STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	8-2206	A. BLDG: 00 B. WING:	03/31/2017

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HILLCREST WOMENS' MEDICAL CENTER - HARRISBURG, P.C. STATE LICENSE NUMBER: **00098701**	**2709 NORTH FRONT STREET HARRISBURG, PA 17110**

(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	M 0000		

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

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M 0000	Continued from page 1 This report is the result of an Annual Registration survey conducted on February 21 &27, 2017, at Hillcrest Women's Medical Center. 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 0004		M 0004		

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M 0004	Continued from page 2 29.33(4) Requirements for Abortion Each medical facility shall arrange for at least one physician who is board eligible by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetric and Gynecology to be available either as a staff member or as a consultant for the purpose of providing consultation as needed and to advise staff members with respect to maintenance of a satisfactory quality of treatment. This REGULATION is not met as evidenced by:	M 0004	A CV, license, and board certification will be faxed to the examiner. We will contact the physician's office each year and ask for their office to supply our clinic with the most current information.	Completion Date: **04/21/2017** Status: **APPROVED** Date: **04/27/2017**

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M 0004	Continued from page 3 Based on a review of facility documents, the facility failed to ensure that one consultant physician was board eligible for the purpose of consultation to advise staff members with respect to satisfactory quality of treatment. Findings include: On February 21, 2017, the facility was asked to produce the consultant physician's credential file. In response to that request, the facility provided a transfer agreement and letter of agreement by the consultant physician to manage patients referred from Hillcrest Women's Medical Center. There was no documentation provided by the facility to show that the physician was board certified in Obstetrics and Gynecology. A second request was made on February 23, 2017 for documentation which showed the consultant physician was board certified in Obstetrics and Gynecology. As of February 27, 2017, the facility has not provided evidence of the board certification.	M 0004		

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M 0004	Continued from page 4	M 0004		
M 0006		M 0006		

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M 0006	Continued from page 5 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	A completed form was sent to the Division of Accute and Ambulatory Care Exception Request, requesting that our clinic have a consideration to be exempted from ABO Blood Typing, Regulation 29.33(6). Our clinic currently conducts blood testing for the RHfactor and hematrocit and/or hemoglobin, which are the only required blood tests needing to be administered in our clinic. Patients with a RH negative blood type, will be administered the Immune Globulin and the dosage will depend upon existing medical protocol. This completed form was emailed to ra-paexceptpa.gov on 4/18/17. If the exception is not granted, we will continue with the protocol we have in place which is if the patient is rendered RH-Negative, a RhoGAM injection will be administered in order to keep the patient's body from forming antibodies that may attack the blood cell. The lab tech will continue to record the patient's Immune Globulin as yes, if RH NEG and record No if patient's Immune	Completion Date: **05/31/2017** Status: **APPROVED** Date: **05/09/2017**

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M 0006	Continued from page 6	M 0006	Globulin is RH positive. ABO Blood Typing Testing will be administered to all patients effective 5/2017, until we receive further notification from the DOH, regarding the clinic's exception request for an exemption.	

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M 0006	Continued from page 7 Based on the review of facility documents, medical records (MR) and interview with staff (EMP) it was determined the facility failed to ensure that all patients, prior to their procedure, had blood drawn for ABO blood group for 12 of 12 records reviewed (MR1, MR2, MR3, MR4, MR4, MR6, MR7, MR8, MR9, MR10, MR11 and MR12). A review on February 27, 2017, of the facility's laboratory policy revealed, " ... standing Orders for Onsite laboratory Testing 1. All Pregnancy Termination patients will have: RH typing, hemoglobin, Pregnancy test ... " The policy did not address blood typing. A review on February 21, 2017, of MR1, MR2, MR3, MR4, MR4, MR6, MR7, MR8, MR9, MR10, MR11 and MR12 revealed a lack of documentation of blood type. Interview on February 21, 2017, at 3:30 PM with EMP1 confirmed that there was no evidence that ABO blood typing was done.	M 0006		

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M 0006	Continued from page 8	M 0006		
M 0013	29.33(13) Requirements for Abortion Each patient shall be supervised constantly while recovering from surgery or anesthesia, until she is released from recovery by a registered nurse or a licensed practical nurse under the direction of a registered nurse or a physician. The nurse shall evaluate the condition of the patient and enter a report of the evaluation and orders in the medical record of the patient. This REGULATION is not met as evidenced by:	M 0013	We have hired an RN who is start 4/26/2017.	Completion Date: **04/21/2017** Status: **APPROVED** Date: **04/27/2017**

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M 0013	Continued from page 9 Based on a medical record review (MR) and interview with staff (EMP), it was determined that the facility failed to provide evidence that a registered nurse was in attendance during the hours patients were present for 12 of 12 medical records reviewed (MR1, MR2, MR3, MR4, MR5, MR6, MR7, MR8, MR9, MR10, MR11 and MR12). Findings include: A review of MR1, MR2, MR3, MR4, MR5, MR6, MR7, MR8, MR9, MR10, MR11 and MR12 revealed that no Registered Nurse supervised the care these patients received. Interview with EMP1 on February 21, 2017, confirmed that the facility did not employ or otherwise utilize the services of a Registered Nurse.	M 0013		

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S 0000	INITIAL COMMENT This report is the result of an Annual Registration survey conducted on February 21 & 27, 2017, at Hillcrest Womens' Medical Center. It was determined that the facility was not in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Ambulatory Care Facilities, Annex A, Title 28, Part IV, Subparts A and F, Chapters 551-573, November 1999.	S 0000		
S 0142		S 0142		

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

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S 0142	Continued from page 1 551.52 ASF Responsibilities 551.52 ASF Responsibilities An ASF shall comply with applicable standards which are required by Federal, State, and local authorities. This includes, but is not limited to, standards at 49 Pa. Code Chapters 17, 21 and 27 (relating to State Board of Medicine, Nursing and Pharmacy) in addition to standards related to radiologic health, sanitation, food, service, electric wiring and life safety code compliance. When the ASF has been inspected by another regulatory agency, it shall have available during the survey by the Department written confirmation of compliance as required by the other regulatory agency. This REGULATION is not met as evidenced by:	S 0142	The Patient Safety Committee, will meet the 1st week of each quarter to assure the safety and care of our patients is being carried out. We will determine ways to improve the needs of our clinic to assure the patient receives the safe care while at our clinic. We will review the past quarter, identify any problems and determine a plan of action. In the following quarter, we will evaluate our progress and compliance with the state regulations and resolution of care problems. The committee consists of the Dr., Administrators, RN, Lab tech and a Community resident. The administrator is the patient safety officer and will investigate reports of incidents and serious events, take immediate action to ensure patient safety and report any and all action taken and provide that information to the medical director. The PSO receives all incident reports, review and evaluates the safety measures of the facility. The committee shall develop ideas and make	Completion Date: **08/31/2017** Status: **APPROVED** Date: **05/01/2017**

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S 0142	Continued from page 2	S 0142	recommendations to eliminate any future incidents. All serious events and incidents will be reported with 24 hours of occurrence or discovery. All incidents shall be reported to DOH immediately; verbally and in writing. The affected patient or designee will be provided a written notification of a serious event within seven days of occurrence. The said documentation shall be sent to the patient or designee by certified mail. Plan to correct will August 2017. As a condition of employment at our clinic, every employee will undergo a required background check. All employees personnel file shall comprise of the required background checks' CPSL, FBI and State Police. Al current employees will be completed by June 2017. Patients under the age of 17, are required to have a biological parent, legal guardianship (issue by the State or documents showing that they are emancipated by the courts. Photo identifications cards such as a	

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S 0142	Continued from page 3	S 0142	driver license, photo identification cards and or passports are required before any services many be rendered by our clinic. We will post the "born by date" at each clinic session to assure the patient meets the age requirement or has appropriate parent/guardian present. Mandatory Abuse Reporting will discussed at our next staff meting which is scheduled on May 13, 2017. Each staff member will be advised of the importance of reporting any incident of abuse as defined by law. We will explore and work closely with various professionals, i.e., physicians, nurses', paramedics, firefighters and law enforcement officers. In service training on how o complete the necessary forms will be conducted on June 10, 2017. Those forms can be found in our office procedural manual. The Administrator will monitor each category listed above.	

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S 0142	Continued from page 4 Based on a review of facility documents and staff interview (EMP), it was determined that the facility failed to conform to all applicable State Laws. The facility was found to be non-compliant with the following State Law related related to Act 13 of 2002, Medical Care Availability and Reduction of Error (MCARE) Act, "Chapter 3. Patient Safety...Section 310. Patient safety committee...The committee shall meet at least quarterly." Based on a review of facility policy and staff interview, it was determined the facility failed to ensure that Patient Safety Committee meetings were conducted quarterly. Findings include: A review on February 21, 2017, "Hillcrest Women's Medical Center Patient Safety Policy" revealed, " ... C. Plan to meet every three months ... "	S 0142		

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S 0142	Continued from page 5 A review on February 21, 2017, of Patient Safety meeting minutes revealed there were no meetings documented for the third and fourth quarter of 2016. An interview on February 21, 2017, at 11:00 AM with EMP1 confirmed that there were no meetings held for the third and fourth quarter of 2016. _____ The facility was not in compliance with the following State Law related to Act 13 of 2002, Medical Care Availability and Reduction of Error (MCARE) Act, "Chapter 3. Patient Safety...Section 310 (a) Composition (2) An ambulatory surgical facilty's, abortion facility's or birth center's patient safety committee shall be composed of the medical centers patient safety officer and at least one health care worker of the medical facility and one resident of the community served by a ambulatory surgical facilty's, abortion facility's or birth center who is not an agent , employee or contractor of the ambulatory surgical facilty, abortion facility or birth center.	S 0142		

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S 0142	Continued from page 6 Findings include: A review of Patient Safety Committee minutes for February 12, 2016, and June 10, 2016, revealed the absence of a community member at both meetings. An interview on February 21, 2017, at 11:00 AM with EMP1 revealed that the facilty was not aware they needed to ask a community member to be part of the Patient Safety Committee and attend the quarterly meetings. _____ Based on a review of facility documents and medical records (MR) it was determined Hillcrest Women's Medical Center was not in compliance with the Child Protective Services Law (CPSL), 23 Pa.C.S. Findings include:	S 0142		

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S 0142	Continued from page 7 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." Based on review of medical records (MR), personnel files (PF) and staff interview (EMP), it was determined that the facility failed to follow their policy and ensure that all staff hired after July 1, 2008, obtained the required background checks as required by Act 179 of 2006 an Act of 2007 (Child Protective Services Law), for eight employees (PF1, PF2, PF3, PF4, PF5, PF6, PF7 and PF8). A review on February 27, 2017, of personnel files (PF1, PF2, PF3, PF4, PF5, PF6 ,PF7 and PF8) revealed that the required background checks were not completed.	S 0142		

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	8-2206	A. BLDG: 00 B. WING:	03/31/2017

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S 0142	Continued from page 8 A review of MR6, a 17 year old patient born in September 1999 revealed she had a procedure on February 10, 2017. An interview on February 21, 2017 at 10:00 AM with EMP1 confirmed that background checks were not completed for the employees. Further interview confirmed that the facility admitted and treated individuals under the age of 18. _____ _____ Based on a review of facility documents and Personnel files (PF) it was determined Hillcrest Women's Medical Center failed to develop policy and provide training so staff would be aware of their reporting responsibilities for dependent adults 18 years old to 59 years old regarding the Adult Protective Services Act of 2010. Findings include:	S 0142		

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S 0142	Continued from page 9 Review of facility policies that were provided to surveyors on February 21, 2017, and February 27, 2017, revealed there was no policy that addressed suspected abuse reporting requirements for dependent adults 18 years old to 59 years old. A review on February 27, 2017, of PF1 through PF8, revealed there was no training with respect to the Adult Protective Services Act of 2010.	S 0142		

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S 0142	Continued from page 10	S 0142		
S 331A	553.31 (a) Administrative responsibilities A full time person in charge shall be appointed who has authority and responsibility for the operation of the ASF at all times. Qualifications, authority, responsibilities and duties of the person in charge shall be defined in a written statement adopted by the governing body. This REGULATION is not met as evidenced by:	S 331A	As of March 25, 2017 an full time administrator and a full time assistant administrator has been appointed, Both job descriptions and resume were faxed to the DOH. Copies have been placed in their personnel folder. The Admin/Asst are responsible for implementing training, developing policies to ensure the Quality Assurance Program conforms with the State Laws. A quality improvement committee, which consist of the Dr., RN, Admin and Asst. Admin, will meet monthly to brainstorm information to review, revise and improve activities as it relates to the daily operation in which the clinic must operate, including discovery protections for our patients and employees. Our 1st meeting is scheduled for May 8, 2017 at 11:30 a.m.	Completion Date: **04/21/2017** Status: **APPROVED** Date: **04/27/2017**

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S 331A	Continued from page 11 Based on review of facility documents and personnel files (PF) and interviews with staff (EMP), it was determined the facility failed to ensure that a full-time person was appointed who had authority and responsibility for the operation of the Ambulatory Surgical Facility, to implement training and develop policies, to ensure the implementation of a Quality Assurance Program and to ensure conformity to State Laws. Findings include: A review of the facility policy manual and documents provided to surveyors on February 21, 2017, revealed there was no written statement, adopted by the Governing Body, of the qualifications, authority, responsibilities and duties of Administrator. A review on February 27, 2017, of PF1, revealed the personnel file did not contain a job description or educational background of the employee.	S 331A		

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S 331A	Continued from page 12 A review on February 27, 2017, of PF2, revealed this personnel file lacked a job description. There was no personnel file submitted as requested on February 23, 2017, for EMP1 who is the acting Administrator of record. Interview with EMP1 on February 21, 2017, at 10:00 AM confirmed that PF1 and PF2 were hired to share the administrative duties. Neither employee had been hired to be a full time administrator. Interview revealed that EMP1 worked in the Maryland and was not a full time employee at Hillcrest Women's Medical Center. Cross Reference § 28 Pa Code: 557.1, 555.33, 559.2, 559.3, 561.15 and 561.25	S 331A		

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S 331A	Continued from page 13	S 331A		
S 5563		S 5563		

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S 5563	Continued from page 14 555.33 (d)(5) Anesthesia Policies and Procedures 555.33 Anesthesia policies and procedures (d) Anesthesia procedures shall provide at least the following: (5) A patient receiving anesthesia shall have an anesthesia record maintained. This shall include a record of vital signs and all events taking place during the induction of, maintenance of and emergence of anesthesia, including the dosage and duration of anesthesia agents, other drugs and IV fluids. This REGULATION is not met as evidenced by:	S 5563	Our policy and goal is to provide safe care to a patient who is receiving local anesthesia by injection. The MA/CNA/ and Dr., will perform a preoperative assessment for the patient who will receive local anesthesia assuring there is no know allergy to a "caine" drug. The Dr. and Nurse shall understand the pharmacology of local anesthesia, its calculation of dose, contraindications and desired effects and resuscitation. The Dr. shall document the administration of the local anesthetic, including the name of the agent, strength and total amount administered. The time of administration and route will be dictated by the Dr. and the findings will be documented in the patient's chart. During the procedure, the MA/CNA will monitor the patient's vital signs, level of consciousness, and self-reported pain level by referring to a visual analog scale. The findings are then recorded in the patient's records. After the surgical procedure, the CNA/MA shall safely transfer the patient to the recovery	Completion Date: **06/30/2017** Status: **APPROVED** Date: **05/01/2017**

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S 5563	Continued from page 15	S 5563	room. The RN will document the patient's physiological and psychological responses. The RN should know the symptoms of and treatment protocol for local anesthetic system toxicity. While the patient recovers for a time of least 20 minutes in the clinic's recovery rom, the nurse should recognize the signs and symptoms of an allergic reaction to the local anesthetic that was administered during the surgical procedure. The Dr. will also monitor the nurses notes that are indicated in each patient's chart. The doctor will remain in the facility until the last patient is safe to discharge.	

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S 5563	Continued from page 16 Based on review of medical records (MR) and interview with staff (EMP), it was determined that the facility failed to document the the name, dose and route of administration of local anesthetic used for abortion procedures performed for seven of 12 medical records reviewed (MR1, MR2, MR3, MR5, MR6, MR7 and MR10). Findings include: A review of facility policies provided to the surveyors on February 27, 2017, revealed there were no policies that addressed the use of local anesthesia by the physician in the procedure room. A review of MR1, MR2, MR3, MR5, MR6, MR7 and MR10 revealed these patients had surgical abortion procedures performed in the facility. The name, dose or route of administration was not recorded on the Intraoperative notes. An interview with EMP1 on February 21, 2017, at 3:30 PM confirmed the lack of documentation and	S 5563		

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S 5563	Continued from page 17 indicated that it was not the physician's practice to document information about the local anesthetic.	S 5563		
S 573A		S 573A		

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S 573A	Continued from page 18 557.3 (a) QA & Improvement Program 557.3 The Quality Assurance and Improvement Program (a) The quality assurance program shall include monitoring and evaluation of data collected, based on defined criteria that reflect current knowledge and clinical experience and relate to the care provided by the service. Sources of data include the medical records, incident reports, infection control records and patient complaints. The medial record shall contain sufficient data to support the diagnosis and determine that the procedures are appropriate to the diagnosis. Facilities that treat pediatric patients shall segregate data regarding such patients. This REGULATION is not met as evidenced by:	S 573A	A quality and risk management program is being implemented. We will meet every quarter to analyze the needs for improvement as it relates to the care given to the patients. A patient and employee survey is being implemented in order that we may foster a culture of continuous improvement by monitoring all events in our clinic. At each quarterly meeting, we will review the findings and progress made and strategized in areas that may need improvements, the quality of the clinic's infrastructure, staff concerns, infection control, emergency preparedness, safety and security of medical records. At our staff meeting on May 13, 2017, we will brainstorm quality improvement and risk Management ideas, to ensure our clinic is operating in the same manner in which all accredited ambulatory and surgical facility, following the statues that are govern by the DOH guidelines. NAF will hold a Quality Assurance Training Session on May 23/24,2017. This program will be monitored by the Dr.	Completion Date: **07/31/2017** Status: **APPROVED** Date: **05/01/2017**

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S 573A	Continued from page 19	S 573A	and Administrator.	

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S 573A	Continued from page 20 Based on review of facility documents and staff interview (EMP), it was determined the facility failed to conduct an ongoing quality assurance and improvement program (QA) with active participation of the medical and nursing staff designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care and pursue opportunities to improve patient care and resolve identified problems. Findings include: Review of facility documentation provided to surveyors on February 21, 2017, revealed the facility did not have a Quality Assurance Program, a plan to implement the program, or evidence that the staff met to discuss ways to improve patient care. Interview on February 21, 2017, at 10:00 AM with EMP1 confirmed the facility did not conduct Quality Assurance meetings or track patient data to identify opportunities for improvement in the care provided. Further interview confirmed there were no	S 573A		

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S 573A	Continued from page 21 performance indicators selected, no data collected for the pediatric population served and no active surveillance for post-procedural infections.	S 573A		
S 5924	559.2 (4) Director of Nursing 559.2 Director of Nursing The director of nursing shall be currently licensed as a registered nurse in this Commonwealth and be responsible and accountable to the person in charge of the ASF for: (4) Establishment of a means of assessing the nursing care needs of patients and staffing to meet those needs, This REGULATION is not met as evidenced by:	S 5924	A RN has been hired and she will maintain the care and needs of each client/patient and she will assist in the creation and development of standards and policies as it relates to the Ambulatory and Surgical Facility Guidelines. The RN is responsible for assisting the Dr. and assess the condition of the patient before and following any procedures conducted at our facility.	Completion Date: **04/26/2017** Status: **APPROVED** Date: **04/27/2017**

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S 5924	Continued from page 22 Based on a medical record review (MR), personnel file review (PF) and interview with staff (EMP), it was determined that the facility failed to provide documentation that a registered nurse was available to assess the nursing care needs of the patients for 12 of 12 medical records reviewed (MR1, MR2, MR3, MR4, MR5, MR6, MR7, MR8, MR9, MR10, MR11 and MR12). Findings include: A review on February 21, 2017, of the facility document "Staff List" revealed there were no registered nurses listed. A review on February 21, 2017, of PF1 through PF8 revealed that none of the personnel, who assisted the doctor with procedures, were licensed as a Registered Nurse. A review of MR1, MR2, MR3, MR4, MR5, MR6, MR7, MR8, MR9, MR10, MR11 and MR12 revealed that no Registered Nurse supervised the	S 5924		

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S 5924	Continued from page 23 care or assessed these patients. Interview with EMP1 on February 21, 2017, confirmed that there was no Registered Nurse employed at the facility to assess patient care needs and develop policies. The facility has not employed an RN since January 27, 2017. Since that time, the facility has done 55 procedures and has not had an RN to assist the doctor and to assess the condition of the patient before and following the procedure. Cross Reference § 28 Pa Code: 557.1, 555.33, 559.2, 559.3, 561.15 and 561.25	S 5924		

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S 593B	559.3 (b) Nursing Personnel 559.3 Nursing Personnel (b) At least 1 registered nurse shall be in attendance during the hours, patients are present. Nursing personnel shall be assigned to duties consistent with their education, training and experience. This REGULATION is not met as evidenced by:	S 593B	An RN has been hired.	Completion Date: **04/26/2017** Status: **APPROVED** Date: **04/27/2017**

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HILLCREST WOMENS' MEDICAL CENTER - HARRISBURG, P.C. STATE LICENSE NUMBER: **00098701**	**2709 NORTH FRONT STREET HARRISBURG, PA 17110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 593B	Continued from page 25 Based on medical record review (MR) for MR 1-12 and interview with staff (EMP), it was determined that the facility failed to provide documentation that a registered nurse was in attendance during the hours patients were present in the facility. Findings include: A review of MR1, MR2, MR3, MR4, MR5, MR6, MR7, MR8, MR9, MR10, MR11 and MR12 revealed that there was no RN in attendance. Interview with EMP1 on February 21, 2017, confirmed that the facility had not employed an RN since January 27, 2017.	S 593B		

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 593B	Continued from page 26	S 593B		
S 6128		S 6128		

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 6128	Continued from page 27 561.15 Locked Storage 561.15 Locked Storage Special locked storage space shall be provided to meet requirements for storage of controlled substances, alcohol and other prescribed drugs as set forth in Chapter 25 (relating to controlled substances, drugs, devices and cosmetics) and 49 Pa Code 27.16 (4) and 27.17 (relating to construction requirements and security for Schedule II controlled substances). This REGULATION is not met as evidenced by:	S 6128	All expired curettes, cultures testing and drugs have been discarded. All drugs are now locked and a logbook of medications can be found in the office procedures manual and posted in each exam room. Each staff member will received proper education and a written policy regarding the proper guidelines for drug storage during the next staff meeting which will be held on May 13, 2017, emphasizing the need to keep meds secured, including oral contraceptives and patches and to make certain all expired inventory is discarded. Key points for basic storage guidelines an an overview effects of using expired drugs will be discussed. The Dr. and administrators are the only staff members with access to the storage room. The administrators will monitor expired, uncapped, and out dated meds on a monthly basis, to ensure the clinic's policy is being adhered to and provide additional training as needed to all personnel.	Completion Date: **07/31/2017** Status: **APPROVED** Date: **05/01/2017**

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 6128	Continued from page 28 Based on observation and interview it was determined the facility failed to secure drug samples. Findings include: A review of policies on February 21 & 27, 2017, confirmed the lack of a policy to address the need to keep medications secure. A tour of the facility on February 21, 2017, at 2:20 PM revealed that there were boxes of Lo Loestran-Fe and Xulane transdermal stored on an open unlocked shelf in the recovery area. Interview on February 21, 2017, at 3:30 PM with EMP1 confirmed there was no log and/or inventory of the amount of drug samples on hand and that the drugs were stored in a manner that was accessible by unauthorized staff and the patients.	S 6128		

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S 6128	Continued from page 29	S 6128		
S 6142	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	All expired drugs in our inventory has been discarded. All medicals supplies that were expired have been discarded. The emergency carts have updated medical supplies and is locked at all times. The Dr., RN, MA, CNA, LPN and administrators are aware of the location of each carts keys. All meds are locked and a logbook of medications can be found in the front office. Each staff member was advised in a staff meeting held on April 5, 2017 and will received QA training and education regarding guidelines for storing medications on May 4, 2017. Our RN will check for distressed drugs and devices on a monthly basis.	Completion Date: **04/05/2017** Status: **APPROVED** Date: **04/27/2017**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 6142	Continued from page 30 This Regulation is not met as evidenced by: Based on observation and interview with staff (EMP), it was determined that the facility failed to consistently dispose of outdated medication and supplies. Findings include: A tour of the facility on February 21, 2017, revealed the following outdated medication/supplies: 1. In the recovery area, one 100 count bottle of Tylenol 500 milligrams (mg) that expired April 2016. 2. In the recovery area, seven individually wrapped 22 gauge three and one-half inch needle and syringes were in paper wraps that were physically deteriorated and yellow with age. 3. On the emergency cart, Lactated Ringers solution, 500 milliliters (ml) container that expired	S 6142		

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S 6142	Continued from page 31 December 2016. 4. On the emergency cart, two 250 ml each Sodium Chloride, for infusion, that expired March 2016. 5. In the procedure room, 20 Chlamydia/Gonorrhea swabs that expired in 2004. 6. In the procedure room, seven ampules of refrigerated Methylergonorin 0.2 mg/ml that expired September 2016. 7. In the procedure room, 124 Rigid Curved Curettes that expired on various dates from February 2015 to November 2016. Interview with EMP1 on February 21. 2017, at 3:30 PM confirmed the Registered Nurse who was previously employed was to check for outdated and expired supplies and this responsibility had not been reassigned since her departure.	S 6142		

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S 6142	Continued from page 32	S 6142		

Certified End Page

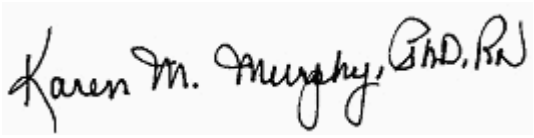
HILLCREST WOMENS' MEDICAL CENTER - HARRISBURG, P.C.

STATE LICENSE NUMBER: 00098701

SURVEY EXIT DATE: 03/31/2017

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

Kelly Hoover Thompson
Deputy Secretary for Quality Assurance



Karen M. Murphy, PhD, RN
Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY