STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	8-0908	A. BLDG: 00 B. WING:	06/08/2012

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PLANNED PARENTHOOD KEYSTONE - WARMINSTER STATE LICENSE NUMBER: **00188701**	**610 LOUIS DRIVE SUITE 303 WARMINSTER, PA 18974**

(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 a special monitoring survey conducted on June 7 -8, 2012, at the Planned Parenthood Associates of Bucks County. It was determined that 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 0001		M 0001		

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:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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M 0001	Continued from page 1 29.33(1) Requirements for Abortion Each medical facility shall have readily available equipment and drugs necessary for resuscitation. If local anesthesia is utilized to perform an abortion in a medical facility during the first trimester, then the following equipment shall be ready to use for resuscitative purposes: (i) Suction Source (ii) Oxygen Source (iii) Assorted size oral airways and endotracheal tubes (iv) Laryngoscope (v) Bag and mask and bag and endotracheal tube attachments for assisted ventilation (vi) Intravenous fluids including blood volume expanders (vii) Intravenous catheters and cut-down instrument tray (viii) Emergency drugs for shock and metabolic imbalance (ix) An individual to monitor respiratory rate, blood pressure and heart rate. This REGULATION is not met as evidenced by:	M 0001	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - A new abortion skills privileging sign off sheet has been developed for all un-licensed staff at the facility(06/04/12) - Human Resource Manager will review all personnel records to ensure skills have been signed off by 07/21/12 - Staff will be trained and signed off by 07/21/12 - In the future, staff will not be permitted to work in the facility until their privileging forms have been signed	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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M 0001	Continued from page 2 Based on review of facility documents and interviews with staff (EMP), it was determined the facility failed to ensure non-licensed employees who monitored the patients' blood pressure had training and competencies for five of nine non-licensed personnel files (PF) reviewed (PF3, PF5, PF7, PF8, and PF9). Findings include: Review on June 8, 2012, of PF3, PF5, PF7, PF8, and PF9's job descriptions for medical care assistants revealed these employees were responsible to monitor patients' blood pressure as needed. Review on June 8, 2012, of PF3, PF5, PF7, PF8, and PF9 revealed no documentation that these non-licensed employees had training and competencies to monitor the patients' blood pressure. Interview with EMP3 on June 8, 2012, at approximately 1:30 PM confirmed there was no	M 0001		

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M 0001	Continued from page 3 documentation PF3, PF5, PF7, PF8, and PF9 had training and competencies to monitor the patients' blood pressure. EMP3 also confirmed PF3, PF5, PF7, PF8, and PF9's job descriptions required these non-licensed employees to monitor the patients' blood pressure as needed.	M 0001		

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S 0000	INITIAL COMMENT This report is the result of an unannounced on-site pre-licensure and occupancy survey completed on June 7 - 8, 2012, at Planned Parenthood Association of Bucks County. 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 and the current edition of the Guidelines for Design and Construction of Hospital and Health Care Facilities.	S 0000		
S 0110		S 0110		

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S 0110	Continued from page 1 551.21 (e)(1-3) Criteria for ambulatory surgery 551.21 Criteria for ambulatory surgery (e) In obtaining informed consent, the practitioner performing the surgery shall be responsible for disclosure of: (1) The risks, benefits and alternatives associated with the anesthesia which will be administered. (2) The risks, benefits and alternatives associated with the procedure which will be performed. (3) The comparative risks, benefits and alternatives associated with performing the procedure in the ambulatory surgical facility instead of in a hospital. This REGULATION is not met as evidenced by:	S 0110	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - Consent form (CIIC – In-Clinic Abortion – Suction- VII-A-2a) has been revised - Expect approval for form by 06/31/12 by Planned Parenthood national governing body - Revised form will be given out to staff on 07/02/12 with training provided by the Center Manager and a sign off sheet for all abortion staff will be back to HR by 07/09/12 - Audits (of a percentage) of abortion charts by Medical Services Administration will be performed on a monthly basis - Failure to adhere to this policy will result in re-training or disciplinary action by Medical Services	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 0110	Continued from page 2	S 0110	Administration.	

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S 0110	Continued from page 3 Based on review of medical records (MR) and staff interview (EMP), it was determined the facility failed to ensure practitioners documented informed consent that included the disclosure of the comparative risks, benefits, and alternatives associated with performing a procedure in the ambulatory surgery facility (ASF) instead of in a hospital for 20 of 20 medical records reviewed (MR1, MR2, MR3, MR4, MR5, MR6, MR7, MR8, MR9, MR10, MR11, MR12, MR13, MR14, MR15, MR16, MR17, MR18, MR19, and MR20). Findings include: Review on June 6, 2012, of MR1 - MR20 revealed the informed consent did not contain information regarding the physician's disclosure of the comparative risks, benefits, and alternatives associated with performing a procedure in the ambulatory surgery facility (ASF) instead of in a hospital. There was no documentation in MR1 - MR20 showing the comparative risks, benefits, and	S 0110		

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S 0110	Continued from page 4 alternatives associated with performing a procedure in the ambulatory surgery facility (ASF) instead of in a hospital were disclosed to the patient. Interview with EMP1 conducted on June 7, 2012, at approximately 2:30 PM confirmed the informed consent in MR1 - MR20 did not address the comparative risks, benefits, and alternatives associated with performing a procedure in the ambulatory surgery facility (ASF) instead of in a hospital were disclosed to the patient.	S 0110		
S 033A		S 033A		

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S 033A	Continued from page 5 553.3 (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	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - The patient safety plan will be reviewed with facility Center Managers on 07/06/12 - Center Mangers will discuss with their staff and all staff will have reviewed and signed off by 07/21/12	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 033A	Continued from page 6 Based on review of the facility's Patient Safety Plan, personnel files (PF), and interview with staff (EMP), it was determined the facility failed to conform to all applicable State laws. Planned Parenthood Association of Bucks was not in compliance with the following State law: The Medical Care Availability and Reduction of Error Act, 40 P.S. § 1303.101 et seq. § 1303.307 Patient Safety Plans. (d) Employee Notification. Upon approval of the patient safety plan, a medical facility shall notify all health care workers of the medical facility of the patient safety plan. Compliance with the patient safety plan shall be required as a condition of employment or credentialing at the medical facility. This is not met as evidenced by: Based on a review of the facility's Patient Safety Plan, personnel files (PF), and interview with staff (EMP), it was determined the facility failed to ensure all health care workers of the medical facility were	S 033A		

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S 033A	Continued from page 7 notified of the Patient Safety Plan in five of 10 personnel files reviewed (PF3, PF4, PF5, PF9, and PF10). Findings include: Review on June 7, 2012, of the facility's "Patient Safety Plan," no date, revealed the facility "shall provide information, initial training, and on-going education and training to its health care workers about compliance-including reporting requirements-with the agency's Patient Safety Plan upon submission of its plan to the Department." Review on June 7, 2012, of PF3, PF4, PF5, PF9, and PF10, revealed no documentation that in-service training was provided to inform these healthcare workers of the facility's patient safety plan. Interview with EMP3 on June 7, 2012, at approximately 1:30 PM, confirmed there was no documentation in PF3, PF4, PF5, PF9, and PF10	S 033A		

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S 033A	Continued from page 8 that the employees were provided in-service training informing them of the facility's patient safety plan.	S 033A		
S 033H		S 033H		

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S 033H	Continued from page 9 553.3 (8) Governing Body Responsibilities 553.3 Governing Body responsibilities include: (8) Establishing personnel policies and practices which adequately support sound patient care to include, the following: This REGULATION is not met as evidenced by:	S 033H	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - PPABC –Warminster will ensure that its Employee Handbook contains the requirement that PPABC – Warminster identify employees with "significant likelihood of regular contact with children"; assure that all required background checks are completed, reviewed and documented in employee personnel files; retain a copy of each of the background clearances and notate that the original documents have been reviewed; assure that, until all background information has been received and reviewed, persons may be employed on provisional status;	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 033H	Continued from page 10	S 033H	assure that the provisional employee must work in the immediate presence of a regular employee and not work alone with children; assure that if the information that is obtained that the provisional employee is disqualified from employment, the individual must be immediately dismissed; and assure that an individual may be provisionally employed for a maximum of 90 days for out of state residents and 30 days for Pennsylvania residents.	

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S 033H	Continued from page 11 Based on review of the Child Protective Services Law, facility documents, personnel files (PF) and interview with staff (EMP), it was determined the facility failed to ensure a process was in place to meet the requirements for background checks as required by Act 179 of 2006 and Act 73 of 2007. Findings include: The Child Protective Services Law (CPSL), 23 Pa.C.S. § 6344.2 requires that employees hired after July 1, 2008, who have a significant likelihood of regular contact with children in the form of care, guidance, supervision or training must obtain three background checks as condition of employment: Pennsylvania State Police Clearance, Department of Public Welfare (DPW) Childline Clearance and Federal (FBI) Criminal Background Check. Review on June 7, 2012, of the facility's policy and procedure manual revealed no documentation the facility developed a policy to ensure employees hired after July 1, 2008, who had a significant	S 033H		

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S 033H	Continued from page 12 likelihood of regular contact with children in the form of care, guidance, supervision or training must obtain three background checks as condition of employment: Pennsylvania State Police (PSP) Clearance, Department of Public Welfare (DPW) Childline Clearance and Federal (FBI) Criminal Background Check. Interview with EMP3 on June 7, 2012, at approximately 2:00 PM confirmed the facility performed surgery on pediatric patients. Further interview with EMP3 confirmed there were no policies and procedures in place that required the three background checks for CPSL.	S 033H		
S 033I		S 033I		

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S 033I	Continued from page 13 553.3 (8)(i) Governing Body Responsibilities 553.3 Governing Body responsibilities include: (8) Establishing personnel policies and practices which adequately support sound patient care to include, the following: (i) Require the employment of personnel with qualifications commensurate with a job's responsibilities and authority, including appropriate licensure and certification. This REGULATION is not met as evidenced by:	S 033I	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - PPABC –Warminster will ensure that its Employee Handbook contains the requirement that PPABC – Warminster identify employees with "significant likelihood of regular contact with children"; assure that all required background checks are completed, reviewed and documented in employee personnel files; retain a copy of each of the background clearances and notate that the original documents have been reviewed; assure that, until all background information has been received and reviewed, persons may be employed on provisional status;	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	8-0908	A. BLDG: 00 B. WING:	06/08/2012

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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S 033I	Continued from page 14	S 033I	assure that the provisional employee must work in the immediate presence of a regular employee and not work alone with children; assure that if the information that is obtained that the provisional employee is disqualified from employment, the individual must be immediately dismissed; and assure that an individual may be provisionally employed for a maximum of 90 days for out of state residents and 30 days for Pennsylvania residents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	8-0908	A. BLDG: 00 B. WING:	06/08/2012

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S 033I	Continued from page 15 Based on a review of facility documents and staff interview (EMP), it was determined the facility failed to include all the required components of the Child Protective Services Law in facility policy as referenced in the Department of Public Welfare Bulletin 3490-08-03 of June 28, 2008, and the Child Protective Services Law (CPSL), 23 Pa.C.S. § 6344.2. Findings include: The Child Protective Services Law (CPSL), 23 Pa.C.S. § 6344.2 requires that employees hired after July 1, 2008 who have a significant likelihood of regular contact with children in the form of care, guidance, supervision or training must obtain three background checks as condition of employment: Pennsylvania State police Clearance, Department of Public Welfare (DPW) Childline Clearance and Federal (FBI) Criminal Background Check. ... The requirements apply to all persons employed after July 1, 2008. Those individuals employed prior to July 1, 2008 who fall into the classification of having	S 033I		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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S 033I	Continued from page 16 significant likelihood of regular contact with children in the form of care, guidance, supervision or training do not have to undergo the background checks. Those individuals employed prior to July 1, 2008 who were not working in a position with significant likelihood of regular contact with children in the form of care, guidance, supervision or training, but who subsequently transfer to a job that falls within classification, must undergo the background checks at the time of job transfer. Those individual employed after July 1, 2008 who do not fall within this classification at the date of hire but who subsequently transfer to a job that falls within this classification, must undergo the background checks at the time of job transfer. Employees who have undergone the background check and transfer to another job in the same facility do not need to undergo the background check again. Employees who leave one facility and commence employment at another facility must undergo the background checks, unless the previous background checks were completed within the past year. ... To assure compliance with the requirements of the Law,	S 033I		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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S 033I	Continued from page 17 facilities must: review employment policies and procedures to provide for identification of employees with 'significant likelihood of regular contact with children'. Assure that all required background checks are completed, reviewed and documented in employee personnel files. Retain a copy of each of the background clearances and notate that the original documents have been reviewed. ... until all background information has been received and reviewed ... persons may be employed on provisional status ... The provisional employee must work in the immediate presence of a regular employee and not work alone with children ... if the information that is obtained revealed that the provisional employee is disqualified from employment, the individual must be immediately dismissed and an individual may be provisionally employed for a maximum of 90 days for out of state residents and 30 days for Pennsylvania residents. ..." Review on June 1, 2012, of the facility's "Employee Handbook," last Board approved revisions-June	S 033I		

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PLANNED PARENTHOOD KEYSTONE - WARMINSTER STATE LICENSE NUMBER: **00188701**	**610 LOUIS DRIVE SUITE 303 WARMINSTER, PA 18974**

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S 033I	Continued from page 18 2009, revealed "Section 3: Employment and Staffing, 3.4 Background Checks- [They] recognizes the importance of maintaining a safe workplace with employees who are honest, trustworthy, qualified, reliable, nonviolent, and who do not present a risk of harm to their co-workers or others ... [They] complies with all applicable federal and state laws pertaining to background checks, including providing the job applicant or employee with the required notices and forms." Review on June 7, 2012, of the facility's "Child Abuse Policy for Staff," last updated June 1, 2009, revealed no documentation the facility included the requirement of reviewing employment policies and procedures to provide for identification of employees with significant likelihood of regular contact with children; assuring that all required background checks are completed, reviewed and documented in employee personnel files; that the original documents were reviewed; that until all background information was received and reviewed persons may be employed on provisional status; that	S 033I		

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S 033I	Continued from page 19 the provisional employee must work in the immediate presence of a regular employee and not work alone with children; if the information that was obtained revealed that the provisional employee was disqualified from employment, the individual must be immediately dismissed; and that an individual may be provisionally employed for a maximum of 90 days for out of state residents and 30 days for Pennsylvania residents. Interview with EMP2 and EMP3 on June 7, 2012, at approximately 2:30 PM confirmed the facility's Child Abuse Policy did not include the required information and this policy did not meet the criteria of the Child Protective Services Law as referenced in the Department of Public Welfare Bulletin 3490-08-03 of June 28, 2008.	S 033I		
S 033N		S 033N		

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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PLANNED PARENTHOOD KEYSTONE - WARMINSTER STATE LICENSE NUMBER: **00188701**	**610 LOUIS DRIVE SUITE 303 WARMINSTER, PA 18974**

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S 033N	Continued from page 20 553.3 (8)(vi) Governing Body Responsibilities 553.3 Governing Body responsibilities include: (8) Establishing personnel policies and practices which adequately support sound patient care to include, the following: (vi) Compliance with federal and State regulations including, The Americans with Disabilities Act of 1990 (42 U.S.C.A. 12101-12213), civil rights and OSHA regulations. This REGULATION is not met as evidenced by:	S 033N	As per our letter to the Department of Health dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - The CDC guideline cited here clearly states that a TB testing program is not required. CPL O2-00-106(H)(1). - Furthermore, if OSHA was the basis for a TB skin test requirement, the auditor would have mentioned it previously because PPABC has been under OSHA authority since its inception and the OSHA TB program has been in place since at least 1996. Id. - Even if the CDC guideline at issue required TB testing, Section 553.3(8)(vi) does not appear to apply CDC guidelines to PPABC-Warminster	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/29/2012**

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 033N	Continued from page 21 Based on review of the Centers for Disease Control and Prevention's Guidelines and interview with staff (EMP), it was determined the facility failed to adopt written policies and procedures for preventing the transmission of tuberculosis. Findings include: Review on June 8, 2012, of the Centers for Disease Control and Prevention's "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005," revealed TB [tuberculosis] Screening Procedures for Settings (or HCWs [health care workers]) Classified as Low Risk All HCWs should receive baseline TB screening upon hire, using two-step TST [tuberculin skin test] or a single BAMT [Blood Assay for Mycobacterium Tuberculosis] to test for infection with *M. tuberculosis*. ... " A request was made to EMP3, on June 8, 2012, for the facility's policy regarding tuberculosis testing. No policy was provided.	S 033N		

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S 033N	Continued from page 22 Interview with EMP3, on June 8, 2012, at approximately 1:45 PM, confirmed the facility did not have a policy and procedure regarding staff health status requirements for the tuberculosis skin testing.	S 033N		
S 033V	553.3 (16) Govern Body Responsibilities 553.3 Governing Body responsibilities include: (16) Assuring that at least one medical professional in the facility when patients are present is currently and on an ongoing basis certified in advanced cardiac life support, or its successor. If a pediatric patient is present in the facility, the certification of the medical professional shall be in advanced pediatric life support as defined in section 551.22 (A)(4). This REGULATION is not met as evidenced by:	S 033V	- The emergency policy will be amended to include pediatric emergency drugs before 07/21/12 - A staff training on using pediatric drugs will be given before 08/17/12 - All staff will sign off on the training and documentation will be placed in their personnel file	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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 033V	Continued from page 23 Based on observation and staff interview (EMP), it was determined the facility failed to ensure guidance for correct dosing and administration of emergency medications for the pediatric patient requiring emergency treatment at the facility. Findings include: Observation on June 7, 2012, of the facility's emergency drug carts located in the surgical procedure rooms three and four revealed medication dosage documentation dedicated to the adult patient. Further observation revealed no documentation of guidance for correct dosing and administration of emergency medications for the pediatric patient requiring emergency treatment at the facility. Interview with EMP2 and EMP4 on June 7, 2012, confirmed the facility's emergency drug cart was dedicated to the adult patient who may require emergency care. Further interview with EMP4 confirmed the facility performs surgical procedures	S 033V		

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S 033V	Continued from page 24 on pediatric patients. EMP4 confirmed there was no guidance for correct dosing and administration of emergency medications for the pediatric patient requiring emergency treatment at the facility.	S 033V		
S 552A	555.22 (a)(1-2) Surgical Services - Preoperative Care 555.22 Pre-operative Care (a) Pertinent medical histories and physical examinations, and supplemental information regarding drug sensitivities documented day of surgery or one of the following: (1) If medical evaluation, examination and referral are made from a private practitioner's office, hospital or clinic, pertinent records thereof shall be available and made part of the clinical record at the time the patient is registered and admitted tot he ASF. This information is considered valid no more than 30 days prior to the date of surgery. (2) A practitioner shall examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed. The information shall be clearly documented in the medical record. This REGULATION is not met as evidenced by:	S 552A	- The RQM Coordinator will change the form "Surgical and Medication Abortion Operative Notes" by adding a physical status classification on 08/10/2012 - Monthly audits of the charts by various staff will ensure compliance - Chart review findings are discussed at the RQM committee meetings and forwarded to the Governing Body by the VP Medical Services	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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 552A	Continued from page 25	S 552A		

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S 552A	Continued from page 26 Based on review of medical records (MR) and staff interview (EMP), it was determined the facility failed to ensure each patient was evaluated and assigned a physical status classification for 20 of 20 medical records reviewed (MR1, MR2, MR3, MR4, MR5, MR6, MR7, MR8, MR9, MR10, MR11, MR12, MR13, MR14, MR15, MR16, MR17, MR18, MR19, and MR20). Findings include: Review on June 7, 2012, of the facility's policy and procedure manual revealed no policy requiring the practitioner to evaluate and assign a physical status (PS) classification [the evaluation of the patient's overall health as it would influence the conduct and outcome of the anesthesia or surgery, or both]. Review on June 7, 2012, of MR1 - MR20 revealed no documentation the practitioner evaluated, determined or documented a PS classification prior to surgery for MR1 - MR20 receiving local anesthesia.	S 552A		

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 552A	Continued from page 27 Interview with EMP1 on June 7, 2012, at approximately 3:00 PM confirmed the practitioner did not evaluate, determine, or documented a PS classification prior to surgery for MR1 - MR20 receiving local anesthesia. Further interview with EMP1 revealed the facility did not require the practitioner to evaluate, determine, or document a PS classification prior to surgery.	S 552A		
S 552B		S 552B		

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 552B	Continued from page 28 555.22 (b) Surgical Services - Preoperative Care 555.22 Pre-operative Care (b) A written statement indicating informed consent, obtained by the practitioner, and signed by the patient, or responsible person, for the performance of the specific procedures shall be procured and made part of patient's clinical record. It shall contain a statement which evidences the appropriateness of the proposed surgery, as well as any alternative treatments discussed with the patient. It shall also identify any practitioner who shall participate in the surgery. This REGULATION is not met as evidenced by:	S 552B	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - The CIIC for in-clinic abortion has been changed by the RQM Coordinator to add documentation that the physician obtains informed consent. - Monthly audits of the charts by various staff will ensure compliance - Chart review findings are discussed at the RQM committee meetings and forwarded to the Governing Body by the VP Medical Services	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 552B	Continued from page 29 Based on review of medical records (MR) and staff interview (EMP), it was determined the facility failed to ensure the informed consent was obtained by the practitioner and signed by the patient or responsible party for the performance of a specific procedure for 20 of 20 medical records reviewed (MR1, MR2, MR3, MR4, MR5, MR6, MR7, MR8, MR9, MR10, MR11, MR12, MR13, MR14, MR15, MR16, MR17, MR18, MR19, and MR20). Findings include: Review on June 7, 2012, of MR1 - MR20 revealed no documentation the informed consent was obtained by the practitioner and signed by the patient or responsible party for the performance of a specific surgical procedure. Interview with EMP1 on June 7, 2012, at approximately 2:00 PM confirmed the informed consent was not obtained by the practitioner and signed by the patient or responsible party for the performance of a specific procedure for MR1 -	S 552B		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	8-0908	A. BLDG: 00 B. WING:	06/08/2012

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PLANNED PARENTHOOD KEYSTONE - WARMINSTER STATE LICENSE NUMBER: **00188701**	**610 LOUIS DRIVE SUITE 303 WARMINSTER, PA 18974**

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S 552B	Continued from page 30 MR20. Further interview with EMP1 confirmed the facility's non-licensed staff obtained the consent for the performance of the specific surgical procedure.	S 552B		
S 552C		S 552C		

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 552C	Continued from page 31 555.22 (c)(1-5) Surgical Services - Preoperative Care 555.22 Pre-operative Care (c) Written instruction for preoperative procedures, which have been approved by the medical staff, shall be given to the patient or responsible person, and shall include: (1) Applicable restrictions upon food and drink before surgery (2) Special preparations to be made by the patient (3) The required proximity of the patient to the ASF for a specific time following surgery if applicable. (4) An understanding that the patient may require admission to the hospital in the event of medical need. (5) The requirement that, upon discharge of a patient who has received sedation or general anesthesia, a responsible person shall be available to escort patient home. With respect to patients who receive local or regional anesthesia, a medical decision shall be made regarding whether such patients require a responsible person to escort them home. This REGULATION is not met as evidenced by:	S 552C	As per our letter to the Department of Health dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - The survey appears to be mistaken - Preoperative written instructions are given to each surgical abortion patient at the state mandated information session (24 hour) on the following forms: -1-R & C/AB -5-AB/INS 8 -19-CIIC/AB * The Center Manager will ensure that a copy of these forms are put into the facility ASF notebook by 07/01/12	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/29/2012**

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 552C	Continued from page 32 Based on review of medical records (MR) and interview with staff (EMP), it was determined the facility failed to ensure the written instructions for preoperative procedures included an understanding the patient may require admission to the hospital in the event of medical need in 20 of 20 medical records reviewed (MR1, MR2, MR3, MR4, MR5, MR6, MR7, MR8, MR9, MR10, MR11, MR12, MR13, MR14, MR15, MR16, MR17, MR18, MR19 and MR20). Findings include: Review on June 8 and 9, 2012, of MR1-MR20 revealed these patients had procedures between January 27, 2012, and June 1, 2012. Further review of MR1-MR20's "Preoperative Instructions," no dates, revealed the instructions did not include an understanding the patients may require admission to the hospital in the event of medical need. Interview with EMP2 on June 9, 2012, at approximately 11:30 AM, confirmed the written	S 552C		

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S 552C	Continued from page 33 instructions for preoperative procedures in MR1-MR20 did not include an understanding the patients may require admission to the hospital in the event of medical need.	S 552C		
S 554A		S 554A		

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 554A	Continued from page 34 555.24 (a) Surgical Services - Postoperative Care 555.24 Postoperative Care (a) The findings and techniques of an operation shall be accurately and completely written or dictated immediately after procedure by the practitioner medical staff member who performed the operation. If a physician assistant or certified registered nurse practitioner performed part of the operation, the findings and techniques of the procedure shall be accurately and completely recorded and the report shall be countersigned by the medical staff member. This description shall become a part of the patient's medical record. This REGULATION is not met as evidenced by:	S 554A	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - The Surgical and Medication Abortion Operative Notes form has a several places to write post operative reports on various components of the procedure –e.g. # cc of lidocain, cervix dilated to #, # mm cannula used, post evacuation curettage done, estimated blood loss, other medications administered - Monthly audits of the charts by various staff will ensure compliance with this form - Chart review findings are discussed at the RQM committee meetings and forwarded to the Governing Body by the VP Medical Services	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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 554A	Continued from page 35	S 554A	- Failure to follow this policy will result in re-training and/or disciplinary action by Medical Services Administration	

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S 554A	Continued from page 36 Based on review of medical records (MR) and staff interview (EMP), it was determined the facility failed to ensure the post operative surgical reports were written or dictated immediately after the procedure by the operating practitioner for 20 of 20 medical records reviewed (MR1, MR2, MR3, MR4, MR5, MR6, MR7, MR8, MR9, MR10, MR11, MR12, MR13, MR14, MR15, MR16, MR17, MR18, MR19, and MR20). Findings include: Review on June 7, 2012, of MR1 - MR20 revealed no documentation the operating practitioner completed a written or dictated post operative surgical report immediately after the surgical procedure for MR1 - MR20. Interview with EMP1 on June 7, 2012, at approximately 2:30PM confirmed the operating practitioner did not complete a written or dictated post operative surgical report immediately after completing the surgical procedure for MR1 -	S 554A		

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S 554A	Continued from page 37 MR20.	S 554A		
S 5910		S 5910		

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S 5910	Continued from page 38 559.1 Nursing Department CHAPTER 559 - NURSING SERVICES 559.1 Nursing Department The ASF shall have an organized nursing department under the supervision of a registered nurse who has responsibility and accountability for the Nursing Service. This REGULATION is not met as evidenced by:	S 5910	As per our letter to the Department of Health dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - PPABC-Warminster requested an exception from this requirement -559.1 -to permit the organized nursing department to be under the supervision of the Medical Director - By letter from Joanne Salsgiver dated April 19, 2012, the Department granted this exception - The Human Resource department will ensure that the facilities organizational chart will be updated to indicate that the Medical Director is the Director of Nursing by 07/01/12	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/29/2012**

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S 5910	Continued from page 39 Based on review of facility documents and staff interview (EMP), it was determined the facility failed to have a Director of Nursing who was responsible and accountable to the person in charge of the facility. Findings include: Review on June 8, 2012, of the facility's organizational chart revealed no position for a Director of Nursing (DON). Interview with EMP5 on June 8, 2012, confirmed the facility did not have a position for a DON. EMP5 confirmed there was no registered nurse responsible and accountable for the Nursing Service.	S 5910		
S 6142		S 6142		

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S 6142	Continued from page 40 561.25 Distressed drugs, devices and cosmetics 561.25 Distressed drugs, devices and cosmetics Drugs, devices and cosmetics which are outdated, visibly deteriorated, unlabeled or inadequately labeled, recalled, discontinued or obsolete shall be identified by the licensed pharmacist or responsible practitioner and shall be disposed of in compliance with applicable Commonwealth and Federal regulations. This REGULATION is not met as evidenced by:	S 6142	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - All opened medications and chemicals have been labeled with an "opened" date - A pharmacy policy including procedures for opening, labeling, discarding and shelf life of medications and biologicals will be developed by Medical Services Administration. - This will be reviewed with facility Center Managers on 07/06/12 - Center Mangers will discuss with their staff and all staff will have reviewed and signed off by 07/14/12	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 6142	Continued from page 41 Based on review of facility documents, observation and staff interview (EMP), it was determined the facility failed to dispose of outdated medications. Findings include: Review on June 7, 2012, of the facility's "Prescription Drug Disposal Policy," last reviewed August 2011, revealed "Policy: To dispose of prescription drugs that are expired ..." Review of the facility's "Prescription Drug Disposal Policy" revealed no documentation regarding the expiration and disposal of a medication after opening. Further review revealed no manufactures recommendations regarding the disposal of medications after opening. 1) Observation on June 7, 2012, of surgical procedure room 3 revealed a 50 millimeter vial of Lidocaine 1% (a local anesthetic) 10 milligram (mg) / millimeter (ml) dated April 24, 2012, and a 1 ml vial of Vasopressin (a medication used to control	S 6142		

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S 6142	Continued from page 42 bleeding) 20 mg/ml containing a date of April 24, 2012. Interview with EMP4 on June 7, 2012, at approximately 9:00 AM confirmed the date of April 24, 2012, on the vials of Lidocaine and Vasopressin. EMP4 confirmed these medications were considered outdated. 2) Observation on June 7, 2012, of examination room 1 revealed a 50 millimeter vial of Lidocaine 1% (a local anesthetic) 10 milligram (mg) / millimeter (ml) dated May 4, 2012. Interview with EMP1 on June 7, 2012, at approximately 9:25 AM, confirmed the date of May 4, 2012, on the Lidocaine 1%. EMP1 confirmed the Lidocaine was considered outdated. 3) Observation on June 7, 2012, of the facility's laboratory revealed 280 ml of 0.9% Sodium Chloride containing a date of April 4, 2012.	S 6142		

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S 6142	Continued from page 43 Interview with EMP4 on June 7, 2012, at approximately 9:15 AM confirmed the date of April 4, 2012, on the Sodium Chloride. EMP4 confirmed the sodium chloride was considered outdated. Interview with EMP1, EMP2 and EMP4 on June 7, 2012, at approximately 9:30 AM confirmed the facility's "Prescription Drug Disposal Policy" did not contain documentation regarding the expiration and disposal of a medication after opening or manufactures recommendations regarding the disposal of medications after opening.	S 6142		
S 6412		S 6412		

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S 6412	Continued from page 44 563.12 (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	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - The RQM Coordinator has changed the form "Recovery Room Record" by adding a post-op diagnosis to the discharge form - Monthly audits of the charts by various staff will ensure compliance - Chart review findings are discussed at the RQM committee meetings and forwarded to the Governing Body by the VP Medical Services	Completion Date: **07/12/2012** Status: **APPROVED** Date: **06/26/2012**

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S 6412	Continued from page 45 Based on review of facility documents, medical records (MR), and staff interview (EMP), it was determined the facility failed to ensure each medical record included a discharge summary with a discharge diagnosis for 20 of 20 medical records reviewed (MR1, MR2, MR3, MR4, MR5, MR6, MR7, MR8, MR9, MR10, MR11, MR12, MR13, MR14, MR15, MR16, MR17, MR18, MR19, and MR20). Findings include: Review on June 7, 2012, of MR1 - MR20 revealed no documentation of a discharge summary including a discharge diagnosis. Interview with EMP1 on June 8, 2012, at approximately 1:45 PM confirmed there was no discharge summary including discharge diagnosis for MR1 - MR20.	S 6412		

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S 6701	567.1 Principle CHAPTER 567 - ENVIRONMENTAL SERVICES 567.1 Principle The ASF shall have a sanitary environment, properly constructed, equipped and maintained to protect surgical patients and ASF personnel from cross-infection and to protect the health and safety of patients. This REGULATION is not met as evidenced by:	S 6701	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - The Infection Control policy will be updated to ensure that it contains instructions for storage of sterile patient supplies - This will be reviewed with the Center Managers on 7/12/12 - Staff will be informed and sign off on the policy by 07/21/12 - Failure to comply to with this policy will result in re-training and/or disciplinary action by Medical Services Administration	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 6701	Continued from page 47 Based on observation and staff interview (EMP), it was determined the facility failed to provide a functional and sanitary environment for the provision of surgical supplies. Findings include: Observation on June 7, 2012, of the facility's soiled workroom revealed the presence of approximately 15 sterile packages stored in the wall mounted cabinet directly above the facility's autoclave. Interview conducted on June 7, 2012, at 11:30 AM with EMP1 and EMP2 confirmed the presence of approximately 15 sterile packages stored in a wall mounted cabinet above the autoclave machine. EMP1 and EMP2 confirmed the sterile packages contained surgical instruments used by the practitioner to perform sterile surgical procedures. EMP2 confirmed the facility did not have a policy that addressed the storage of sterile patient supplies.	S 6701		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	8-0908	A. BLDG: 00 B. WING:	06/08/2012

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S 6737	567.23 Clean Linen 567.23 Clean Linen Clean linen shall be available to meet the daily and emergency needs of the ASF. Clean linen shall be handled and stored to minimize contamination from surface contact or airborne deposits. This REGULATION is not met as evidenced by:	S 6737	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - Medical Services Administration is in the process of asking for bids for a company to provide us with professionally laundered scrubs and blankets thus eliminating the need for using the washer & dryer - Company informs us that there is 6 week "turn on" date from date of contract - Soiled linens will be kept in a clearly marked basket while clean linens will be stored in a separate cabinet or cupboard by 07/21/12 - All drape sheets and chuck pads have been placed in cabinets away from any chance of " fluid splatter"	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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 6737	Continued from page 49 Based on observation and staff interview (EMP), it was determined the facility failed to store clean scrubs in a manner to minimize contamination from surface contact. Findings include: Observation on June 7, 2012, of the facility's staff locker room revealed a stackable washer and dryer. Further observation revealed approximately four stacks of staff scrubs on a shelving unit next to the stackable washer and dryer. Interview with EMP2 on June 7, 2012, at approximately 9:05 AM confirmed the presence of the stackable washer and dryer in the staff locker room and the clean scrubs stored on the shelving unit alongside the washer. Further interview with EMP2 revealed the facility staff does not have a separate clean linen area for the storage of clean linens and a soiled linen area for the storage of soiled linens.	S 6737		

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S 6737	Continued from page 50	S 6737		
S 6738		S 6738		

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 6738	Continued from page 51 567.24 Soiled Linen 567.24 Soiled Linen Soiled linen shall be collected and stored to avoid microbial dissemination into the environment. Soiled linen shall be kept segregated from clean linen. Soiled linen from isolation areas shall be identified and separately bagged. Precautions shall be taken in the subsequent processing of soiled linen from isolation areas to prevent microbial dissemination and infection. This REGULATION is not met as evidenced by:	S 6738	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - Medical Services Administration is in the process of asking for bids for a company to provide us with professionally laundered scrubs and blankets thus eliminating the need for using the washer & dryer - Company informs us that there is 6 week "turn on" date from date of contract - Soiled linens will be kept in a clearly marked basket while clean linens will be stored in a separate cabinet or cupboard by 07/21/12 - All drape sheets and chuck pads have been placed in cabinets away from any chance of contamination	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 6738	Continued from page 52 Based on observation and staff interview (EMP), it was determined the facility failed to store soiled linen separate from the clean linen and failed to ensure soiled linen was washed at a temperature to prevent microbial dissemination. Findings include: 1) Observation on June 7, 2012, of the facility's staff locker room revealed a stackable washer and dryer. Further observation revealed approximately four stacks of staff scrubs on a shelving unit next to the stackable washer and dryer and a container labeled soiled linen alongside the shelving unit. Interview with EMP2 on May 31, 2012, at approximately 9:10 AM confirmed facility staff bring the soiled linens from the procedure rooms to the staff bathroom, separate the soiled linens and scrubs, and place the soiled linens and scrubs in the washer. Further interview confirmed the clean linen and scrubs were stored in the staff locker room with the soiled linen and scrubs.	S 6738		

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S 6738	Continued from page 53 2) Observation on June 7, 2012, revealed a sign posted on the front of the facility dryer instructing staff that soiled clothing and soiled items were to be washed in hot water at 160 degrees Fahrenheit. Further observation revealed no thermometer or documentation the facility was washing soiled linens and scrubs at 160 degrees Fahrenheit. Interview with EMP2 on June 7, 2012, at approximately 9:15 AM confirmed the sign posted on the front of the facility dryer instructed staff to wash soiled clothing and soiled items in at 160 degrees Fahrenheit. Further interview with EMP2 confirmed there was no thermometer or documentation the facility was washing soiled linens and scrubs at 160 degrees Fahrenheit.	S 6738		
S 6745		S 6745		

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S 6745	Continued from page 54 567.42 (a) Policies and Procedures 567.42 Policies and procedures (a) A schedule of preventive maintenance shall be developed for the physical plant, biomedical and all other equipment. This REGULATION is not met as evidenced by:	S 6745	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - The Risk and Quality Management Coordinator and the person who manages facilities will develop a policy regarding preventive maintenance for the physical plant, biomedical and all other equipment by 07/21/12 - The person who manages facilities will present the policy to the Center Managers by 09/09/12 - All staff will review the policy and sign off by 09/17/12 - The RQM Coordinator will include the schedule in the Risk and Quality Management work plan	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 6745	Continued from page 55 Based on review of policies and procedures and interview with staff (EMP), it was determined the facility failed to ensure written procedures were developed for a schedule of preventive maintenance for the physical plant, biomedical, and other equipment. Findings include: On June 8, 2012, the surveyor requested the facility's written preventative maintenance policies and procedures. None were provided. Interview with EMP2, on June 8, 2012, at approximately 1:15 PM, confirmed the facility did not have written preventative maintenance policies and procedures.	S 6745		
S 6746		S 6746		

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S 6746	Continued from page 56 567.42 (b) Policies and Procedures 567.42 Policies and procedures (b) Written procedures shall be readily available for employes to follow in the event of a breakdown in equipment, mechanical systems or utilities. This REGULATION is not met as evidenced by:	S 6746	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - The Risk and Quality Management Coordinator and the person who manages facilities will develop a policy regarding breakdowns of equipment, mechanical systems or utilities 07/21/12 - The person who manages facilities will present the policy to the Center Managers by 09/09/12 - All staff will review the policy and sign off by 09/17/12 - The RQM Coordinator will include the schedule in the Risk and Quality Management work plan	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 6746	Continued from page 57 Based on review of policies and procedures and interview with staff (EMP), it was determined the facility failed to ensure written procedures were readily available for employees to follow in the event of a breakdown in equipment, mechanical systems or utilities. Findings include: On June 8, 2012, the surveyor requested the facility's written procedures for employees to follow in the event of a breakdown in equipment, mechanical systems or utilities. None were provided. Interview with EMP2 on June 8, 2012, at approximately 1:15 PM, confirmed the facility did not have written procedures for the employees to follow in the event of a breakdown in equipment, mechanical systems or utilities.	S 6746		

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S 6747		S 6747		

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S 6747	Continued from page 59 567.43 Ventilation System The ventilation system shall be inspected and maintained in accordance with the written maintenance schedule to ensure that a properly conditioned air supply meeting minimum filtration, humidity and temperature requirements is provided in critical areas such as the surgical and recovery suites under Chapter 571 (relating to construction standards). This REGULATION is not met as evidenced by:	S 6747	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - Temperature & humidity monitors for procedure rooms and recovery room will be purchased by our purchasing department by 06/29/12 - A policy will be developed by Medical Services Administration/RQM regarding the monitoring of temperature and humidity levels in the procedures rooms and recovery room. - Center Managers and staff will be trained by Training Manager/Medical Services administration on how to use this monitor by 0713/12 - A log will be developed by the RQM coordinator to document temperature and humidity levels	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 6747	Continued from page 60	S 6747	- The use of the log will be part of the training - Regular audits will be done by Medical Service administration to ensure policy is being followed and temperature and humidity are noted	

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 6747	Continued from page 61 Based on observation and staff interviews (EMP), it was determined the facility failed to monitor temperature and humidity in two of two rooms used by the facility to perform surgical procedures and the recovery area. Findings include: The survey team requested the temperature and humidity documentation for surgical procedure rooms three and four where the facility to performed procedures and the recovery area. Interview with EMP1 on June 7, 2012, at approximately 3:30 PM confirmed the facility did not monitor or maintain a record of the temperature and humidity levels in surgical procedure rooms three and four or the recovery room in order to ensure these areas were meeting proper temperature and humidity levels.	S 6747		

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S 6907	569.14 Internal Disaster and Fire Plans 569.14 Internal Disaster and Fire Plans The ASF shall have an internal disaster and fire plan incorporating evacuation procedures and the safety of both closed records and the records of those patients being evacuated. These plans shall be made available to personnel and evacuation diagrams shall be posted throughout the ASF. This REGULATION is not met as evidenced by:	S 6907	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - The evacuation plan for charts will be added to the fire and safety plan by 07/21/12 - PPABC-Warminster will be switching to an electronic health records system in January 2013	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 6907	Continued from page 63 Based on review of facility documents and staff interview (EMP), it was determined the facility failed to ensure the facility's internal disaster and fire plan incorporated evacuation procedures and the safety of both closed medical records and the records of those patients being evacuated. Findings include: Review on June 8, 2012, of the facility's internal disaster and fire safety plan revealed no documentation the facility incorporated evacuation procedures for the safety of both closed medical records and the records of those patients being evacuated. Interview with EMP2 on June 8, 2012, at approximately 2:15 PM confirmed the facility's internal disaster and fire safety plan did not contain documentation the facility incorporated evacuation procedures for the safety of both closed medical records and the records of those patients being evacuated.	S 6907		

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S 6907	Continued from page 64	S 6907		
S 6908	569.15 Safety Education Program 569.15 Safety Education Program Employes shall participate in the safety program and perform the duties delegated to them and be instructed in the operation of the fire warning system, the proper use of fire fighting equipment and the procedure to follow if electric power is impaired. This REGULATION is not met as evidenced by:	S 6908	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - A fire and safety training is scheduled for July 2 & 3 with an outside consultant - Staff will sign off on the training and it will be kept in their personnel file - Ongoing, this training will be added to the RQM work plan and provided on an annual basis	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	8-0908	A. BLDG: 00 B. WING:	06/08/2012

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PLANNED PARENTHOOD KEYSTONE - WARMINSTER STATE LICENSE NUMBER: **00188701**	**610 LOUIS DRIVE SUITE 303 WARMINSTER, PA 18974**

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S 6908	Continued from page 65 Based on review of facility documents, personnel files (PF), and interview with staff (EMP), it was determined the facility failed to ensure employees were instructed in the operation of the fire warning system, the proper use of firefighting equipment, and the procedure to follow if the electric power was impaired in five of ten personnel files reviewed (PF3, PF5, PF7, PF8, and PF9). Findings include: Review on June 8, 2012, of the facility policy "Fire Policies and Procedures," dated July 2010, revealed no provision to ensure employees were instructed in the operation of the fire warning system, the proper use of firefighting equipment, and the procedure to follow if the electric power was impaired. Review on June 8, 2012, of PF3, PF5, PF7, PF8, and PF9 revealed no documentation these employees were instructed in the operation of the fire warning system, the proper use of firefighting equipment, and the procedure to follow if the	S 6908		

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S 6908	Continued from page 66 electric power was impaired. Interview with EMP3, on June 8, 2012, at approximately 1:30 PM, confirmed there was no documentation in PF3, PF5, PF7, PF8, and PF9 that these employees were instructed in the operation of the fire warning system, the proper use of firefighting equipment, and the procedure to follow if the electric power was impaired.	S 6908		
S 6919		S 6919		

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S 6919	Continued from page 67 569.35 (1-7) General Safety Precautions 569.35 General Safety Precautions The following safety precautions shall be met: (1) Doorway, corridors and stairwells shall be properly lighted and free of obstructions. (2) Doors into patient rooms may not be locked. (3) Exit doors may not be locked from the inside while patients are in the ASF. (4) Doors opening to shafts shall be equipped with self-closing devices and positive latches. (5) Wastebaskets, cubicle curtains, window shades and drapes shall be rendered flame retardant. (6) Call bells in the shower, tub room or water closet shall be easily accessible to patients. (7) Only nonflammable agents may be present in a surgical suite. This REGULATION is not met as evidenced by:	S 6919	As per our letter to the Department of Health dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 24, 2012. The effective date for this regulation is June 19, 2012, and the survey took place on June 7 & 8, 2012. PPABC-Warminster has taken the following steps to ensure compliance. - Patients are not left alone after the procedure - Patients are occasionally left alone before the procedure and they will be instructed to use the phone in case of emergency - A sticker will be put on the phone saying "emergency – dial ####" - Toilet rooms in the recovery room will have call bells	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/29/2012**

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PLANNED PARENTHOOD KEYSTONE - WARMINSTER STATE LICENSE NUMBER: **00188701**	**610 LOUIS DRIVE SUITE 303 WARMINSTER, PA 18974**

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S 6919	Continued from page 68 Based on observation and staff interview (EMP), it was determined the facility failed to ensure call bells were installed in two of two operating rooms (used by the facility to perform surgical procedures) and in toilet rooms utilized by patients. Findings include: Observation on June 7, 2012, of the facility's operating room three and four and in toilet rooms utilized by patients revealed no call bells for patients to utilize to summon facility staff if help was required. Interview with EMP1 on June 7, 2012, at approximately 10:30 AM confirmed the facility's operating rooms three and four and in toilet rooms utilized by patients did not have call bells for patients to utilize to summon facility staff if help was required.	S 6919		

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STATE LICENSE NUMBER: **00188701**	

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S 7100		S 7100		

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S 7100	Continued from page 70 571.1 CHAPTER 571 - Construction Standards 571.1 Minimum Standards ASF construction shall be in accordance with the latest edition of the "Guidelines for Design and Construction of Hospital and Health Care Facilities," as published by the American Institute of Architects/Academy of Architecture for Health including those guidelines established for various outpatient facilities. In the alternative, a facility shall meet the construction guidelines for specified types of surgical procedures as listed in appendix A. Where renovation or replacement work is performed within an existing facility, all new work or additions shall comply with the requirements for new construction. This REGULATION is not met as evidenced by:	S 7100	As per our letter to Joanne Salsgiver dated June 11, 2012, our facility is seeking accreditation as a Class A ASF. Our accreditation survey is scheduled for July 17, 2012. We are optimistic that we will be able to obtain accreditation, but in the event that we are not successful, we will pursue licensure as a Class B ASF. To that end, if the Class A accreditation process concludes unsuccessfully, we will pursue the alternate plan of compliance submitted by the Planned Parenthood health centers seeking licensure as Class B ASF, adjusting the dates as appropriate. Accordingly, at that time and if necessary, PPABC- Warminster – will confer with its architect and Division of Safety and Inspection to identify feasible alterations to its health center and seek exceptions to the construction requirements of 28 PA. Code section 571.1 where necessary. PPABC-Warminster has taken the	Completion Date: **07/21/2012** Status: **APPROVED** Date: **06/26/2012**

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S 7100	Continued from page 71	S 7100	following steps to ensure compliance. - Toilet rooms will have breakaway door jambs - Temperature and humidity monitors will be installed in the wall cabinets where the wrapped sterile instruments are stored	

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S 7100	Continued from page 72 Based on review of the current edition of the Guidelines for Design and Construction of Hospital and Health Care Facilities, observation, and interview with staff (EMP), it was determined the facility failed to ensure it was in compliance with the current construction guidelines. Findings include: 1) Review of the current edition of the Guidelines for Design and Construction of Hospital and Health Care Facilities revealed "3.8-3.4.2.2 Cubicle curtains or other provisions for privacy during post-operative care shall be provided. Observation on June 7, 2012, of the patient recovery room area revealed seven patient recovery chairs for post-operative care. There were no cubicle curtains for privacy for the seven recovery chairs. Interview on June 7, 2012, with EMP1 confirmed the post-operative recovery room chairs did not	S 7100		

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S 7100	Continued from page 73 have cubicle curtains for privacy. 2) Review of the current edition of the Guidelines for Design and Construction of Hospital and Health Care Facilities revealed "3.8-5.1.2.1 Soiled workroom. This room shall be physically separated from all other areas of the facility. ... 3.8-5.1.2.2 Clean/assembly workroom. Clean and soiled work areas shall be physically separated ... (2) This workroom shall have a hand-washing station. (3) This room shall contain appropriate and sufficient workspace and equipment for terminal sterilizing of medical and surgical equipment and supplies." Observation of the facility on June 7, 2012, revealed the soiled work area and the clean work area were located together. Further observation of the area revealed the clean and soiled work areas were open to the hallway where patients and staff passed to access Operating Rooms 3 and 4. The hand washing sink in the soiled area was designated to use for the clean area.	S 7100		

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S 7100	Continued from page 74 Interview on June 7, 2012, with EMP1 confirmed the clean and soiled work areas shared the same space that was open to the hallway where patients and staff passed through. 3) Review of the current edition of the Guidelines for Design and Construction of Hospital and Health Care Facilities revealed "3.8-5.1.2.3 Storage for clean/sterile supplies (1) storage for packs, etc. shall include provisions for ventilation, humidity and temperature control. Observation on June 7, 2012, of the clean and soiled work area revealed wrapped sterile supplies stored directly above the autoclave. There were no temperature, humidity or ventilation monitors observed in this area where the sterile wrapped packages were stored. Interview on June 7, 2012, with EMP1 confirmed the sterile supplies were stored in the cabinet directly above the autoclave that was located in the physically combined clean and soiled work area.	S 7100		

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S 7100	Continued from page 75 EMP1 confirmed there was no provision to monitor temperature, humidity or ventilation in the area where sterile packages were kept. 4) Review of the current edition of the Guidelines for Design and Construction of Hospital and Health Care Facilities revealed "3.8-7.2.2.2 Door openings ... (2) Toilet room doors for patient use shall open outward or be equipped with hardware that permits access from the outside in emergencies." Observation on June 7, 2012, of the patient restroom in the hallway near the exam rooms, revealed the door opened inward. Interview on June 7, 2012, with EMP1 confirmed the patient restroom door opened inward. 5) Review on June 7, 2012, of the current edition of the Guidelines for Design and Construction of Hospital and Health Care Facilities revealed: "3.8-3.6.5 Scrub facilities ... 3.8-3.6.1 Hands free scrub station(s) shall be provided outside of but near the entrance to each operating room."	S 7100		

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S 7100	Continued from page 76 Observation on June 7, 2012, of the surgical procedure rooms revealed there were no scrub sinks located outside of the operating rooms. Further observation revealed that the sinks inside the procedure rooms were not hands free. Interview with EMP1 and EMP2 on June 7, 2012, at approximately 11:30 AM confirmed there were no scrub sinks located outside of the procedure rooms and the sinks in the room were not hands free.	S 7100		

Certified End Page

PLANNED PARENTHOOD KEYSTONE - WARMINSTER

STATE LICENSE NUMBER: 00188701

SURVEY EXIT DATE: 06/08/2012

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