Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **8-5143**	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: **09/30/2017**

NAME OF PROVIDER OR SUPPLIER: **PHILADELPHIA WOMEN'S CENTER, INC.** STATE LICENSE NUMBER: **00178701**	STREET ADDRESS, CITY, STATE, ZIP CODE: **777 APPLETREE STREET, 7TH FLOOR PHILADELPHIA, PA 19106**

(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 January 18-19, 2017, at The Philadelphia Women's 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:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

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S 0000	INITIAL COMMENT This report is the result of a full State Licensure survey conducted on January 18-19, 2017, at The Philadelphia Women's Center. 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 0006		S 0006		

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: **8-5143**	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: **09/30/2017**

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S 0006	Continued from page 1 51.3 (d) Notification 51.3 Notification (d) A health care facility shall submit to the Department architectural plans and blueprints of proposed new construction, alteration or renovation to the facility. This material shall be submitted at least 60 days before the initiation of construction, alteration or renovation. The Department will review these documents to assure compliance with relevant life safety code and other regulatory requirements. The Department will respond to the facility by either issuing an approval or disapproval or requesting further information with 45 days of receipt of the facility's submission. The facility may not initiate construction, alteration, renovation until it has received an approval from the Department. This REGULATION is not met as evidenced by:	S 0006	1. Contain elements detailing how the facility will correct the deficiency as it relates to the individual; The facility will follow required procedures to notify the Department whenever new construction, alteration, or renovation is occurring. The facility in consult with the Department recognizes the space as a pre procedure area and as such is in compliance with pre-procedure room requirements. 2. Indicate how the facility will act to protect patients in similar situations; A full time staff member will continue to be present in the pre-procedure area to monitor patients and communicate patient needs to staff. 3. Include the measures the facility will take or the systems it will alter to ensure that the problem does not recur; To meet pre-procedure area requirements, we have confirmed that a handwashing station is available for use. Additionally, we have ordered patient privacy screens	Completion Date: **11/01/2017** Status: **APPROVED** Date: **10/03/2017**

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S 0006	Continued from page 2	S 0006	and a nurse's work station In the event the facility proposed new construction, alteration or renovations to the facility, the DOH would be notified as required by regulation. 4. Indicate how it plans to monitor its performance to make sure that solutions are sustained; and Governing body and Administrator reviewed regulation and will ensure compliance with regulation as written	

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S 0006	Continued from page 3 Based on observation and interview with staff (EMP), it was determined the facility failed to notify the Department, prior to changing the "Dress Down Room" waiting area to a preoperative/postoperative room. Findings include: Review on January 30, 2017, of Department of Health facility file documentation, revealed no documented evidence the facility submitted a request for occupancy to change the use of the "Dress Down Room" waiting area to a patient preoperative/postoperative room. Observation on January 18, 2017, at 3:20 PM of the facility revealed the following changes were made to the patient "Dress Down Room" waiting area including the addition of four (4) reclining chairs and ceiling mounted fixtures to administer IVs. Further observation revealed the area did not provide every patient a method of privacy for each	S 0006		

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S 0006	Continued from page 4 of the four recliner chairs in the room. Interview on January 18, 2017, at 3:55 PM with EMP1 confirmed the above mentioned room was currently being utilized as a preoperative/postoperative area for procedure preparation and discharge. Interview on January 18, 2017, 3:55 PM with EMP1 confirmed the above mentioned room was changed from a waiting area to a preoperative/postoperative waiting room. EMP1 also confirmed the facility did not notify the Department of the change of use of this area and did not request an occupancy.	S 0006		

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S 0006	Continued from page 5	S 0006		
S 0118		S 0118		

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S 0118	Continued from page 6 551.22 (a)(4) Criteria for Performance of Pediatric Patient 551.22. Criteria for Performance of Ambulatory Surgery on Pediatric Patients (a) In addition to the criteria set forth at 551.21 (relating to criteria for ambulatory surgery), the following criteria shall apply to the performance of ambulatory surgery on children under 18 years of age. (4) A medical professional who has successfully completed a course in advanced pediatric life support offered by the American Academy of Pediatrics and either the American College of Emergency Physicians or the American Heart Association shall be present in the facility. This REGULATION is not met as evidenced by:	S 0118	1. Contain elements detailing how the facility will correct the deficiency as it relates to the individual; PALS Training conducted onsite for nursing staff on 1.30.17 2. Indicate how the facility will act to protect patients in similar situations; The center will conduct/facilitate PALS training for staff as appropriate. A medical professional with PALS will be in building at all times a patient under 18 years old is receiving abortion care. 3. Include the measures the facility will take or the systems it will alter to ensure that the problem does not recur; The center will conduct/facilitate PALS training for appropriate staff and ensure required staffing. 4. Indicate how it plans to monitor its performance to make sure that solutions are sustained; and The site's Director of Nursing will review certifications and employee files- when a nurse has completed her initial training competencies, the	Completion Date: **01/30/2017** Status: **APPROVED** Date: **09/21/2017**

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S 0118	Continued from page 7	S 0118	site DoN will schedule the RN for PALS training. The DoN, along with the center's Office Manager will review staff employment files to ensure that PALS training is current. This audit will take place every 3 months.	

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S 0118	Continued from page 8 Based on a review of facility documents, credential files (CF), personnel files (PF), and interview with staff (EMP), it was determined that the facility failed to provide staff trained in Pediatric Advanced Life Support (PALS) for surgical procedures performed on children under 18 years of age. Findings include: Review of facility policy "Criteria for Performance of Ambulatory Surgery on Pediatric Patients (AKA PALS [also known as Pediatric Advanced Life Support]), issued June 15, 2016," revealed "a medical professional who has successfully completed a course in PALS offered by the American Academy of Pediatrics and either the American College of Emergency Physicians or the American Heart association shall be present at the facility. It was acertained that patients under the age of 18 received abortion services at the facility from September 1, 2016, to December 31, 2016.	S 0118		

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S 0118	Continued from page 9 A request was made to EMP1 on January 19, 2017, for a list of providers that perform surgical procedures at the facility and a list of providers that perform anesthesia at the facility. EMP1 provided a list that revealed 12 providers are credentialed at the facility to perform surgical services and three providers were credentialed at the facility to provided anesthesia services. Further review of the list revealed six of the surgical service providers were not PALS certified and performed surgical services at the facility from September 1, 2016 thru December 31, 2016. Continued review revealed two anesthesia providers were not PALS certified and provided anesthesia services at the facility from September 1, 2016, thru December 31, 2016. Review of the facility's schedule from September 1, 2016 to December 31, 2016, revealed surgical procedures were performed on pediatric patients under the age of 18 and a medical professional that successfully completed a course in PALS was not present at the facility on the following dates:	S 0118		

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S 0118	Continued from page 10 September 3,6,9,10,13,23 and 30, 2016; October 11,12,14, 15,18,19,21 and 26, 2016; November 8,9,16,18 and 29, December 7,9,16,23 and 28, 2016. An interview with EMP1 on January 19, 2017, at approximately 11:10 AM confirmed the facility performed surgical abortions on the above mentioned dates and there were no PALS certified staff present at the facility on those dates. Further interview confirmed Registered Nurses that work at the facility are not PALS certified.	S 0118		
S 033F		S 033F		

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S 033F	Continued from page 11 553.3 (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	During the inspection, the auditors were given a copy of "Management of Occupational Exposure and Sharps" which details storage and disposal of sharps in the center. The emergency "grab and go bag" that is detailed as non-compliant in the observation was replaced with a hard-shell locking suitcase on February 2, 2017 1. Contain elements detailing how the facility will correct the deficiency as it relates to the individual; Governing Body approved change to hard-shell locking suitcase replacing "grab and go" duffel bag on 2.2.17 2. Indicate how the facility will act to protect patients in similar situations; Hard-shell locking suitcase to be used for storage of emergency items to be used upon center evacuation. Suitcase to be locked in cabinet in PACU when not in use. 3. Include the measures the facility will take or the systems it will alter to ensure that the problem does not recur;	Completion Date: **04/04/2017** Status: **APPROVED** Date: **08/22/2017**

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S 033F	Continued from page 12	S 033F	Hard-shell locking suitcase to be used for storage of emergency items to be used upon center evacuation. Suitcase to be locked in cabinet in PACU when not in use. Director of Nursing updating staff during evacuation drill to be held on 4.4.17 4. Indicate how it plans to monitor its performance to make sure that solutions are sustained; and The site's Director of Nursing or her designee will review the contents/storage/security of emergency supplies for evacuation when crash cart items are reviewed and documented (currently inspections occur monthly) 5. Provide dates when corrective action will be completed. 4.4.17	

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S 033F	Continued from page 13 Based on observation and interview with staff (EMP), it was determined the facility failed to adopt policies and procedures necessary for the orderly conduct of the ASF. Findings include: A request was made on January 18, 2017, to EMP2 for the policy that provided provisions for the secure storage of sharps. None provided. Observation of the Post Anesthesia Care Unit (PACU) on January 18, at 3:40 PM revealed a red emergency bag that was partially unzipped and contained assorted sizes of syringes and needles. Further observation revealed there was no provision to lock or secure the bag for the safe storage of sharps. An interview conducted on January 18, 2017, at 3:45 PM with EMP2 confirmed the red emergency bag that contained the needles and syringes was not stored in a secured area and the facilty did not	S 033F		

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S 033F	Continued from page 14 provided a mechanism to lock the bag to secure the sharps that were contained in the bag.	S 033F		

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S 033F	Continued from page 15	S 033F		
S 312D		S 312D		

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S 312D	Continued from page 16 553.12 (b)(3) Implementation 553.12 (b) The following are minimal provisions for the patient's bill of rights: (3) A patient has the right to consideration of privacy concerning his own medical care program. Case discussion, consultation, examination and treatment are considered confidential and shall be conducted discreetly. This REGULATION is not met as evidenced by:	S 312D	1. Contain elements detailing how the facility will correct the deficiency as it relates to the individual; The facility will ensure that patients in this area retain their right to privacy by purchasing additional privacy screens and making screens available to patients who request them. In addition, case discussion, consultation, examination, and treatment continue to be conducted in a private office, exam or procedure room. 2. Indicate how the facility will act to protect patients in similar situations; Patient privacy screens have been ordered. They will be installed and will be offered and made available to all patients who request them in the space. 3. Include the measures the facility will take or the systems it will alter to ensure that the problem does not recur; Patient privacy screens have been ordered. They will be installed and will be offered and made available to	Completion Date: **11/01/2017** Status: **APPROVED** Date: **10/03/2017**

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(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 312D	Continued from page 17	S 312D	all patients who request them in the space. 4. Indicate how it plans to monitor its performance to make sure that solutions are sustained; and Sufficient privacy screening has been ordered and will be made available to all patients at their request. DON will ensure that privacy screening is available and appropriate to the number of patients in this pre-procedure area.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

NAME OF PROVIDER OR SUPPLIER: **PHILADELPHIA WOMEN'S CENTER, INC.**

STATE LICENSE NUMBER: **00178701**

STREET ADDRESS, CITY, STATE, ZIP CODE: **777 APPLETREE STREET, 7TH FLOOR PHILADELPHIA, PA 19106**

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S 312D	Continued from page 18 Based on observation and staff interview (EMP), it was determined the facility failed to ensure patient privacy in the facility's laminaria preoperative/postoperative area. Findings include: Review of facility policy "Procedures for Distribution (Patient's Bill of Rights), revised July 16, 2012," revealed "Pennsylvania Patient's Bill of Rights ... (3) a patient has the right to consideration of privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are considered confidential and shall be conducted discreetly." Observation on January 18, 2017,of the facility's preoperative/postoperative laminaria area revealed four patient reclining chairs. Further observation revealed no cubicle curtains and one privacy screen located behind the entrance door to the area. Interview with EMP1 on January 18, 2017 at approximately 3:15 PM confirmed there were no	S 312D		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

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S 312D	Continued from page 19 cubicle curtains or sufficient privacy screens to ensure patient confidentiality. cross reference: Governing Body Responsibilities 555.3(3)	S 312D		
S 331A		S 331A		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

NAME OF PROVIDER OR SUPPLIER:
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S 331A	Continued from page 20 553.31 (a) Administrative responsibilities A full time person in charge shall be appointed who has authority and responsibility for the operation of the ASF at all times. Qualifications, authority, responsibilities and duties of the person in charge shall be defined in a written statement adopted by the governing body. This REGULATION is not met as evidenced by:	S 331A	1. Contain elements detailing how the facility will correct the deficiency as it relates to the individual; The Administrator is a full time employee who has authority and responsibility for the operation of the ASF at all times. The Deputy Administrator is a full time staff member who is located at the facility on a daily basis to oversee the day to day operations of the facility. 2. Indicate how the facility will act to protect patients in similar situations; The facility will continue to have a full time employee who has authority and responsibility for the operation of the ASF at all times. 3. Include the measures the facility will take or the systems it will alter to ensure that the problem does not recur; The facility will maintain a full time employee who has authority and responsibility for the operation of the ASF at all times. 4. Indicate how it plans to monitor its performance to make sure that solutions are sustained; Governing Body will ensure the	Completion Date: **02/07/2017** Status: **APPROVED** Date: **09/21/2017**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

NAME OF PROVIDER OR SUPPLIER:
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S 331A	Continued from page 21	S 331A	employment of a full time person who has authority and responsibility for the operation of the ASF at all times.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

NAME OF PROVIDER OR SUPPLIER: **PHILADELPHIA WOMEN'S CENTER, INC.**

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S 331A	Continued from page 22 Based on review of facility documents and interview with staff (EMP), it was determined the Governing Body failed to ensure a full time person was in charge of the day to day operation of the facility and failed to ensure a full time person was present at the facility that had authority and responsibilities for the operation of the Ambulatory Surgical Facility at all times. Findings include: Review on January 19, 2017, at 10:00 AM, of the facility policy "Governing Board Bylaws," dated January 24, 2006, revealed no documented evidence the Governing Body Bylaws defined and adopted a full time person in charge of the facilities day to day operations. Review of of the job description for EMP1 "Philadelphia Women's Center, Administrator, Job Description, revised August 3, 2010," revealed "General Summery-The main function of the	S 331A		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

NAME OF PROVIDER OR SUPPLIER: **PHILADELPHIA WOMEN'S CENTER, INC.**

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S 331A	Continued from page 23 Administrator of the Philadelphia Women's Center is to manage and oversee the day-to-day operations of the facility." Further review revealed the document was signed by EMP1 September 22, 2016. Review on January 19, 2017, of "Philadelphia Women's Center Organizational Chart," updated January 15, 2016, revealed "Administrator ... (EMP1) ... " Review of facility's employee claendar for the January 2017, revealed EMP1 divided time between the Philadelphia Women's Center and another facility, and is not full time at the facility to oversee the day to day operations. Interview on January 19, at 11:00 AM, with EMP1 confirmed that they were considered the full-time Administrator for the Philadelphia Women's Center. Further interview confirmed EMP1 was not located at the facility on a daily basis to oversee the day to day operations at the facility.	S 331A		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

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S 331A	Continued from page 24	S 331A		
S 6412		S 6412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **8-5143**	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: **09/30/2017**

NAME OF PROVIDER OR SUPPLIER: **PHILADELPHIA WOMEN'S CENTER, INC.**
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S 6412	Continued from page 25 563.12 (11) Form and Content of Record 563.12 Form and content of record The ASF shall maintain a separate medical record for each patient. Each record shall be accurate, legible and promptly completed. Patient medicals shall be constructed to stand alone and be easily identified as ASF records. Medical records must include at least the following: (11) Discharge summary including discharge diagnosis. This REGULATION is not met as evidenced by:	S 6412	1. Contain elements detailing how the facility will correct the deficiency as it relates to the individual; Electronic medical record will be updated to auto populate discharge summary and diagnosis. The discharge summary will be offerred at the patient's time of discharge (for both one and two day procedures) and include the following information; - Procedure type - Sedation type - Medications Administered - Revisit (if applicable) 2. Indicate how the facility will act to protect patients in similar situations; The system will be corrected and automatic. RNs will be trained to utilize the screen labeled as "Discharge Summary" 3. Include the measures the facility will take or the systems it will alter to ensure that the problem does not recur; The system will be corrected and automatic. RNs will be trained to	Completion Date: **06/01/2017** Status: **APPROVED** Date: **08/22/2017**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

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S 6412	Continued from page 26	S 6412	utilize the screen labeled as "Discharge Summary" 4. Indicate how it plans to monitor its performance to make sure that solutions are sustained; and Discharge Summary to be added to Nursing PACU Competency to ensure that staff are trained at this and can comply. 5. Provide dates when corrective action will be completed 6.1.17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

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S 6412	Continued from page 27 Based on review of facility policy and procedures, review of medical records (MR) and interview with staff (EMP), it was determined the facility failed to ensure a discharge summary including discharge diagnosis was included in five of five medical record reviewed (MR8, MR9, MR10, MR11, and MR17). Findings include: Review on January 19, 2017, of facility policy "Form and Content of Record," approved June 2016 revealed " ... Medical records shall include at least the following: (11) Discharge summary including discharge diagnosis." 1) Review on January 19, 2017, of MR8, MR9, MR10, MR11, and MR17 revealed these patients were admitted to the facility for a "Two-Day Procedure." Further review of MR8, MR9, MR10, MR11, and MR17 revealed there was no documented evidence of a discharge summary including a discharge diagnosis for Day One or Day Two of the "Two-Day Procedure" in MR8, MR9,	S 6412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

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S 6412	Continued from page 28 MR10, MR11, and MR17. 2) Interview with EMP1 on January 19, 2017 at 11:30 AM confirmed there was no documented evidence of a discharge summary including a discharge diagnosis for Day One or Day Two of the "Two-Day Procedure" in MR8, MR9, MR10, MR11, and MR17.	S 6412		
S 6702		S 6702		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **8-5143**	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: **09/30/2017**

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S 6702	Continued from page 29 567.2 (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	As per facility policy, each sterilized pack contains "Date, Initials of person sterilizing instruments, contents of the pack, Machine and cycle information ... " Our autoclaves are not equipped with printers/printouts- all documentation is done by hand. As was explained on the dates of inspection, each pack of instruments contains two mechanisms to ensure that autoclave cycle has been completed and that the instruments are sterile and ready for use (including load duration, reaching optimal temperature/moisture, etc) as there is an indicator placed on the cleaned and wrapped instruments via autoclave indicator tape and an individual indicator imbedded with the instruments upon wrapping. Pertinent instruments utilized during the procedure are documented in the EMR under the surgical operative notes. In order to better track all packs back to the load in which they were run. OR staff will document the information demarcated on each	Completion Date: **04/04/2017** Status: **APPROVED** Date: **08/22/2017**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

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S 6702	Continued from page 30	S 6702	instrument pack in the OR surgical report, documenting contents of pack, date, contents, machine used along with confirmation that both indicators were activated confirming instrument sterility. 1. Contain elements detailing how the facility will correct the deficiency as it relates to the individual; OR staff will be trained to document the information demarcated on each instrument pack in the OR surgical report, documenting contents of pack, date, machine used along with confirmation that both indicators were activated confirming instrument sterility. 2. Indicate how the facility will act to protect patients in similar situations; Adherence to the additional documentation will be reviewed during the center's chart QI process. 3. Include the measures the facility will take or the systems it will alter to ensure that the problem does not recur; Adherence to the additional	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

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S 6702	Continued from page 31	S 6702	documentation will be reviewed during the center's chart QI process. 4. Indicate how it plans to monitor its performance to make sure that solutions are sustained; and Adherence to the additional documentation will be reviewed during the center's chart QI process. 5. Provide dates when corrective action will be completed 4.4.17	

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S 6702	Continued from page 32 Based on review of facility policies and procedures, observation of the sterilization area, review of medical records (MR) 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 procedures to maintain a tracking system for infection for investigation of infection in five of five medical records reviewed (MR8, MR9, MR10, MR11, and MR17). Findings include: Review on January 19, 2017, of facility policy "Philadelphia Women's Center Infection Prevention and Control Plan," reviewed June 2016 revealed "Philadelphia Women's Center (PWC) maintains a sanitary environment, properly constructed, equipped and maintained to protect patients and personnel from cross-infection and to protect the health and safety of patients ... Components of the	S 6702		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

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S 6702	Continued from page 33 Infection Control Program: ... Records of confirmed infection which originate at PWC among patients and personnel ... Sterilization and Disinfection procedures ... " Review on January 19, 2017, of facility policy "Sterilization and Disinfection," approved June 2016 revealed " ... Labeling Sterile Packs- All packages sterilized at PWC will contain the following information: Date, Initials of person sterilizing instruments, contents of the pack, Machine and cycle information ... " Observation of the Sterile Processing area on January 19, 2017, at 10:00 AM revealed the facility had three steam autoclaves that did not provide automated cycle information printouts for each sterilization load. Further observation of the sterilized instrument packets revealed there was no documentation of the temperature obtained for the sterilization cycle for each instrument packet. Review on January 19, 2017, of MR8, MR9,	S 6702		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

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S 6702	Continued from page 34 MR10, MR11, and MR17 revealed these patients were admitted to the facility for a procedure. Further review of MR8, MR9, MR10, MR11, and MR17 revealed no documented evidence of the type surgical instrument(s) used during the procedure or the sterilization cycle information for each surgical instrument(s) used during the procedure. Interview with EMP2 on January 19, 2017, at 10:00 AM confirmed the three steam autoclaves used by the facility were not capable of providing a printout of cycle information for each load of instruments being sterilized. Interview with EMP1 on January 19, 2017, at 11:30 AM confirmed the facility used the steam autoclaves for sterilizing stainless steel instruments that included vaginal speculums, dilators, curettes, forceps and weighted speculums. Further interview with EMP1 confirmed there was no documentation of the temperature obtained during the sterilization cycle for each instrument packet, and there was no	S 6702		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

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S 6702	Continued from page 35 documented evidence of the type surgical instrument(s) used or the sterilization cycle information for the surgical instrument(s) used during each patient's procedure in MR8, MR9, MR10, MR11, and MR17 to maintain a tracking system for the investigation of infection.	S 6702		
S 6740		S 6740		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

NAME OF PROVIDER OR SUPPLIER:
PHILADELPHIA WOMEN'S CENTER, INC.

STATE LICENSE NUMBER: **00178701**

STREET ADDRESS, CITY, STATE, ZIP CODE:
777 APPLETREE STREET, 7TH FLOOR
PHILADELPHIA, PA 19106

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S 6740	Continued from page 36 567.32 Policies and Procedures 567.32 Policies and procedures Procedures shall be developed for cleaning and care of equipment, for establishment of cleaning schedules, for cleaning methods and for proper use of cleaning supplies and disposal of waste. Suitable equipment shall be provided to facilitate cleaning. This REGULATION is not met as evidenced by:	S 6740	1. Contain elements detailing how the facility will correct the deficiency as it relates to the individual; Site policy "Waste Disposal" will be updated to reflect current practice- Tissue slated for medical waste disposal is kept in a locked freezer labeled biohazard. The only tissue not located in the freezer is packaged for courier pick up in the lower locked and labeled cabinet. 2. Indicate how the facility will act to protect patients in similar situations; We will continue to store tissue in the locked/labeled freezer prior to medical waste disposal pick up. Pathology lab pick up is packaged and ready to go as per the pathology laboratory's recommendations in preservative. 3. Include the measures the facility will take or the systems it will alter to ensure that the problem does not recur; Site policy "Waste Disposal" will be updated to reflect current practice-	Completion Date: **09/22/2017** Status: **APPROVED** Date: **09/21/2017**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

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S 6740	Continued from page 37	S 6740	We will continue to store tissue in the locked/labeled freezer prior to medical waste disposal pick up. Pathology lab pick up is packaged and ready to go as per the pathology laboratory's recommendations in preservative 4. Indicate how it plans to monitor its performance to make sure that solutions are sustained; and We will continue to store tissue in the locked/labeled freezer prior to medical waste disposal pick up. Pathology lab pick up is packaged and ready to go as per the pathology laboratory's recommendations in Formaldehyde. Spot checks on this are performed daily by management team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

NAME OF PROVIDER OR SUPPLIER: **PHILADELPHIA WOMEN'S CENTER, INC.**

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S 6740	Continued from page 38 Based on observation,review of facility policy and interview with staff (EMP), it was determined the facility failed to follow their policy to keep fetal tissue in a secure freezer. Findings include: Review of facility policy "Waste Disposal (C) - Medical Waste, revised 12/14/15," revealed "Medical Waste Management Policy- Biohazardous Medical Waste ... Processing: ... H. Fetal specimens or tissue removed during abortion procedures that are not sent to an outside pathologist for examination will be kept in a secure freezer for regular pick up by the contracted medical waste hauler." Observation on January 18, 2017, at 3:40 PM of the "Pathology and Decontamination Room" revealed a freezer labeled biohazard and one lower cabinet that was not refrigerated, labeled "Biohazard," and locked. Interview on January 18, 2017, at 3:45 PM with	S 6740		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8-5143	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 09/30/2017

NAME OF PROVIDER OR SUPPLIER:
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S 6740	Continued from page 39 EMP1 confirmed overflow of fetal specimens and tissue that were removed at the time of abortion are stored in the non-refrigerated locked cabinet for regular pick up by the medical waste hauler.	S 6740		

Certified End Page

PHILADELPHIA WOMEN'S CENTER, INC.

STATE LICENSE NUMBER: 00178701

SURVEY EXIT DATE: 09/30/2017

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

Nancy J. Lescavage
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