Pennsylvania Department of Health

|                   | OF DEFICIENCIES AND                               | (XI) PROVIDER/SUPPLIER/C<br>IDENTIFICATION NUMBER     |          | (X2) MULTIP                        | LE CONSTRUCTION:                                 | (X3) DATE SURVE<br>COMPLETED: | ΞY                    |
|-------------------|---|---|----------|------------------------------------|--|-------------------------------|-----------------------|
| PLAN OF COR       | RRECTION (POC)                                    |   |          |                                    | 0  |                               |                       |
|                   |   | 8-0908  |          |                                    |  | 08/22/2017                    |                       |
|                   | VIDER OR SUPPLIER:<br>PARENTHOOD KEYST(           | ONE -   |          | S, CITY, STATE, ZII<br>DRIVE SUITE |  |                               |                       |
| WARMIN            |   |   | WARMINST | ER, PA 1897                        | 4  |                               |                       |
| STATE LICENS      | SE NUMBER: <b>00188701</b>                        |   |          |                                    |  |                               |                       |
| (X4) ID<br>PREFIX |   | I OF DEFICIENCIES (EACH DE<br>ED BY FULL REGULATORY O |          | ID<br>PREFIX TAG                   | PROVIDER'S PLAN OF CORRI<br>CORRECTIVE ACTION SI |                               | (X5)<br>COMPLETE      |
| TAG               |   | IFYING INFORMATION)                                   | R LOC    |                                    | CROSS-REFERENCED TO THE                          |                               | DATE                  |
| M 0000            | INITIAL COMMENT                                   |   |          | M 0000                             |  |                               |                       |
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|                   |   |   |          |                                    |  |                               |                       |
|                   |   |   |          |                                    |  |                               |                       |
|                   | This report is the result of                      |   |          |                                    |  |                               |                       |
|                   | survey conducted on Au<br>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                          |   |          |                                    |  |                               |                       |
|                   |   |   |          |                                    |  |                               |                       |
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| M 0032            |   |   |          | M 0032                             |  |                               |                       |
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|                   |   |   |          |                                    |  |                               |                       |
| LABORATORY        | I<br>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 |

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Pennsylvania Department of Health

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

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

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Pennsylvania Department of Health

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

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|                          | OF DEFICIENCIES AND<br>RRECTION (POC)  | (XI) PROVIDER/SUPPLIER/C<br>IDENTIFICATION NUMBER<br><b>8-0908</b>   |  | (X2) MULTIP<br>A. BLDG: <u>    (</u><br>B. WING: <u> </u> |   | (X3) DATE SURVEY<br>COMPLETED:<br>08/22/2017 |                          |
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|                          | WIDER OR SUPPLIER:<br>) PARENTHOOD KEYST<br>STER   | ONE -  | STREET ADDRESS,<br>610 LOUIS DI<br>WARMINSTE   | RIVE SUITE  | 303   |  |                          |
| STATE LICEN              | SE NUMBER: <b>00188701</b>   |  |  |   |   |  |                          |
| (X4) ID<br>PREFIX<br>TAG | MUST BE PRECEEI  | IT OF DEFICIENCIES (EACH DE<br>DED BY FULL REGULATORY O<br>FIFYING INFORMATION)  |  | ID<br>PREFIX TAG  | PROVIDER'S PLAN OF CORR<br>CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE | HOULD BE                                     | (X5)<br>COMPLETE<br>DATE |
| M 0032                   | Continued from page 4  |  |  | M 0032  |   |  |                          |
|                          | Based on review of farecords (MR), and starecords ( | iff interview (EMP), i<br>y failed to conform to<br>s.<br>Keystone - Warminste<br>) was not in complian<br>w: Act 13 of 2002, M<br>Reduction of Error (<br>tient safety committee<br>tility reports and notif<br>ons. "Incident." An e<br>n involving the clinic<br>facility which could<br>t did not either cause<br>or require the delivery<br>services to the patien<br>a serious event.<br>." An undesirable or<br>purrence or situation i<br>medical facility or th | it was<br>b all<br>er<br>nce with<br>Medical<br>MCARE)<br>e and<br>fications.<br>vent,<br>cal care of<br>have<br>an<br>of<br>nt. The<br>nvolving<br>ne |   |   |  |                          |

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|                          | OF DEFICIENCIES AND<br>RECTION (POC)   | (XI) PROVIDER/SUPPLIER/C<br>IDENTIFICATION NUMBER<br><b>8-0908</b>   |   | A. BLDG: _       | PLE CONSTRUCTION:  | (X3) DATE SURVE<br>COMPLETED:<br>08/22/2017 | EY                       |
|                          | VIDER OR SUPPLIER:<br>) PARENTHOOD KEYSTO<br>STER  | DNE -  | STREET ADDRESS,<br>610 LOUIS DF<br>WARMINSTE  | RIVE SUIT        | E 303  |   |                          |
| STATE LICENS             | SE NUMBER: <b>00188701</b>   |  |   |                  |  |   |                          |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT<br>MUST BE PRECEEDI  | <sup>°</sup> OF DEFICIENCIES (EACH DE<br>ED BY FULL REGULATORY O<br>FYING INFORMATION)   |   | ID<br>PREFIX TAG | PROVIDER'S PLAN OF CORREC<br>CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE 4 | OULD BE                                     | (X5)<br>COMPLETE<br>DATE |
| M 0032                   | Continued from page 5  |  |   | M 0032           |  |   |                          |
|                          | which could seriously<br>"Serious event." An ev-<br>involving the clinical of<br>facility that results in di-<br>safety and results in an<br>the delivery of addition<br>patient. The term does<br>Section 308 Reporting<br>notify patient. A medic<br>appropriate designee sl<br>notification to a patien<br>or, with the consent of<br>family member or desi<br>occurrence or discover<br>patient is unable to giv<br>be given to an adult mer<br>family. If an adult mer<br>cannot be identified or<br>given to the closest adu<br>unemancipated patient<br>age, the parent or guard<br>accordance with this su | vent, occurrence or s<br>care of a patient in a<br>leath or compromise<br>a unanticipated injury<br>hal health care service<br>and notification. (b)<br>cal facility through a<br>hall provide written<br>t affected by a seriou<br>the patient, to an av-<br>gnee, within seven d<br>ty of a serious event.<br>the consent, the notifice<br>ember of the immedia<br>located, notification<br>all family member.<br>s who are under 18 y<br>dian shall be notifice | situation<br>medical<br>spatient<br>y requiring<br>ces to the<br>dent.<br>Duty to<br>n<br>us event<br>ailable<br>lays of the<br>If the<br>cation shall<br>iate<br>the family<br>n shall be<br>For<br>years of<br>d in |                  |  |   |                          |

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Pennsylvania Department of Health

|                          | OF DEFICIENCIES AND<br>RRECTION (POC)   | (XI) PROVIDER/SUPPLIER/C<br>IDENTIFICATION NUMBER<br>8-0908  |  | (X2) MULTIP<br>A. BLDG: <u>0</u><br>B. WING: <u></u> |   | ON: (X3) DATE SURVEY<br>COMPLETED:<br>08/22/2017 |                          |  |
|--------------------------|---|--|--|--|---|--|--------------------------|--|
|                          | VVIDER OR SUPPLIER:<br>) PARENTHOOD KEYST<br>(STER  | ONE -  | STREET ADDRESS<br>610 LOUIS DI<br>WARMINSTI  | RIVE SUITE   | 303   |  |                          |  |
| STATE LICEN              | SE NUMBER: <b>00188701</b>  |  |  |  |   |  |                          |  |
| (X4) ID<br>PREFIX<br>TAG | MUST BE PRECEED   | T OF DEFICIENCIES (EACH DE<br>EED BY FULL REGULATORY O<br>IFYING INFORMATION)  |  | ID<br>PREFIX TAG                                     | PROVIDER'S PLAN OF CORRE<br>CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE | IOULD BE   | (X5)<br>COMPLETE<br>DATE |  |
| M 0032                   | 2 Continued from page 6   |  |  | M 0032   |   |  |                          |  |
|                          | requirements of this su<br>to the provisions of Se<br>under this subsection a<br>acknowledgement or a<br>Section 313. Medical<br>notifications. (a) Serie<br>facility shall report the<br>to the department and<br>of the medical facility<br>occurrence of the serie<br>failure reports. A med<br>occurrence of an infra<br>department within 24<br>confirmation of the occ<br>infrastructure failure.<br>boardsIf a medical<br>licensee providing hea<br>facility during a seriou<br>event in accordance w<br>medical facility shall n<br>board of the failure to<br>report or notifyFail | ection 311 (a). Notifies<br>shall not constitute and<br>admission of liability<br>facility reports and<br>ous event reports. A<br>e occurrence of a seri-<br>the authority within<br>'s confirmation of the<br>ous event (c) Infra-<br>ical facility shall rep-<br>structure failure to the<br>hours of the medical<br>ecurrence or discover<br>(e) Notification to<br>facility discovers that<br>alth care services in the<br>us event failed to rep-<br>rith section 308 (a), the<br>notify the licensee's 1<br>do report. (f) Failure | ication<br>n<br>r.<br>medical<br>ious event<br>24 hours<br>e<br>astructure<br>ort the<br>facility's<br>ry of the<br>licensure<br>at a<br>he medical<br>ort the<br>he<br>icensing<br>e to |  |   |  |                          |  |

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Pennsylvania Department of Health

|                          | OF DEFICIENCIES AND<br>RRECTION (POC)  | (XI) PROVIDER/SUPPLIER/C<br>IDENTIFICATION NUMBER:<br>8-0908   |  | A. BLDG: _       | IPLE CONSTRUCTION:  | (X3) DATE SURVE<br>COMPLETED:<br><b>08/22/2017</b> | ΞY                       |
|--------------------------|--|--|--|------------------|---|--|--------------------------|
|                          | VVIDER OR SUPPLIER:<br>D PARENTHOOD KEYSTC<br>STER   | DNE -  | STREET ADDRESS,<br>610 LOUIS DF<br>WARMINSTE   | RIVE SUIT        | E 303   |  |                          |
| STATE LICENS             | se number: <b>00188701</b>   |  | 1  |                  |   |  |                          |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT<br>MUST BE PRECEEDE  | T OF DEFICIENCIES (EACH DE<br>ED BY FULL REGULATORY OI<br>IFYING INFORMATION)  |  | ID<br>PREFIX TAG | PROVIDER'S PLAN OF CORREC<br>CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE / | OULD BE  | (X5)<br>COMPLETE<br>DATE |
| M 0032                   | Continued from page 7  |  |  | M 0032           |   |  |                          |
|                          | or an infrastructure fail<br>or to develop and comp<br>plan in accordance with<br>patient in accordance v<br>violation of the Health<br>addition to any penalty<br>under the Health Care 1<br>facility which fails to r<br>infrastructure failure on<br>accordance with this cl<br>administrative penalty<br>by the Department.<br>This is not met as evide<br>Based on review of face<br>records (MR) and staff<br>determined the facility<br>a confirmed uterine per<br>abortion was reported to<br>(Department) as a seried<br>applicable medical reco-<br>failed the facility failed | ply with the patient s<br>th section 307 or to n<br>with section 308 (b) s<br>a Care Facilities Act.<br>y which may be impor-<br>Facilities Act, a med<br>report a serious event<br>or to notify a licensur-<br>hapter may be subject<br>of \$1,000 per day in<br>lenced by:<br>cility documents, med<br>f interview (EMP), it<br>y failed to ensure a pa-<br>erforation following a<br>the Department of H<br>ous event for one of e-<br>ord reviewed (MR13 | safety<br>notify the<br>shall be a<br>In<br>osed<br>dical<br>it or an<br>re board in<br>ct to an<br>mposed<br>edical<br>t was<br>atient with<br>a surgical<br>lealth<br>one<br>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   |   | :<br>A. BLDG  | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>00</u><br>B. WING: <u></u> |             | ΈY                       |  |  |  |  |
|---|--|---|---|---|-------------|--------------------------|--|--|--|--|
|   | D PARENTHOOD KEYST   | ONE -   | STREET ADDRESS, CITY, STATE, ZIP CODE:<br>610 LOUIS DRIVE SUITE 303<br>WARMINSTER, PA 18974 |   |             |                          |  |  |  |  |
| STATE LICEN   | ISE NUMBER: <b>00188701</b>  |   |   |   |             |                          |  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG  | MUST BE PRECEED  | T OF DEFICIENCIES (EACH DE<br>ED BY FULL REGULATORY O<br>IFYING INFORMATION)  |   | G PROVIDER'S PLAN OF CC<br>CORRECTIVE ACTIO<br>CROSS-REFERENCED TO    | N SHOULD BE | (X5)<br>COMPLETE<br>DATE |  |  |  |  |
| M 0032  | Continued from page 8  |   | M 0032  |   |             |                          |  |  |  |  |
| provide written notification following deten<br>of a serious event for one of one applicable<br>record reviewed (MR13).<br>Findings include:  |  |   |   |   |             |                          |  |  |  |  |
| Review on August 22, 2017, or<br>Safety Plan," effective May 3<br>"Policy: In compliance with A<br>Care Availability and Reducti<br>Act, of the Commonwealth of<br>Planned Parenthood has estab<br>Plan which designates a Patient<br>(PSO), establishes a Patient Sa<br>identifies a system for the repu-<br>serious events, prohibits retail<br>health care workers for report<br>serious events, and provides for<br>notification to clients affected<br>Definitions: A. Patient Safety<br>independent state agency Creat<br>2002, the Medical Care Availability | e May 31, 2017, revea<br>e with Act 13, the Ma<br>Reduction of Error (I<br>realth of Pennsylvania<br>as established a Patie<br>a Patient Safety Offi-<br>atient Safety Commi-<br>the reporting of inci-<br>its retaliatory action a<br>reporting incidents<br>ovides for the written<br>affected by s serious<br>t Safety Authority (P<br>ney Created by Act 1 | aled<br>edical<br>MCare)<br>a,<br>ent Safety<br>ficer<br>ttee,<br>dents and<br>against<br>or<br>event.<br>SA): an<br>3 of<br>eduction |   |   |             |                          |  |  |  |  |

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Pennsylvania Department of Health

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

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

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Pennsylvania Department of Health

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

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|                          | STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/<br>PLAN OF CORRECTION (POC) IDENTIFICATIO<br>8-0908  |   |  | (X2) MULTIPLE CONSTRUCTION:<br>A. BLDG: <u>00</u><br>B. WING:               |                          | (X3) DATE SURVEY<br>COMPLETED:<br>08/22/2017 |  |
|--------------------------|---|---|--|---|--------------------------|--|--|
|                          | VIDER OR SUPPLIER:<br>PARENTHOOD KEYST(<br>STER   | ONE -   | STREET ADDRESS,<br>610 LOUIS DF<br>WARMINSTE | RIVE SUITI  | E 303                    |  |  |
| STATE LICENS             | SE NUMBER: <b>00188701</b>  |   |  |   |                          |  |  |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMEN<br>MUST BE PRECEED<br>IDENT  |   | ID<br>PREFIX TAG                             | PROVIDER'S PLAN OF CORRE<br>CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE | (X5)<br>COMPLETE<br>DATE |  |  |
| M 0032                   | Continued from page 12  |   | M 0032                                       |   |                          |  |  |
|                          | <ul> <li>confirmed the patient of myometrial perforation hemorrhage; the patient ED and required the docare services while a procedure at PPKey - Warminster.</li> <li>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.</li> <li>2) Review on August 2 the facility determined event requiring the deliver.</li> </ul> | ic<br>on in the<br>health<br>owing a<br>, 2017, at<br>s surgical<br>rforation<br>care<br>ent.<br>PSRS as<br>eview of<br>d from an<br>ned this<br>as a<br>evealed<br>aced an |  |   |                          |  |  |

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