

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>06/12/2017</b>
--	--	---	--

NAME OF PROVIDER OR SUPPLIER: <b>DREXEL OB/GYN ASSOCIATES AT FEINSTEIN</b>  STATE LICENSE NUMBER: <b>89LC8701</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>216 N. BROAD STREET 4th floor PHILA, PA 19102</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	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

M 0000	INITIAL COMMENT  This report is the result of an Annual Registration survey conducted on June 12, 2017, at Drexel Ob/gyn Associates At Feinstein. It was determined the facility was not 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		
M 0006		M 0006		

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

--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>06/12/2017</b>
NAME OF PROVIDER OR SUPPLIER: <b>DREXEL OB/GYN ASSOCIATES AT FEINSTEIN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>216 N. BROAD STREET 4th floor PHILA, PA 19102</b>		
STATE LICENSE NUMBER: <b>89LC8701</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)	(X5) COMPLETE DATE
M 0006	Continued from page 1  29.33(6) Requirements for Abortion  Prior to the performance of an abortion, the attending physician shall insure that the patient has had tests for hemoglobin or hematocrit, blood group and RH type, and urine protein and sugar. All of the foregoing laboratory results shall be entered into the medical record of the patient.  This REGULATION is not met as evidenced by:	M 0006	For both deficiencies 1 and 2, the Mifepristone/Misoprostol protocol has been updated to read as follows: "Evaluation and Consent day...H/H, Rh, urine protein/glucose, pregnancy tests as indicated" as stated in PA Dept of Health Regulations 28 Pa Code, Chapter 29, Subchapter D, Ambulatory Gynecological Surgery in Hospitals and Clinics.  Secondary to the revision of the Mifepristone/Misoprostol protocol, a separate checklist containing: H/H, Rh, urine protein/glucose, and pregnancy test has been created by the Ryan Service Primary Medical Assistant and Ryan Service Care Coordinator. The medical assistant will be responsible for collection of the labwork/tests, and initial/date the checklist after performance. Pregnancy test and urine/glucose will be entered in the EMR on the same day they were performed by the medical assistant.  The Care Coordinator will review the	Completion Date: <b>07/27/2017</b> Status: <b>APPROVED</b> Date: <b>07/21/2017</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>06/12/2017</b>
NAME OF PROVIDER OR SUPPLIER: <b>DREXEL OB/GYN ASSOCIATES AT FEINSTEIN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>216 N. BROAD STREET 4th floor PHILA, PA 19102</b>		
STATE LICENSE NUMBER: <b>89LC8701</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)	(X5) COMPLETE DATE
M 0006	Continued from page 2	M 0006	<p>labwork (CBC/Rh) once resulted in the EMR and date/initial the checklist.</p> <p>Prior to the medical termination and while signing the Medical Abortion Consent, the completed information of the checklist (i.e. H/H, urine glucose/protein) will be reviewed by the MD performing the termination and initialed/signed-off in the indicated space on the Medical Abortion Consent.</p> <p>The Ryan Service Care Coordinator has educated the staff on the creation of the changes to Mifepristone/Misoprostol protocol and Medical AB consent, creation of the checklist, roles, and proper documentation of completed items on the Medical Abortion Consent and in the EMR.</p> <p>Plan of correction includes staff education in changes to policy and procedure, and quality monitoring to ensure adherence. Plan of correction will be implemented by 7/27/17.</p> <p>Quality monitoring will include:</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>06/12/2017</b>
NAME OF PROVIDER OR SUPPLIER: <b>DREXEL OB/GYN ASSOCIATES AT FEINSTEIN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>216 N. BROAD STREET 4th floor PHILA, PA 19102</b>		
STATE LICENSE NUMBER: <b>89LC8701</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)	(X5) COMPLETE DATE
M 0006	Continued from page 3	M 0006	<p>documentation of compliance by random selection/review of 2-4 charts by the Nursing Director , once prior to the 45 day time-period from the completion of the survey date, then monthly.</p> <p>Compliance to changes will be reported to OB/GYN Department Chair at the end of the initial period, then monthly.</p> <p>If found to be non-compliant, a performance review plan will be created for the provider responsible for the deficiency as described above, and implemented by the Director of the Ryan Service, who also has overall responsibility to ensure the plan of correction.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>06/12/2017</b>
NAME OF PROVIDER OR SUPPLIER: <b>DREXEL OB/GYN ASSOCIATES AT FEINSTEIN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>216 N. BROAD STREET 4th floor PHILA, PA 19102</b>		
STATE LICENSE NUMBER: <b>89LC8701</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)	(X5) COMPLETE DATE
M 0006	Continued from page 4  Based on facility policies and procedures, medical records (MR) and interview with staff (EMP) it was determined that the facility failed to ensure that tests were conducted for urine protein and sugar for two (2) of fifteen (15) medical records reviewed (MR6, MR9) and for hemoglobin or hematocrit (H/H) for one (1) of 15 (15) medical records reviewed (MR6).  Findings include:  Review on June 12, 2017, of facility policy "Mifepristone/Misoprostol Protocol" dated November 30, 2015, revealed " ... Evaluation and Consent Day ... H/H, ... and any other test as indicated ... "  1) Review on June 12, 2017, of MR6 and MR9 revealed no documented evidence that laboratory tests for urine protein and urine sugar were completed prior to the medical procedure.  Interview with EMP1 on June 12, 2017, at 12:20	M 0006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>06/12/2017</b>
NAME OF PROVIDER OR SUPPLIER: <b>DREXEL OB/GYN ASSOCIATES AT FEINSTEIN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>216 N. BROAD STREET 4th floor PHILA, PA 19102</b>		
STATE LICENSE NUMBER: <b>89LC8701</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)	(X5) COMPLETE DATE
M 0006	Continued from page 5  PM confirmed there was no documented evidence in MR6 and MR9 that laboratory tests for urine sugar and protein were completed prior to the medical procedure.  2) Review on June 12, 2017, of MR6 revealed no documented evidence that laboratory tests for H/H were completed prior to the medical procedure.  Interview on June 12, 2017, at 12:20 PM with EMP1 confirmed MR6 had no documented evidence that laboratory tests for H/H prior to a medical procedure.	M 0006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>06/12/2017</b>
NAME OF PROVIDER OR SUPPLIER: <b>DREXEL OB/GYN ASSOCIATES AT FEINSTEIN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>216 N. BROAD STREET 4th floor PHILA, PA 19102</b>		
STATE LICENSE NUMBER: <b>89LC8701</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)	(X5) COMPLETE DATE
M 9999	<p>Recommendation</p> <p>This REGULATION is not met as evidenced by:</p>	M 9999	<p>POC is optional and not required.</p> <p>1)Creation of a Patient Safety Plan specific to the Ryan Service. Submission of Patient Safety Plan to Safety Committee for approval</p> <p>2)Though Ryan Service patient safety meetings will continue to be held in conjunction with other office/dept safety meetings, the Ryan Service safety meeting will be discussed separately, and document Patient Safety Meeting minutes will be documented separately.</p> <p>3)Pt Safety Meetings have been conducted since Jan, 2017 and will continue to be conducted and documented quarterly as suggested.</p> <p>4)Acquire community members to attend quarterly meetings, document their attendance in the meeting minutes.</p>	<p>Completion Date: <b>07/17/2017</b></p> <p>Status: <b>APPROVED</b></p> <p>Date: <b>07/19/2017</b></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>06/12/2017</b>	
NAME OF PROVIDER OR SUPPLIER: <b>DREXEL OB/GYN ASSOCIATES AT FEINSTEIN</b>  STATE LICENSE NUMBER: <b>89LC8701</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>216 N. BROAD STREET</b> <b>4th floor</b> <b>PHILA, PA 19102</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)	(X5) COMPLETE DATE
M 9999	<p>Continued from page 7</p> <p>Based on review of facility documents and interview with staff (EMP1), it was determined the facility failed to ensure an approved Patient Safety Plan was established for the facility, failed to ensure the Patient Safety Meeting Minutes were specific to the facility, failed to ensure the Patient Safety Committee met quarterly and failed to ensure a member of the community was appointed to the committee.</p> <p>Findings include:</p> <p>1) On June 12, 2017, surveyor requested the facility's Patient Safety Plan. None was provided.</p> <p>2) Review on June 12, 2017, of facility documents "Patient Safety Committee Meeting Minutes," dated February 28, 2017, April 25, 2017, and May 23, 2017, revealed the facility had Patient Safety Meetings integrated with another office practice.</p> <p>3) Review of the "Patient Safety Meeting Minutes" revealed no documented evidence meetings</p>	M 9999		



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>06/12/2017</b>	
NAME OF PROVIDER OR SUPPLIER: <b>DREXEL OB/GYN ASSOCIATES AT FEINSTEIN</b>  STATE LICENSE NUMBER: <b>89LC8701</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>216 N. BROAD STREET</b> <b>4th floor</b> <b>PHILA, PA 19102</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)	(X5) COMPLETE DATE
M 9999	Continued from page 8  occurred in 2016.  4) Review on June 12, 2017, of facility documents "Patient Safety Committee Meeting Minutes," dated February 28, 2017, April 25, 2017, and May 23, 2017, revealed no documented evidence a community member was in attendance at the meetings.  5) Interview on June 12, 2017, with EMP1 confirmed there was no documented evidence of a Patient Safety Plan for the facility, the facility's Patient Safety Meetings were integrated with another office practice, there was no documented evidence of meetings for 2016, and there was no facility community member appointed to the committee.	M 9999		



# Certified End Page

**DREXEL OB/GYN ASSOCIATES AT FEINSTEIN**

**STATE LICENSE NUMBER: 89LC8701**

**SURVEY EXIT DATE: 06/12/2017**

**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**

Handwritten signature of Nancy J. Lescavage in black ink.

*Nancy J. Lescavage*  
*Deputy Secretary for Quality Assurance*

Handwritten signature of Rachel L. Levine, MD in black ink.

*Rachel L. Levine, MD*  
*Secretary of Health*



THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY