Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER/SUPPLIER IDENTIFICATION NUMBER			A. BLDG: <u>0</u>	(X2) MULTIPLE CONSTRUCTION: (X3) DATE SURVICOMPLETED: A. BLDG:00 09/16/2014		EY	
NAME OF PROVIDER OR SUPPLIER: PPSP FAR NORTHEAST HEALTH CENTER STATE LICENSE NUMBER: 9HEG8701			STREET ADDRESS, 2751 COMLY PHILADELPI	ROAD		I	
(X4) ID PREFIX TAG	SUMMARY STATEMEN MUST BE PRECEED IDENT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE	
M 0000	INITIAL COMMENT		M 0000				
	This report is the result survey conducted on A Northeast Health Cent facility was in complia the Pennsylvania Depa § 28 Pa Code, Chapter Ambulatory Gynecolo Clinics.	PSP Far ed the ements of egulations spitals and					
LABORATOR'	Y DIRECTOR'S OR PROVIDER/SUPPL	IER REPRESENTATIVE'S SIGN	IATURE	<u> </u>	TITLE:	(X6) DATE:	
State Form		LF6411				IF CONTINUAT	TON SHEET Page 1 of 1

LF6411

IF CONTINUATION SHEET Page 1 of 1

Pennsylvania Department of Health

	·P			-				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		A. BLDG:0	LE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:		
	8-5144			B. WING:		09/16/2014		
NAME OF PROVIDER OR SUPPLIER: PPSP FAR NORTHEAST HEALTH CENTER STATE LICENSE NUMBER: 9HEG8701			STREET ADDRESS 2751 COMLY PHILADELP	ROAD		L		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	CORRECTIVE ACTION SH	ER'S PLAN OF CORRECTION (EACH (X5) RECTIVE ACTION SHOULD BE COMPLET EFERENCED TO THE APPROPRIATE DATE		
S 0000 S 6701	INITIAL COMMENT This report is the result of a full State Licensure survey conducted on August 21, 2014, at PPSP Far Northeast Health Center. It was determined 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.		PSP Far d the uirements s Rules lities,	S 0000 S 6701				
LABORATORY	DIRECTOR'S OR PROVIDER/SUPPL	IER REPRESENTATIVE'S SIGN.	ATURE		TITLE:	(X6) DATE:		
State Form	State Form LF6411 IF CONTINUATION SHEET Page 1 of 6							

IF CONTINUATION SHEET Page 1 of 6

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER 8-5144			(X2) MULTIPLE CONSTRUCTION: (X3) DATE SUI COMPLETED: A. BLDG:00					
NAME OF PROVIDER OR SUPPLIER:			STREET ADDRESS, CITY, STATE, ZIP CODE:					
PPSP FAR NORTHEAST HEALTH CENTER			2751 COMLY ROAD					
STATE LICENSE NUMBER: 9HEG8701			PHILADELPHIA, PA 19154					
(X4) ID	SUMMARY STATEMEN		ID PROVIDER'S PLAN OF CORRECTION (EACH			(X5)		
PREFIX	MUST BE PRECEEI		PREFIX TAG CORRECTIVE ACTION SHOULD BE			COMPLETE		
TAG	IDENT		CROSS-REFERENCED TO THE APPROPRIATE			DATE		
S 6701	Continued from page 1 567.1 Principle CHAPTE SERVICES 567.1 Principle The ASF shall have a constructed, equipped and maintained t ASF personnel from cross-infection and to prot patients. This REGULATION is no	sanitary environment, pr o protect surgical patients ect the health and safety o	roperly s and	S 6701	UPDATED 10/2/14 1) The wall paneling in the I sedation procedure room wil evaluated by a contractor by 10/15/14 and the work to rep seams will be completed by PPSP's Director of Facilities ensure work by contractors i complete and in compliance 567.1. The Director of Facilities co monthly walk-throughs (environmental rounds)of the site and will add the walls th checklist they use. In addition ASF person-in-charge will b facility issues to the immedia attention of PPSP's Director Facilities and the Director of Operations. The Director of is responsible for ensuring completion of any needed fa repairs by engaging our inter- maintenance team or outside contractors. 2) Repair to the outer protect	Il be pair wall 11/15/14. will s with nducts e ASF the on, the rring any ate of f Center Facilities cility rnal	Completion Date: 11/15/2014 Status: APPROVED Date: 10/20/2014	

LF6411

IF CONTINUATION SHEET Page 2 of 6

Pennsylvania Department of Health

	i										
STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 8-5144			A. BLDG:	PLE CONSTRUCTION: 	(X3) DATE SURVE COMPLETED: 09/16/2014	Y					
NAME OF PROVIDER		TENTED	STREET ADDRESS, 2751 COMLY		IP CODE:						
	ORTHEAST HEALTH C	EN I EK	PHILADELPH		154						
STATE LICENSE NU	JMBER: 9HEG8701										
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DEI D BY FULL REGULATORY OI YING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE				
S 6701 Con	ontinued from page 2			S 6701							
					 material on the recliner chair recovery area has been sched and will be completed by 10. Maintenance of chair fabric or monitored by the ASF person-in-charge and damage addressed immediately or the will be removed from the recarea until repair is complete. ASF person-in-charge worki agency Purchasing Manager medical equipment vendor is responsible for any needed repair/replacements. 3) Repair to the arm rest of the patient chair in the lab has be scheduled and will be completed 10/15/14. Furniture used in patient area be maintained in good workin without tears. ASF person-in-charge will monit ensure compliance. The ASF person-in-charge working with agency Purchasing Manager medical equipment vendor is magency Purchasing Manager medical equipment vendor is person-in-charge working without tears. ASF person-in-charge working without tears area without tears. ASF person-in-charge working without tears area working without tears. ASF person-in-charge working without tears area working without tears. ASF person-in-charge working without tears area working without tears. ASF person-in-charge working without tears. ASF	huled /15/14. will be e will be e chair covery The ng with and s he een eted by as will ng order or and F ith and					

State Form

LF6411

IF CONTINUATION SHEET Page 3 of 6

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 8-5144			A. BLDG:	PLE CONSTRUCTION: 00	(X3) DATE SURVI COMPLETED: 09/16/2014	ΞŶ	
NAME OF PROVIDER OR SUPPLIER: PPSP FAR NORTHEAST HEALTH CENTER STATE LICENSE NUMBER: 9HEG8701			STREET ADDRESS, 2751 COMLY PHILADELPI	ROAD			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DI MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
S 6701	Continued from page 3			S 6701	responsible for any needed repair/replacements. Working together, the ASF person-in-charge and PPSP's Director of Facilities will en safe and sanitary environment through increased monitorin immediate action. Unresolve will be brought to the attenti Patient Services Administrat (Director of Risk and Qualit) Management or Director of Coperations)who will ensure compliance.	sure a nt g and ed issues on of tion y	

State Form

LF6411

IF CONTINUATION SHEET Page 4 of 6

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			A. BLDG:	PLE CONSTRUCTION:	(X3) DATE SURV COMPLETED: 09/16/2014	ETED:	
	DVIDER OR SUPPLIER: R NORTHEAST HEALTH (8-5144 CENTER	STREET ADDRESS, 2751 COMLY PHILADELPH	CITY, STATE, ZI ROAD	IP CODE:	07/10/2014	
STATE LICEN	SE NUMBER: 9HEG8701		IIILADELII	па, га ту			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEED IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE J	OULD BE	(X5) COMPLETE DATE	
5 6701	Continued from page 4			S 6701			
	Based on observation a (EMP), it was determine provide a safe and same Findings include: 1) Observation on Au sedation procedure root in the room was noted seams in four different opening in each of the Interview on August 2 EMP1 confirmed that sedation room was not wall seams in four different opening in each of the 2) Observation on Au recovery area revealed noted to have three different protective material wa Interview on August 2	failed to Failed to Failed to Paneling the wall d an with the IV om the reated an was he outer omised.					

LF6411

IF CONTINUATION SHEET Page 5 of 6

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER: 8-5144			A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 09/16/2014	ΞY				
NAME OF PROVIDER OR SUPPLIER:			STREET ADDRESS,		LIP CODE:					
PPSP FAR NORTHEAST HEALTH CENTER			2751 COMLY ROAD PHILADELPHIA, PA 19154							
STATE LICENSE NUMBER: 9HEG8701				,						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH D MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)			ID PREFIX TAG	CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
S 6701	Continued from page 5			S 6701						
	EMP1 confirmed that the recovery area rec									
			cliner							
	chair that was noted to	have three different	tears,							
	where the outer protect	tive material was no	ted to be							
	compromised.									
	3) Observation on August 21, 2014, of the Lab									
	specimen room revealed a patient chair's arm rest									
	had a tear, where the outer protective material was									
	noted to be compromised.									
	Interview on August 21, 2014, at 2:35 PM, with									
	EMP1 confirmed the Lab specimen room p									
	chair's arm rest had a t									
		,	omised							
	protective material was noted to be compromi		,				1			

LF6411

IF CONTINUATION SHEET Page 6 of 6



Certified End Page

PPSP FAR NORTHEAST HEALTH CENTER STATE LICENSE NUMBER: 9HEG8701 SURVEY EXIT DATE: 09/16/2014

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. Lescavag

Nancy J. Lescavage Deputy Secretary for Quality Assurance



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

Rachel L. Levine, MD Secretary of Health