 9TH STREET ALLENTOWN, PA 18101							
STATE LICEN	SE NUMBER: 00218701									
(X4) ID PREFIX TAG	MUST BE PRECEED	F OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID FIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE .	OULD BE	(X5) COMPLETE DATE			
M 0007	Continued from page 8		MC	0007						
	Based on review of fac records (MR) and staff determined the facility policy to ensure Immu to one of two Rh-nega Findings include: Review on August 23, Policy," effective Janu "Policy: All patients se is surgical or medication of Rh status on their ch Manger and all staff w days Procedures: 1. Rh unless reliable written available. a. Rh testing procedure. b. Patients is card or lab report of th c. If testing was done of result may also be used chart with a red folder If Rh-negative, Rh0 (E	f interview (EMP), it failed to follow the ne Globulin was adr tive patients (MR6). 2017, of the facility ary 23, 2015, reveal- eeking an abortion, v on, must have docum hart. Responsibility: rorking on abortion p typing must be perf documentation of R g is done on-site on t may present a blood eir Rh status in lieu during a previous vis d. 2. If Rh-negative, and mark results on	s was facility's ninistered 's "Rh ed whether it nentation Center procedure formed, h type is the day of donor of testing. it, this flag the forms. 3.							

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	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 8-3910		A. BLDG: _	IPLE CONSTRUCTION: _00	(X3) DATE SURVE COMPLETED: 08/23/2017	EY
	WIDER OR SUPPLIER:) PARENTHOOD KEYST()WN	DNE -	STREET ADDRESS, 29 NORTH 9T ALLENTOWN	TH STREET	ſ		
STATE LICENS	SE NUMBER: 00218701		1				
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEED	T OF DEFICIENCIES (EACH DE) DED BY FULL REGULATORY OF IFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE J	OULD BE	(X5) COMPLETE DATE
M 0007	Continued from page 9			M 0007			
	will be prescribed acco Standards and guidelin Rh0 (D) immune globu patient in writing and n medical record. 5. If the sign the appropriate ree Not Obtained). Rh0 (I (RhoGam) is always g Room and documented Room Record" Review of MR6 on Au patient was admitted of medication abortion. The blood and determined (a blood group that lace blood cell). There was indicating the patient H performed, that RhoGa prevent antibodies from complications with fut prescribed for the patient administration of RhoG	nes. 4. Information repulsion must be documented the patient refuses, shelease (Release When D) immune globulin given in the Post Procedu ugust 23, 2017, revea on August 11, 2017, f The facility tested the the patient was Rh-n cks the Rh antigen in s no documentation is had previous Rh typin am (a medication use m forming and to avoid ture pregnancies) was ent, or the patient refi	regarding o the l in her ne must n Test cedure ure aled the for a e patient's negative the red in MR6 ng ed to oid s				

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-3910		A. BLDG: _	IPLE CONSTRUCTION: 00	(X3) DATE SURVE COMPLETED: 08/23/2017	EY
	VIDER OR SUPPLIER: PARENTHOOD KEYSTO WN	DNE -	STREET ADDRESS, 29 NORTH 91 ALLENTOWN	TH STREET	ſ		
STATE LICENS	e number: 00218701						
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE /	OULD BE	(X5) COMPLETE DATE
M 0007	M 0007 Continued from page 10			M 0007			
	Interview with EMP1 a 2017, at approximately was admitted to the fac abortion; the facility te determined the patient EMP2 confirmed there MR6 indicating previo EMP1 and EMP2 confi prescribed for the patien documentation the patien of RhoGam. EMP1 and facility did not administ their Rh-negative statu	2:00 PM confirmed cility for a medicatio ested the patient's blo was Rh-negative. E was no documentat us Rh typing was pe firmed RhoGam was ent, and there was no fent refused the admi d EMP2 confirmed t ster RhoGam to the p	MR6 n ood and MP1 and ion in rformed. not not not				
M 0032				M 0032			

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Pennsylvania Department of Health

	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIEI PLAN OF CORRECTION (POC) IDENTIFICATION NUMB 8-3910 NAME OF PROVIDER OR SUPPLIER:			A. BLDG: <u>00</u>		(X3) DATE SUR COMPLETED: 08/23/2017		
	D PARENTHOOD KEYST	ONE -	STREET ADDRESS, 29 NORTH 97 ALLENTOWN	TH STREET	ſ			
STATE LICEN	SE NUMBER: 00218701							
(X4) ID PREFIX TAG	MUST BE PRECEED	I OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O IFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE /	OULD BE	(X5) COMPLETE DATE	
M 0032	Continued from page 11			M 0032				
	29.43(b) Facility Approval All medical facilities excep approved facilities upon su the Department from a pers facility and, at the discretion satisfactory completion of a This REGULATION is not	bmission of an application con authorized to represe on of the Department, an on-site survey.			The policy and procedures o "Emergency Supplies" was p to surveyors during the visit 08/23/2017. One of the purp the Emergency Supplies polic check for expired and used s monthly. It specifically state following: "The clinician is responsible for checking the emergency supplies for expire dates and used supplies on a monthly basis. The center m is responsible for ordering ne supplies as needed and ensure that monthly checks are com Esmolol Hydrochloride 100 (milligrams/10ml (milliters)) medication used to treat incr- heart rate and increased blood pressure was ordered prior to visit on 08/23/2017. The new medication was on site durin visit, but not in the emergence During this visit, the new ord medication was placed in the emergency kit. In addition, t 32-ounce bottles of emergen wash located in the laborator	provided on oses of icy is to supplies s the ration anager ew ring upleted." mg) a eased od o the v ordered ng the cy kit. dered e he three cy eye	Completion Date: 09/07/2017 Status: APPROVED Date: 10/06/2017	

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-3910		(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING:		(X3) DATE SURVEY COMPLETED: 08/23/2017	
PLANNED PARENTHOOD KEYSTONE -			STREET ADDRESS, 29 NORTH 91 ALLENTOWN	TH STREET			
STATE LICENS	se number: 00218701						
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI	^C OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE 4	OULD BE	(X5) COMPLETE DATE
M 0032	Continued from page 12			M 0032			
					were expired. New bottles w ordered on the same day of v 08/23/2017. The bottles arriv can be located in the laborate Action Plan:	visit ved and	
					 "Daily, Weekly, Monthly I This form is a tool for Cente Managers, Clinicians and Me Care Assistants must comple accordingly. The form lists a related to maintaining compl Center Managers and the RC Manager are responsible for ensuring the form is complet the tasks are done. One of th listed on this form is checkin Emergency Supplies on a me basis to ensure that medicati discarded and ordered prior expiration dates. The Daily, Weekly, Mont will be audited by the Dir. or and Quality Management in as well as remotely. 	r edical ete all tasks liance. QM te and te tasks ng the onthly ons are to their hly Form f Risk	

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/CI PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER: 8-3910			(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING:		(X3) DATE SURVEY COMPLETED: 08/23/2017		
NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN		STREET ADDRESS, 29 NORTH 9T ALLENTOWN	TH STREET	- -			
STATE LICENSE NUMBER: 00218701							
(X4) ID PREFIX TAG	MUST BE PRECEED	ED BY FULL REGULATORY O		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH (XS CORRECTIVE ACTION SHOULD BE COMPI CROSS-REFERENCED TO THE APPROPRIATE DAT		
M 0032	E NUMBER: 00218701 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEF MUST BE PRECEEDED BY FULL REGULATORY OR IDENTIFYING INFORMATION) Continued from page 13			M 0032	3. Director of RQM is respon the effectiveness check of th and the final POC summary reported to the CEO of PP K A policy on "Daily, Weekly, Monthly Form" has been communicated to the Center Managers and Clinicians on 09/11/2017 and at every sche monthly meeting with Center Managers and Administratio which includes Director of R The RQM Dir (who is an RN visit each facility every two ensure that these policies are followed and help with any r education or demonstration. Emergency Supplies process again discussed at the recent meeting. The staff was advis about the importance of eme supplies checks being monit and expired supplies discard appropriately. This includes wash supplies as well.	is plan will be everystone. eduled er n, cQM N) will weeks to being needed The s was 10.2.17 sed orgency ored ed	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER: 8-3910		:	(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 08/23/2017			
NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN		STREET ADDRESS, 29 NORTH 9T ALLENTOWN	TH STREET					
STATE LICENS	e number: 00218701							
(X4) ID PREFIX TAG	MUST BE PRECEED	° OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE /	(X5) COMPLETE DATE		
M 0032	Continued from page 14			M 0032				
					Emergency drugs will be kep with a red plastic lock and the kit placed in a locked room wind in use. The clinician will check the emergency supplies for expiri- dates as well as used supplies monthly basis. The Center Manager is respo- for ordering new supplies we also monitored by the RQM RQM will review this process detail with the Allentown state October 12, 2017 and scheded with other Centers to occur be end of October.	ten the when not ration s on a onsible hich is Director. ss in uff on ale visits		

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER: 8-3910			(X2) MULTIPLE CONSTRUCTION: A. BLDG: B. WING:		(X3) DATE SURVEY COMPLETED: 08/23/2017		
	OVIDER OR SUPPLIER: D PARENTHOOD KEYSTO OWN	DNE -	STREET ADDRESS, 29 NORTH 97 ALLENTOWN	TH STREET	P CODE:		
STATE LICEN	ISE NUMBER: 00218701						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIEN 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		
M 0032	Continued from page 15			M 0032			
	Based on review of fac and staff interview (EN facility failed to ensure removed from the eme ensure expired emerge from the laboratory are Findings include:	ed the is were l to					
	Review on August 23, 2017, of the facility "Emergency Supplies," dated effective Janu 2015, revealed "Policy: An adequate amoun current emergency medical supplies will be each Medical Center and will be easily acco medical center staff. Emergency drugs will in a locked Kit when not in use. Responsibi The Clinician is responsible for checking th emergency supplies for expiration dates and supplies on a monthly basis. The Center Ma responsible for ordering new supplies as ne ensuring that monthly checks are completed Procedures:4 b. Expired supplies mu						

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER: 8-3910			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 08/23/2017		
	OVIDER OR SUPPLIER: D PARENTHOOD KEYST OWN	ONE -	STREET ADDRESS, 29 NORTH 97 ALLENTOW	TH STREET		I	
STATE LICEN	SE NUMBER: 00218701						
(X4) ID PREFIX TAG	SUMMARY STATEMEN MUST BE PRECEEE IDENT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE	
M 0032	Continued from page 16			M 0032			
discarded or destroyed"		1"					
	1) Observation tour of approximately 11:15 4 with two vials of esmo	rgency kit					
	medication used to tre	te and					
	(milliliters), which exp	anis <i>)/</i> 101111					
	Interview with EMP2 confirmed the emerge esmolol hydrochloride						
	2) Observation tour of approximately 11:15 <i>A</i> bottle of emergency end laboratory area and two emergency eyewash lo expired in July 2017.	ounce le f					
	Interview with EMP2 confirmed the one 32-	-					

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 8-3910			(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING:		(X3) DATE SURVEY COMPLETED: 08/23/2017			
NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: 00218701			STREET ADDRESS, CITY, STATE, ZIP CODE: 29 NORTH 9TH STREET ALLENTOWN, PA 18101					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE	
M 0032	Continued from page 17 eye wash located in the laboratory area and 32-ounce bottles of emergency eyewash loc the lab, which expired in July 2017.			M 0032				

1DNK11

IF CONTINUATION SHEET Page 18 of 18



Certified End Page

PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: 00218701 SURVEY EXIT DATE: 08/23/2017

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

Vancy & hescawag

Nancy J. Lescavage Deputy Secretary for Quality Assurance



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

Rachel L. Levine, MD Secretary of Health