Pennsylvania Department of Health

	OF DEFICIENCIES AND	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIP	LE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	ΞY
PLAN OF COR	RRECTION (POC)				0		
		8-0908				08/22/2017	
	VIDER OR SUPPLIER: PARENTHOOD KEYST(ONE -		S, CITY, STATE, ZII DRIVE SUITE			
WARMIN			WARMINST	ER, PA 1897	4		
STATE LICENS	SE NUMBER: 00188701						
(X4) ID PREFIX		I OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI CORRECTIVE ACTION SI		(X5) COMPLETE
TAG		IFYING INFORMATION)	R LOC		CROSS-REFERENCED TO THE		DATE
M 0000	INITIAL COMMENT			M 0000			
	This report is the result of						
	survey conducted on Au Parenthood Keystone - V		ned				
	Warminster) as the result		nual				
	registration survey cond	-					
	was determined the facil	•	ince				
	with the requirements of Department of Health R	•	de				
	Chapter 29, Subchapter						
	Surgery in Hospitals and						
M 0032				M 0032			
LABORATORY	I DIRECTOR'S OR PROVIDER/SUPPL	IER REPRESENTATIVE'S SIGN	IATURE	<u> </u>	TITLE:	(X6) DATE:	<u> </u>
State Form		S0E912	2			IF CONTINUATI	ON SHEET Page 1 of 14

IF CONTINUATION SHEET Page 1 of 14

Pennsylvania Department of Health

PLAN OF COR	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-0908	:	A. BLDG: _ B. WING: _	PLE CONSTRUCTION: 	(X3) DATE SURV COMPLETED: 08/22/2017	EY
	VIDER OR SUPPLIER: PARENTHOOD KEYST(STER	DNE -	STREET ADDRESS, 610 LOUIS DI WARMINSTE	RIVE SUIT	E 303		
STATE LICENS	e number: 00188701						
(X4) ID PREFIX TAG	MUST BE PRECEED	^C OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE /	OULD BE	(X5) COMPLETE DATE
M 0032	Continued from page 1			M 0032			
	29.43(b) Facility Approval All medical facilities excep approved facilities upon sul the Department from a pers facility and, at the discretion satisfactory completion of a This REGULATION is not	omission of an application on authorized to represe n of the Department, an on-site survey.			Action Plan: Update current Parenthood Keystone policy procedures on Incidents to er all reporting to PSRS reflect following process: 1.Center Staff (Clinicians/RNs/MDs/Cente Managers/Medical Care Ass must report incidents and/or occurrences to the Director or and Quality Management wi required time frame. RQM I hired 9/6/2017. 2)The RQM Director is also Patient Safety Officer and w the outlined policy and proce and time frames. 3)The RQM Director will re to the Department of Health the required time frame. 4) The RQM Director is also Patient Safety Officer and w the Patient Safety Authority and procedures.	and nsure s the r istants) of Risk thin the Director the ill follow edures port the within	Completion Date: 09/07/2017 Status: APPROVED Date: 10/04/2017

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Pennsylvania Department of Health

PLAN OF COR	OF DEFICIENCIES AND RECTION (POC) VIDER OR SUPPLIER: PARENTHOOD KEYST((XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-0908 DNE -	STREET ADDRESS, 610 LOUIS DE	A. BLDG: _ B. WING: _ CITY, STATE, Z	E 303	(X3) DATE SURVE COMPLETED: 08/22/2017	Υ
WARMINS	STER		WARMINSTE	CR, PA 189	74		
	e number: 00188701				r		
(X4) ID PREFIX TAG	MUST BE PRECEED	ſ OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE 4	OULD BE	(X5) COMPLETE DATE
M 0032	Continued from page 2			M 0032			
					 5) The RQM Director will co with Chief Medical Officer a to assess using the Harm Sco inform CEO of Planned Pare Keystone. 6) The RQM Director will su PSRS report - a serious PSR will be submitted for MR13. will also receive a "serious e written notification from the Director. 7) e. Also, if the event has be reported as a serious event, p will receive written notificat within the required time fram 8) Going forward, the RQM will initiate unannounced inti investigations, complete root 	as needed ore and enthood ubmit S report . MR13 event RQM een patient ion ne. Director ternal	
					cause analysis and implement changes to process as needed informing the CEO, as appro-	nt d,	
					9) The RQM Director will all update any reports in PSRS a needed. in consultation with	as	

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Pennsylvania Department of Health

PLAN OF COR	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-0908		A. BLDG: _ B. WING: _	IPLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 08/22/2017	ΞY
	VIDER OR SUPPLIER: PARENTHOOD KEYST(STER	DNE -	610 LOUIS DF WARMINSTE	RIVE SUIT	E 303		
STATE LICENS	e number: 00188701						
(X4) ID PREFIX TAG	MUST BE PRECEED	f OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O IFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE /	OULD BE	(X5) COMPLETE DATE
M 0032	Continued from page 3			M 0032	Chief Medical Officer. If an resulted in additional deliver services to the patient. 10)This policy and procedur set to go into effect on 09/12 Planned Parenthood Keystor be presenting this policy to Clinicians and Center Manag 09/11/2017. 11) Follow-up review meetin corrective action plan is beir with all PA Center Manager	y of es are 2/2017. he will gers on ng on this ng held	
					Monday October 2, 2017.		

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	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-0908		(X2) MULTIP A. BLDG: <u> (</u> B. WING: <u> </u>		(X3) DATE SURVEY COMPLETED: 08/22/2017	
	WIDER OR SUPPLIER:) PARENTHOOD KEYST STER	ONE -	STREET ADDRESS, 610 LOUIS DI WARMINSTE	RIVE SUITE	303		
STATE LICEN	SE NUMBER: 00188701						
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M 0032	Continued from page 4			M 0032			
	Based on review of farecords (MR), and starecords (iff interview (EMP), i y failed to conform to s. Keystone - Warminste) was not in complian w: Act 13 of 2002, M Reduction of Error (tient safety committee tility reports and notif ons. "Incident." An e n involving the clinic facility which could t did not either cause or require the delivery services to the patien a serious event. ." An undesirable or purrence or situation i medical facility or th	it was b all er nce with Medical MCARE) e and fications. vent, cal care of have an of nt. The nvolving ne				

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IF CONTINUATION SHEET Page 5 of 14

Pennsylvania Department of Health

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-0908		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 08/22/2017	EY
	VIDER OR SUPPLIER:) PARENTHOOD KEYSTO STER	DNE -	STREET ADDRESS, 610 LOUIS DF WARMINSTE	RIVE SUIT	E 303		
STATE LICENS	SE NUMBER: 00188701						
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M 0032	Continued from page 5			M 0032			
	which could seriously "Serious event." An ev- involving the clinical of facility that results in di- safety and results in an the delivery of addition patient. The term does Section 308 Reporting notify patient. A medic appropriate designee sl notification to a patien or, with the consent of family member or desi occurrence or discover patient is unable to giv be given to an adult mer family. If an adult mer cannot be identified or given to the closest adu unemancipated patient age, the parent or guard accordance with this su	vent, occurrence or s care of a patient in a leath or compromise a unanticipated injury hal health care service and notification. (b) cal facility through a hall provide written t affected by a seriou the patient, to an av- gnee, within seven d ty of a serious event. the consent, the notifice ember of the immedia located, notification all family member. s who are under 18 y dian shall be notifice	situation medical spatient y requiring ces to the dent. Duty to n us event ailable lays of the If the cation shall iate the family n shall be For years of d in				

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IF CONTINUATION SHEET Page 6 of 14

Pennsylvania Department of Health

	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-0908		(X2) MULTIP A. BLDG: <u>0</u> B. WING: <u></u>		ON: (X3) DATE SURVEY COMPLETED: 08/22/2017		
	VVIDER OR SUPPLIER:) PARENTHOOD KEYST (STER	ONE -	STREET ADDRESS 610 LOUIS DI WARMINSTI	RIVE SUITE	303			
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M 0032	2 Continued from page 6			M 0032				
	requirements of this su to the provisions of Se under this subsection a acknowledgement or a Section 313. Medical notifications. (a) Serie facility shall report the to the department and of the medical facility occurrence of the serie failure reports. A med occurrence of an infra department within 24 confirmation of the occ infrastructure failure. boardsIf a medical licensee providing hea facility during a seriou event in accordance w medical facility shall n board of the failure to report or notifyFail	ection 311 (a). Notifies shall not constitute and admission of liability facility reports and ous event reports. A e occurrence of a seri- the authority within 's confirmation of the ous event (c) Infra- ical facility shall rep- structure failure to the hours of the medical ecurrence or discover (e) Notification to facility discovers that alth care services in the us event failed to rep- rith section 308 (a), the notify the licensee's 1 do report. (f) Failure	ication n r. medical ious event 24 hours e astructure ort the facility's ry of the licensure at a he medical ort the he icensing e to					

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Pennsylvania Department of Health

	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 8-0908		A. BLDG: _	IPLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 08/22/2017	ΞY
	VVIDER OR SUPPLIER: D PARENTHOOD KEYSTC STER	DNE -	STREET ADDRESS, 610 LOUIS DF WARMINSTE	RIVE SUIT	E 303		
STATE LICENS	se number: 00188701		1				
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	T OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OI IFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE /	OULD BE	(X5) COMPLETE DATE
M 0032	Continued from page 7			M 0032			
	or an infrastructure fail or to develop and comp plan in accordance with patient in accordance v violation of the Health addition to any penalty under the Health Care 1 facility which fails to r infrastructure failure on accordance with this cl administrative penalty by the Department. This is not met as evide Based on review of face records (MR) and staff determined the facility a confirmed uterine per abortion was reported to (Department) as a seried applicable medical reco- failed the facility failed	ply with the patient s th section 307 or to n with section 308 (b) s a Care Facilities Act. y which may be impor- Facilities Act, a med report a serious event or to notify a licensur- hapter may be subject of \$1,000 per day in lenced by: cility documents, med f interview (EMP), it y failed to ensure a pa- erforation following a the Department of H ous event for one of e- ord reviewed (MR13	safety notify the shall be a In osed dical it or an re board in ct to an mposed edical t was atient with a surgical lealth one 3); and				

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Pennsylvania Department of Health

	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER PLAN OF CORRECTION (POC) IDENTIFICATION NUMBE 8-0908 8-0908		: A. BLDG	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: <u></u>		ΈY				
	D PARENTHOOD KEYST	ONE -	STREET ADDRESS, CITY, STATE, ZIP CODE: 610 LOUIS DRIVE SUITE 303 WARMINSTER, PA 18974							
STATE LICEN	ISE NUMBER: 00188701									
(X4) ID PREFIX TAG	MUST BE PRECEED	T OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O IFYING INFORMATION)		G PROVIDER'S PLAN OF CC CORRECTIVE ACTIO CROSS-REFERENCED TO	N SHOULD BE	(X5) COMPLETE DATE				
M 0032	Continued from page 8		M 0032							
provide written notification following deten of a serious event for one of one applicable record reviewed (MR13). Findings include:										
Review on August 22, 2017, or Safety Plan," effective May 3 "Policy: In compliance with A Care Availability and Reducti Act, of the Commonwealth of Planned Parenthood has estab Plan which designates a Patient (PSO), establishes a Patient Sa identifies a system for the repu- serious events, prohibits retail health care workers for report serious events, and provides for notification to clients affected Definitions: A. Patient Safety independent state agency Creat 2002, the Medical Care Availability	e May 31, 2017, revea e with Act 13, the Ma Reduction of Error (I realth of Pennsylvania as established a Patie a Patient Safety Offi- atient Safety Commi- the reporting of inci- its retaliatory action a reporting incidents ovides for the written affected by s serious t Safety Authority (P ney Created by Act 1	aled edical MCare) a, ent Safety ficer ttee, dents and against or event. SA): an 3 of eduction								

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Pennsylvania Department of Health

	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-0908		A. BLDG:	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 08/22/2017			
	OVIDER OR SUPPLIER: D PARENTHOOD KEYST STER	FONE -	STREET ADDRESS, CITY, STATE, ZIP CODE: 610 LOUIS DRIVE SUITE 303 WARMINSTER, PA 18974						
STATE LICEN	SE NUMBER: 00188701								
(X4) ID PREFIX TAG	MUST BE PRECEE	NT OF DEFICIENCIES (EACH DE DED BY FULL REGULATORY O ITIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SF CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE		
M 0032	0032 Continued from page 9			M 0032					
	to report certain even the safety of clients. System (PSRS): a ma statewide information occurrences or situati resulted in unanticipa 13-covered medical f measure of the extent the patient and the de patient G. Inciden situation involving th Services client that co did not either cause a require the delivery of to the client I. Sen occurrence or situation a client in the abortion compromises client s unanticipated injury f additional health serve C. Reporting of Ind	ree standing abortion in its that may or do com- its that may or do com- its that may or do com- andatory, confidential, in system for reporting ions that have (or coul- ated injury to a patient facility. D. Harm Scor- t to which an incident egree of harm caused to t: an event, occurrence the clinical care of an A- ould have injured the our unanticipated injury of additional health car- rious Event: an event, on involving the clinic on facility that results in affety and results in an requiring the delivery vices to the client. Pro- cidents 2. After ens- ed, the Patient Safety	apromise Reporting (a of events, (d have) (t in an Act re: a "reached" to the e or Abortion client but y or re services cal care of in death or h of occedure: suring all						

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Pennsylvania Department of Health

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 8-0908		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED: 08/22/2017	EY
	VIDER OR SUPPLIER:) PARENTHOOD KEYST(STER	DNE -	STREET ADDRESS, 610 LOUIS DI WARMINSTE	RIVE SUIT	E 303		
STATE LICENS	se number: 00188701						
(X4) ID PREFIX TAG	MUST BE PRECEED	^C OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE /	OULD BE	(X5) COMPLETE DATE
M 0032	Continued from page 10			M 0032			
	will determine if the in following criteria for r meant to be guidelines incident a "near miss" care of a client, and ha harm to the client? ii. additional health care s iii. Is the event a medic drug reaction? This co Review the details on a Serious Events i. Did t death, injury or hospita aggressive episode? ii error or an adverse dru result in clients being e infection? E. Notific have been affected by notified in writing with occurrence or discover 1) Review on August 2 the patient was admitte 2017, for a surgical abu	eporting. These crite only. a. Incidents i. which involved the o s the potential for se Were unanticipated services to the client cation error or an adv uld also be a serious a case-by case basis he event result in pa- alization? ii. Was the i. Is the event a med g reaction? iv. Did t exposed to a health a cation of Clients 1. C a serious event will b nin seven days of the ty of the serious ever 22, 2017, of MR13 re- ed to the facility on N	eria are Is the clinical rious injuries or avoided? verse event. b. tient e event an ication he event cquired Clients with be event"				

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Pennsylvania Department of Health

	T OF DEFICIENCIES AND DRRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 8-0908	A. BLDG:	PLE CONSTRUCTION: 00	(X3) DATE SURV COMPLETED: 08/22/2017	EY				
	OVIDER OR SUPPLIER: D PARENTHOOD KEYS NSTER	TONE -	STREET ADDRESS, CITY, STATE, ZIP CODE: 610 LOUIS DRIVE SUITE 303 WARMINSTER, PA 18974							
STATE LICE	NSE NUMBER: 00188701									
(X4) ID PREFIX TAG	MUST BE PRECE	ENT OF DEFICIENCIES (EACH DE EDED BY FULL REGULATORY OI NTIFYING INFORMATION)		PROVIDER'S PLAN OF CO CORRECTIVE ACTIC CROSS-REFERENCED TO	N SHOULD BE	(X5) COMPLETE DATE				
M 0032	032 Continued from page 11		M 0032							
documented the patient had a questionable perforation (the uterine wall was pierced w or holes) which occurred during the early p the procedure. Documentation revealed the refused transfer to the local hospital. The presented to the local hospital Emergency Department (ED) following discharge from Warminster. The patient was diagnosed w myometrial (the muscular layer of the uter perforation with minimal pelvic hemorrhag required observation in the ED and the del additional health care services while a pati ED.		ith a hole portion of patient patient n PPKey - ith a ne wall) ge, ivery of ent in the								
	EMP2 on August 22 PM confirmed MR1 for a surgical abortion the patient had a que which occurred during procedure; the patient	1 and phone interview 2, 2017, at approximate 3 was admitted to the f on; the physician docur estionable uterine perfo ng the early portion of nt refused transfer to th ed to the local ED follo facility. EMP1 and EM	ly 3:20 Facility mented pration the local owing							

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Pennsylvania Department of Health

	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/ PLAN OF CORRECTION (POC) IDENTIFICATIO 8-0908			(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING:		(X3) DATE SURVEY COMPLETED: 08/22/2017	
	VIDER OR SUPPLIER: PARENTHOOD KEYST(STER	ONE -	STREET ADDRESS, 610 LOUIS DF WARMINSTE	RIVE SUITI	E 303		
STATE LICENS	SE NUMBER: 00188701						
(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	(X5) COMPLETE DATE		
M 0032	Continued from page 12		M 0032				
	 confirmed the patient of myometrial perforation hemorrhage; the patient ED and required the docare services while a procedure at PPKey - Warminster. Phone interview with 1 approximately 3:25 PM abortion procedure ress requiring the delivery services met the definit EMP2 revealed the evoan incident. EMP2 co MR13, the event should incident to a Serious E event was not reported serious event. 2) Review on August 2 the facility determined event requiring the deliver. 	ic on in the health owing a , 2017, at s surgical rforation care ent. PSRS as eview of d from an ned this as a evealed aced an					

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Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER PLAN OF CORRECTION (POC) IDENTIFICATION NUMBE 8-0908			(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING:		(X3) DATE SURVEY COMPLETED: 08/22/2017				
NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - WARMINSTER			STREET ADDRESS, CITY, STATE, ZIP CODE: 610 LOUIS DRIVE SUITE 303 WARMINSTER, PA 18974						
STATE LICENSE NUMBER: 00188701 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF DEFICIENCIES (EACH DI TAG IDENTIFYING INFORMATION) M 0032 Continued from page 13				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE		
	services. The facility determined the patient's event met the definition of a serious event. The facility was not able to provide documentation the patient received written notification regarding the serious event. Interview with EMP1 and phone interview with								
	EMP2 on August 22, 2017, at approximately 3:25 PM confirmed MR13 experienced an event requiring the delivery of additional health care services, and MR13's event met the definition of a serious event. EMP2 confirmed the facility did not provide written notification to MR13 regarding this patient's serious event.								

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Certified End Page

PLANNED PARENTHOOD KEYSTONE - WARMINSTER STATE LICENSE NUMBER: 00188701 SURVEY EXIT DATE: 08/22/2017

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

Vancy & hescavage

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