| | NT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/OF (CORRECTION (POC) IDENTIFICATION NUMBER | | | | IPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: | |
|---|---|---------------------------|--------------------------------------|---|--------------------|-----------------------------|--|
| | | | | | | 04/01/2014 | |
| NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN | | | STREET ADDRESS, 29 NORTH 91 ALLENTOW | TH STREET | Γ | | |
| STATE LICENSE NUMBER: 00218701 | | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT MUST BE PRECEEDE IDENTII | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A | OULD BE | (X5) COMPLETE DATE | |
| M 0000 | This report is the result of an annual Registration survey conducted on February 27, 2014, at the Planned Parenthood of Northeast and Mid-Penn - Allentown Health Center. It was determined the facility was not in substantial 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 0032 | 0032 | | | M 0032 | | | |
| LABORATORY I | DIRECTOR'S OR PROVIDER/SUPPLI | ER REPRESENTATIVE'S SIGN. | ATURE | | TITLE: | (X6) DATE: | |
| | | | | | | | |

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| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER | | | (X2) MULTIPLE CONSTRUCTION: A. BLDG:00 | | (X3) DATE SURVEY COMPLETED: | |
|--|--|--|--------------------------------------|---|--|---|---|
| | | 8-3910 | | B. WING: | | 04/01/2014 | |
| NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: 00218701 | | | STREET ADDRESS, 29 NORTH 91 ALLENTOW | TH STREET | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D PREFIX MUST BE PRECEEDED BY FULL REGULATORY (TAG IDENTIFYING INFORMATION) | | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A | OULD BE | (X5) COMPLETE DATE |
| M 0032 | Continued from page 1 29.43(b) Facility Approval All medical facilities except approved facilities upon sub the Department from a persofacility and, at the discretion satisfactory completion of a This REGULATION is not | omission of an application authorized to represent of the Department, in on-site survey. | | M 0032 | The Patient Safety Officer and Associate Medical Director of Planned Parenthood Keystor (PPKey) have always careful reviewed the Patient Safety Authority definitions of serice event and incident reports, and previously determined that the event did not constitute a serievent or an incident. This we based upon a review of the plant safety reporting system, individual that an incident needs to have of the following components involved the clinical care of in a medical facility (yes), compromised patient safety resulted in an unanticipated that required additional health services (no). Abnormal bleeding after a surface abortion is not unusual nor is unanticipated. It has been Plant policy to report on incidents have compromised patient saresulted in an unanticipated (e.g. perforated uterus or hemorrhaging requiring a ble transfusion). | of ne | Completion Date: 04/10/2014 Status: APPROVED Date: 05/08/2014 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION: A. BLDG:00 | | (X3) DATE SURVEY COMPLETED: | |
|---|-----------------------|---|---------------------------------------|---|---|--|--|
| | | 8-3910 | | | <u></u> | 04/01/2014 | |
| NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: 00218701 | | ONE - | STREET ADDRESS, 29 NORTH 9T ALLENTOWN | TH STREET | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY CONTROL TAG IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A | OULD BE | (X5) COMPLETE DATE | |
| M 0032 | Continued from page 2 | | | M 0032 | In response to a recent communication from official Department of Health, Plant Parenthood Keystone will m current practice to include re on any ambulance transfer a serious event. This will begin 04/10/14 The Center Manager or Regin Manager of the facility will be responsible to report any am transfer, in addition to any caction that may compromise safety to the Patient Safety Cand/or the Associate Medical Director. The Patient Safety Officer and Associate Medical Director review the case and submit at to the Patient Safety Authoritime frame required. A Plan of Correction will be determined and communicate PPKey medical facility involved the patient Safety of Correction will a discussed at the Abortion Ceemanagers' regular conference and be added to the agendative Patient Safety Committee. | ned odify its eporting is a solutional be bulance other patient Difficer l individual in report ty in the solved. The bulance of the olived. The bulance of the olived is also be enter e call of both | |

State Form EJJ711 IF CONTINUATION SHEET Page 3 of 16

| STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER. PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER | | | (X2) MULTIPLE CONSTRUCTION: | | (X3) DATE SURVEY COMPLETED: | | |
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| | , , | 8-3910 | | A. BLDG: _ B. WING: _ | | 04/01/2014 | |
| NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: 00218701 | | NE - | STREET ADDRESS, 29 NORTH 9T ALLENTOWN | H STREET | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D PREFIX MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION) | | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A | OULD BE | (X5) COMPLETE DATE |
| M 0032 Con | entinued from page 3 | | | M 0032 | Risk and Quality Manageme committee meetings. Those committee agenda results ar shared at the affiliate's Board Directors meetings. This will be monitored by th Regional Managers. Failure to file events as spec result in disciplinary action Findings re storage of charts 1) Lids were immediately on the box containing file for while the surveyors were on 2) The file folder boxes with moved by 4/18/14 to another location which is secure from damage — a locked office. The carried out by the Center Manager and monitored by the Regional Manager. 3) Failure to secure confid and safety of files will result disciplinary action | re also d of e ified will : r placed lders site. iil be r m water this will he | |

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| | OF DEFICIENCIES AND RECTION (POC) | (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER | | (X2) MULTI | IPLE CONSTRUCTION: | (X3) DATE SURVE COMPLETED: | ΕY | | |
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| | F CORRECTION (POC) IDENTIFICATION NUM 8-3910 | | | A. BLDG: _ B. WING: _ | | 04/01/2014 | | | |
| | | 8-3910 | | D. WING. | | 04/01/2014 | | | |
| | VIDER OR SUPPLIER: | NATE | STREET ADDRESS, CITY, STATE, ZIP CODE: 29 NORTH 9TH STREET | | | | | | |
| ALLENTO |) PARENTHOOD KEYSTO WN | JNE - | ALLENTOW | | | | | | |
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| M 0032 | Continued from page 4 | | | М 0032 | | | | | |
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| | D 1 | .11.4 | 401 | | | | | | |
| | Based on review of factorics (MR), and staff | | | | | | | | |
| | determined the facility | * | | | | | | | |
| | applicable State Laws. | | all | | | | | | |
| | applicable State Laws. | | | | | | | | |
| | Planned Parenthood of | Northeast Mid-Pen | n and | | | | | | |
| | Bucks County Planned | · · · · · · · · · · · · · · · · · · · | * | | | | | | |
| | in compliance with the | | | | | | | | |
| | of 2002, Medical Care | • | | | | | | | |
| | of Error (MCARE) Ac | - | | | | | | | |
| | safety committee and 1 | 1303.313 Medical fa | cility | | | | | | |
| | reports and notification | ıs. | - | | | | | | |
| | | | | | | | | | |
| | Section 302. Definition | ns. "Incident." An e | vent, | | | | | | |
| | occurrence or situation | involving the clinic | al care of | | | | | | |
| | a patient in a medical f | facility which could | have | | | | | | |
| | injured the patient but | did not either cause | an | | | | | | |
| | unanticipated injury or | require the delivery | of | | | | | | |
| | additional health care s | • | t. The | | | | | | |
| | term does not include a | | | | | | | | |
| | "Infrastructure failure." | | | | | | | | |
| | unintended event, occu | | _ | | | | | | |
| | the infrastructure of a r | medical facility or th | e | | | | | | |
| | | | | | | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 | | (X3) DATE SURVEY COMPLETED: | |
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| | | 8-3910 | | B. WING: | | 04/01/2014 | |
| PLANNED ALLENTO | VIDER OR SUPPLIER: PARENTHOOD KEYSTO WN SE NUMBER: 00218701 | ONE - | STREET ADDRESS, 29 NORTH 9T ALLENTOWN | TH STREET | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION) | | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE | HOULD BE | (X5) COMPLETE DATE |
| M 0032 | discontinuation or sign which could seriously "Serious event." An evinvolving the clinical of facility that results in an the delivery of addition patient. The term does Section 313. Medical notifications. (a) Serious facility shall report the to the department and of the medical facility occurrence of the serious failure reports. A medical occurrence of an infrast department within 24 hours confirmation of the occurrence of the serious department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast department within 24 hours and the confirmation of the occurrence of an infrast depar | compromise patient vent, occurrence or stare of a patient in a leath or compromise unanticipated injury hal health care services not include an incide facility reports and ous event reports. A report occurrence of a serification of the sus event (c) Infra cal facility shall report reports of the medical currence or discovery (e) Notification to facility discovers that the care services in the services in the compromise of the medical currence or discovery (e) Notification to facility discovers that the care services in the services in the services in the services are services in the services of a patient of the medical currence or discovery that the care services in the services in the services in the services of the medical currence or discovery that the care services in the services in the services in the services of a patient of the services in the services of a patient of the services of the services in the services of the serv | safety. situation medical s patient y requiring ces to the dent. medical ous event 24 hours e structure ort the e facility's y of the licensure t a he medical | M 0032 | | | |

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| NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: 00218701 (X4) ID PREFIX TAG Continued from page 6 event in accordance with section 308 (a), the A. B.LDG: _00 B. WING: STREET ADDRESS, CITY, STATE, ZIP CODE: 29 NORTH 9TH STREET ALLENTOWN, PA 18101 PROVIDERS PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE M 0032 O4/01/2014 | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER | | | (X2) MULTI | IPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: | | | | | |
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| PLANNED PARENTHOOD KEYSTONE - ALLENTOWN, PA 18101 STATE LICENSE NUMBER: 00218701 (X4) ID PREFIX TAG NUMBER PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) M 0032 Continued from page 6 event in accordance with section 308 (a), the | | | 0-3910 | | | | | | | | |
| ALLENTOWN, PA 18101 STATE LICENSE NUMBER: 00218701 (X4) ID PREFIX TAG CORRECTION (EACH COMPLETE TAG LIDENTIFYING INFORMATION) MO32 Continued from page 6 Event in accordance with section 308 (a), the | | | ONE - | | | | | | | | |
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| (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE COMPLETE CONSTRUCTION page 6 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH COMPLETE CO | | 00210701 | | | | | | | | | |
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| event in accordance with section 308 (a), the | TAG | IDENTIFYING INFORMATION) | | | | CROSS-REFERENCED TO THE | APPROPRIATE | DATE | | | |
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| | | | * | | | | | | | | |
| medical facility shall notify the licensee's licensing | | 1 | • | • | | | | | | | |
| board of the failure to do report. (f) Failure to | | | • | | | | | | | | |
| report or notifyFailure to report a serious event | | _ · | - | | | | | | | | |
| or an infrastructure failure as required by this section | | | 1 | | | | | | | | |
| or to develop and comply with the patient safety plan in accordance with section 307 or to notify the | | | | | | | | | | | |
| | | l ^ | | • | | | | | | | |
| patient in accordance with section 308 (b) shall be a violation of the Health Care Facilities Act. In | | l ^ | * * | | | | | | | | |
| | | | | | | | | | | | |
| addition to any penalty which may be imposed under the Health Care Facilities Act, a medical | | 1 | - | | | | | | | | |
| facility which fails to report a serious event or an | | | · | | | | | | | | |
| infrastructure failure or to notify a licensure board in | | - | - | | | | | | | | |
| accordance with this chapter may be subject to an | | | • | | | | | | | | |
| administrative penalty of \$1,000 per day imposed | | | | | | | | | | | |
| by the Department. | | | 01 \$1,000 pcr day ii | прозси | | | | | | | |
| by the Department. | | by the Department. | | | | | | | | | |
| This is not met as evidenced by: | | This is not met as evidenced by: | | | | | | | | | |
| | | | | | | | | | | | |
| Based on review of facility documents, medical | | Based on review of fac | cility documents, me | dical | | | | | | | |
| records (MR) and staff interview (EMP), it was | | records (MR) and staff | f interview (EMP), it | was | | | | | | | |
| determined the facility failed to ensure a patient | | determined the facility | failed to ensure a pa | atient | | | | | | | |
| transfer from the facility to an acute care hospital | | transfer from the facilit | ty to an acute care h | ospital | | | | | | | |
| | | | | | | | | | | | |

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| STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER: | | | COMPL | | (X3) DATE SURVE COMPLETED: | | |
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| | | 8-3910 | | | | 04/01/2014 | |
| NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: 00218701 | | | STREET ADDRESS, 29 NORTH 97 ALLENTOWN | TH STREET | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT MUST BE PRECEEDE | OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A | OULD BE | (X5) COMPLETE DATE |
| M 0032 | emergency department Department for one of reviewed (MR6). Findings include: Review on February 22 "Patient Safety Plan," of "Describe responsibilit Officer] 1. To handle a within 24 hours 2. To extend the reports of incidents and action as is immediatel safety against any harm investigation of a report event which includes department of PSA [Patient Safety Amproviding written notifications event within 7 PS.1303.302, 35PS 10 3206) 4. Report to the Committee] regarding patient safety as a result report of an incident or | 7, 2014, of the facilitated January 2013, ies of the PSO [Patiell reports of serious ensure the investigated serious events 3. Try necessary to ensure identified from the eveloping a plan, not athority] (if appropriation o [sic] the padays (as per 40 101-10105, 18 Ps C. PSC [Patient Safety any action taken to plat of an investigation of the padays of the padays (as per 40 101-10105, 18 Ps C. PSC [Patient Safety any action taken to plat of an investigation | ty's revealed ent Safety events ion of all to take re patient erious otifying iate) and atient of a S.A. | M 0032 | | | |

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| | | (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER | e: | | (X3) DATE SURVEY COMPLETED: | | |
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| | | 8-3910 | | | 00 | 04/01/2014 | |
| PLANNED ALLENTO | VIDER OR SUPPLIER: PARENTHOOD KEYSTOWN E NUMBER: 00218701 | ONE - | STREET ADDRESS, 29 NORTH 9T ALLENTOWN | TH STREET | ? | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT MUST BE PRECEEDE | OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE | OULD BE | (X5) COMPLETE DATE |
| M 0032 | Review of MR6 on Fel the patient presented to 2013, for an elective in performed internal succeptoducts of conception an ultrasound be performed. CF1 document empty. CF1 completed the patient's uterus. CI of conception were found ultrasound be performed products of conception review of MR6 revealed excessive bleeding with instructed CF2 to admit (medication used to mailligrams (mg) intransexcessive bleeding context. EMP3 to call 911 to remain the MR6 to the hospital's excessive with EMP2 and the mailligrams with EMP2 and the mailligram with EMP2 and the mailligra | the facility on Mara- disclinic abortion. CFI tion and documented were found. CF1 re- rmed. Further review at the patient's uter dia second internal si F1 documented no parada and requested a si ed. CF1 documented were found. Continued the patient began the noticeable large classifier Methergine anage hemorrhage) (muscularly (IM). The attinued and CF1 instances ambulance trans- temergency department. | ch 15, F1 d no equested w rus was uction of roducts second d no nued with ots. CF1 D.2 e patient's ructed nsport of nt (ED). | M 0032 | | | |

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| | STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER | | | | | (X3) DATE SURVEY COMPLETED: | |
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| | | 8-3910 | | A. BLDG: _ B. WING: _ | 00 | 04/01/2014 | |
| PLANNED ALLENTO | VIDER OR SUPPLIER: PARENTHOOD KEYSTO WN SE NUMBER: 00218701 | ONE - | STREET ADDRESS, 29 NORTH 9T ALLENTOWN | TH STREET | | | |
| (X4) ID PREFIX TAG | PREFIX MUST BE PRECEEDED BY FULL REGULATORY TAG IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A | OULD BE | (X5) COMPLETE DATE |
| M 0032 | Continued from page 9 2014, at approximately performed internal succeach time there were not found. Continued internal excessive bleeding transferred to the hospit following an in-clinic at A request was made of February 27, 2014, for investigation and the fattransfer from the facility emergency department report to the Department were provided. Phone interview with Fat approximately 2:15 I submit this occurrence submitted as an incider | tion two times on Moor products of conceptiview confirmed the standard ED for excessive abortion. TEMP1 and EMP2 of the facility's internated in the standard ED for excessive abortion. TEMP1 and EMP2 of the facility's report of MI ty to an acute care here. No investigation of the or Patient Safety. EMP1 on February 2 PM revealed if the facility would have been | R6, and option patient gine, and e bleeding on I R6's ospital or facility Authority 7, 2014, acility did | M 0032 | | | |

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| | TATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIEF LAN OF CORRECTION (POC) IDENTIFICATION NUMBER | | | (X2) MULTI A. BLDG: _ | PLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: | |
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| | | 8-3910 | | B. WING: _ | | 04/01/2014 | |
| PLANNED ALLENTO | VIDER OR SUPPLIER: PARENTHOOD KEYSTO WN SE NUMBER: 00218701 | ONE - | STREET ADDRESS, 29 NORTH 91 ALLENTOW | TH STREET | 1 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT MUST BE PRECEEDE | OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHORES REFERENCED TO THE ACTION THE ACTION TO THE ACTION OF THE | OULD BE | (X5) COMPLETE DATE |
| M 0032 | Based on review of face records (MR), and staff determined the facility applicable State Laws. Planned Parenthood of Bucks County Planned in compliance with the of 2002, Medical Care of Error (MCARE) Ac safety committee and 1 reports and notification. Section 310. Patient sa ResponsibilitiesA parmedical facility shall d (1) Receive reports fro pursuant to section 309 (2) Evaluate investigat safety officer on all reg (3) Review and evaluate measures utilized by the shall include the consideration. | f interview (EMP), if failed to conform to failed to conform to failed to conform to Parenthood Central following state law: Availability and Ret 40.\\$1303.310 Paties 303.313 Medical fains. fety committee. (b) trient safety committee oall of the following methe patient safety continues and actions of the corts. te the quality of paties the medical facility. As a safety of the contact of the corts. | t was o all on, and was not : Act 13 duction ent cility wee of a g: officer he patient ent safety a review | M 0032 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> | | (X3) DATE SURVEY COMPLETED: | | |
|--|--|--|---|------------|---|-------------|------------------|
| | 8-3910 | | | | | 04/01/2014 | |
| NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: 00218701 | | | STREET ADDRESS, 29 NORTH 9T ALLENTOWN | TH STREET | • | | |
| (X4) ID | | OF DEFICIENCIES (EACH DE | EICIENCV | ID | DROVIDEDIC DI ANI OF CODDEC | CTION (FACH | (X5) |
| PREFIX TAG | MUST BE PRECEEDE | ED BY FULL REGULATORY OF FYING INFORMATION) | | PREFIX TAG | PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A | OULD BE | COMPLETE DATE |
| M 0032 | Continued from page 11 | | | М 0032 | | | |
| | under sections 304(a)(3308(a). (4) Make recommendate serious events and incise (5) Report to the adming governing body of the basis regarding the nursincidents and its recommendations events and incise This is not met as evident Based on review of fact records (MR) and staff determined the facility make recommendation transfer from the facility emergency department records reviewed (MR). Findings include: Review on February 22 "Patient Safety Plan," of the serious events and incise the serious events and inci | tions to eliminate furdents. Inistrative officer and medical facility on a mber of serious even mendations to eliminate dents. The control of the facility documents, me control of the facility documents, me control of the form one of one medical form one of one medical of the facility documents. | dical was aluate and 's ospital ical | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION: A. BLDG:00 | | (X3) DATE SURVEY COMPLETED: | |
|---|--|---|--|---|---|--------------------------------|--------------------------|
| 8-3910 | | | | <u></u> | 04/01/2014 | | |
| NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN | | | STREET ADDRESS, 29 NORTH 91 ALLENTOW | TH STREET | | | |
| · · · · · · · · · · · · · · · · · · · | | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE | OULD BE | (X5) COMPLETE DATE |
| M 0032 | " Responsibilities 1. Receive reports/investigating and log for PSO [Patient Safety Officer] 2. Evaluating investigations 3. Review [and] evaluate the quality of patient safety measures utilized by the agency 4. Establish a system for health care work to reports serious events and incidents 24/7" Review of MR6 on February 27, 2014, revealed this patient presented to the facility on March 15, 2013, for an elective in-clinic abortion, this patient began with excessive bleeding with noticeable late clots and was transported by ambulance transport to the hospital emergency department (ED). A request was made of EMP1 and EMP2 on February 27, 2014, for the facility's internal investigation and the facility to an acute care hospital emergency department. No investigation or report to the Department and Patient Safety Authority were provided. Review on February 27, 2014, of the facility's | | Evaluate e the by the e workers" ealed rch 15, s patient able large ansport). on l R6's ospital or report | M 0032 | | | |

State Form EJJ711 IF CONTINUATION SHEET Page 13 of 16

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION: | | (X3) DATE SURVEY COMPLETED: | | |
|--|--|--|--|---|--------------------------|--------------------------------|------|--|
| 8-3910 | | | A. BLDG:00 B. WING: 04/01/2 | | 04/01/2014 | /2014 | | |
| NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: 00218701 | | | STREET ADDRESS, CITY, STATE, ZIP CODE: 29 NORTH 9TH STREET ALLENTOWN, PA 18101 | | | | | |
| (X4) ID | | OF DEFICIENCIES (EACH DE | FICIENCY | ID | PROVIDER'S PLAN OF CORRE | CTION (FACH | (X5) | |
| PREFIX TAG | MUST BE PRECEEDE IDENTII | | PREFIX TAG | CORRECTIVE ACTION SH CROSS-REFERENCED TO THE | OULD BE | COMPLETE DATE | | |
| M 0032 | Continued from page 13 | | | M 0032 | | | | |
| | | | | | | | | |
| | Patient Safety Commit | tee Meeting minutes | s from | | | | | |
| | January 2013 through . | | | | | | | |
| | documentation MR6's | | | | | | | |
| | was discussed at the facility's Patient Safety | | | | | | | |
| | Committee meeting or that the facility reviewed, | | | | | | | |
| | evaluated or made recommendations regarding | | | | | | | |
| | MR6's excessive bleed | clinic | | | | | | |
| | abortion. | | | | | | | |
| | L. STEMPS LEMPS EL 07 | | | | | | | |
| | Interview with EMP2 and EMP3 on February 2' 2014, at approximately 2:25 PM confirmed the | | | | | | | |
| | facility's Patient Safety | | | | | | | |
| | did not include a discus | _ | | | | | | |
| | transfer to the hospital | | | | | | | |
| | reviewed, evaluated or | ions | | | | | | |
| | regarding MR6's exces | ing an | | | | | | |
| | in-clinic abortion. | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | Dagad on ravious of fa- | ility doguments -1- | amustica | | | | | |
| | Based on review of fac and staff interview (EM | • | | | | | | |
| | , | , · | | | | | | |
| | facility failed to ensure patient medical records were | | | | | | | |
| | | | | | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION: | | (X3) DATE SURVEY COMPLETED: | | |
|--|---|---|--|-----------------------------|--|--------------------------------|--------------------------|--|
| 8-3910 | | | A. BLDG: B. WING: | | 04/01/2014 | | | |
| NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: 00218701 | | | STREET ADDRESS, CITY, STATE, ZIP CODE: 29 NORTH 9TH STREET ALLENTOWN, PA 18101 | | | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE | | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A | OULD BE | (X5) COMPLETE DATE | |
| M 0032 | SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY OF | | ty's vised I medical medical gibly at n a sistent m on ontaining plastic d the name early ary 27, ed these | M 0032 | | | | |

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| PLAN OF CORRECTION (POC) IDI | | (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 8-3910 | | | (X3) DATE SURVEY COMPLETED: 04/01/2014 | | | |
|--|---|--|---|--|--|--|--|--|
| NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD KEYSTONE - ALLENTOWN STATE LICENSE NUMBER: 00218701 | | | STREET ADDRESS, CITY, STATE, ZIP CODE: 29 NORTH 9TH STREET ALLENTOWN, PA 18101 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT MUST BE PRECEEDI | | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A | (X5) COMPLETE DATE | | | |
| M 0032 | abortions over the last three years. Further interview with EMP2 confirmed these boxe containing confidential patient information covered with a box cover to protect patient; and prevent disclosure of a patient's name. 2) Observation of the facility's storage room. February 27, 2014, revealed three water-state ceiling tiles directly above 59 storage boxes on plastic shelving units. Interview with EMP2 and EMP3 on Februar 2014, at the time of the observation revealed file folders contain information of patients was abortions over the last three years. Further interview with EMP2 and EMP3 confirmed boxes containing patient medical records we stored in a manner to protect from water darks. | | es should be privacy m on ained s stored ary 27, ed these who had d these vere not | M 0032 | | | | |

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Certified End Page

PLANNED PARENTHOOD KEYSTONE - ALLENTOWN

STATE LICENSE NUMBER: 00218701 SURVEY EXIT DATE: 04/01/2014

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Nancy J. Lescavage

Deputy Secretary for Quality Assurance

Nancy J. Lescavag

Rachel L. Levine, MD Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY