STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		140006	B. WING		04	/01/2014	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
PLANNED	PARENTHOOD OF GRI	EATER TEXAS SURCE WACO, T	SS AVENUE X 76701				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
A 000	TAC 139 Initial Comr	nents	A 000				
	Note: The State Form document. All inform unchanged except for correction, correction space. Any discrepa citation(s) will be refe Texas Attorney Gene If information is inado provider/supplier, the should be notified im	n is an official, legal ation must remain or entering the plan of a dates, and the signature ancy in the original deficiency erred to the Office of the aral (OAG) for possible fraud.					
SOD - State F	orm						
		SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE	

STATE FORM 6899 H70511 If continuation sheet 1 of 1

PRINTED: 05/06/2014 FORM APPROVED Texas Department of State Health Services STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 007339 04/25/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5607 SCHUMACHER **AARON WOMENS CENTER/WOMENS PAVILION** HOUSTON, TX 77057 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) A 000 TAC 139 Initial Comments A 000 Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. TEX. GOV'T CODE. § 552.101 + TEX. HEALTH & SAFETY CODE §§ 245.011 & 245.023 Deficiency was cited. The Staff was given an opportunity to provide additional information. Instruction to complete and submit an acceptable plan of correction was given verbally and in writing. The facility's staff was informed the Department will review the findings and make a final determination regarding

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(a) A licensed abortion facility shall have a readily accessible written protocol for managing medical emergencies and the transfer of patients

possible enforcement actions.

Emergency Services 139.56.

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7 11 13 37 12 31 13 13				
		007339	B. WING		04	04/25/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE			
AARON W	OMENS CENTER/WOM	IENS PAVILION	CHUMACHER ON, TX 77057				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
A 000	Continued From pag	e 1	A 000				
	requiring emergency	care to a hospital. The hat the the physicians who					
	that provides obstetr	itting privileges at a hospital ical or gynecological health located not further than 30 on facility;					
	(2) provide the pregr	nant woman with:	BRY ACTION CONTROL CON				
	woman may reach the personnel employed facility with access to medical records 24 he assistance for any country the performance or in	umber by which the pregnant ne physician or health care by the physician or by the othe woman's relevant nours a day, to request complications that arise from induction of the abortion or uestions regarding the					
	nearest hospital to the woman at which an element abortion could be tree (b) The facility shall equipment and personal resuscitation as describing to Anest (c) Personnel providing be currently certified American Heart Assoc Cross, or the American Institute, or in according the woman and the state of the	have the necessary connel for cardiopulmonary cribed in 139.59 of this hesia Services). Ing direct patient care shall in basic life support by the ociation, the America Red an Safety and Health lance with their individual e requirements, and if					
	This Requirement is	Not Met, as Evidenced By:				I DATA DA VICINI DE DESCRIPTO	
SOD - State Fo		Not Met, as Evidenced By:	TO CONTRACT OF THE CONTRACT OF				

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		7. BOILBING						
		007339	B. WING		04/25/2014			
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
AARON W	OMENS CENTER/WOME	ENS PAVILION	UMACHER N, TX 77057					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETE			
A 000	Continued From page	2	A 000					
	failed to provide the nof the nearest hospital pregnant woman at wifrom the abortion coul women who had a profuse. Findings: Review of procedure 1-9 revealed the nine procedure at the facilian Review of discharge dated by the nine (9). Follow- Up Care" reveinformation with the nof the nearest hospital emergency arising from	information for patient #s (9) patients had an abortion ity on 4/23/2014. instructions signed and patients titled "Instruction for ealed there was no ame and telephone number all to their homes at which an om the abortion procedure instructions documented						
	"Warning Signs"							
	problems such as: Fever(if your tempera Severe cramping or a Heavy bleeding (more bleeding for more tha days,heavier than you Don't Worry in Advance the above occurring a you call this clinic if yo we will be best suited for you or advise you	ature goes above 100.4) bdominal pains. e than two pads an hour) or n two(2) consecutive						

SOD - State Form

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION	IUMBER:	A. BUILDING:		COM	PLETED	
		007339		B. WING		04	/25/2014	
NAME OF DE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE ZID CADE			
NAME OF P	ROVIDER OR SUPPLIER				TE, ZIP CODE			
AARON WOMENS CENTER/WOMENS PAVILION 5607 SCHUMACHER HOUSTON, TX 77057								
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENC		ID	PROVIDER'S PLAN OF CO	RRECTION	////	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED I LSC IDENTIFYING INFOR	BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
A 000	Continued From page	e 3		A 000				
	reasonable be made							
	within 30 minutes of t							
	notifying our facility, t	•		of-				
	an emergency room							
	hospital. Calls will be	•	-	1				
	Nurse or licensed Vo	•	•	open a dela della				
	No matter how far aw			A A A A A A A A A A A A A A A A A A A				
	problem occurs be sure to call us immediately. Your calls will be answered 24 hours a day. Complaint against the facility may be made to:"(the department number and address was listed.). Review of the facility's policy/procedure dated 1/4/2014 revealed a policy titled: "Emergency		•	Particular and a second				
			3 113teu.).	STATE AND ADDRESS OF THE STATE AND ADDRESS OF THE STATE ADDRESS OF THE S				
			dated					
			To the same of the					
	Hospital Number" revealed the following							
	information:	realed the lenething		m movement of the second				
				ann ny manada				
	"All patients will be pr	rovided with the nar	me and	an envertil ar				
	telephone number of			demonstrative in the second				
	home of the patient a	•		onada de la companya della companya				
	arising from the abort			BOTO COLORADO CARRADO CARRAD			j	
	anoning from the abortion would be trouted.			Avventores				
				DOG NOT THE PERSON NAMED IN COLUMN NAMED IN CO				
				0				
000000	During an interview a	t the facility on 4/25	5/2014 at					
	10:15 am with Staff ((A) Licensed Vocati	onal					
Nurse she stated she was the facility's nurse and		urse and						
	administrator. Accord	ling to Staff (A) the	facility	e a a a a a a a a a a a a a a a a a a a				
	was aware of the rec	quirement to give th	e women					
	the name and telepho			Biggs and a control of the control o				
	near their home wher	re they can go for		Manual Annual An				
	emergency care. She	stated a policy wa	s	State of the State				
	developed, however,	the policy was not	yet	A B a Still account				
	implemented							
				Broad Annual Control				
	During an interview o		-	Name of the Associated Page 1				
	with Staff (B) Office I			NO. SEED OFFICE AND ADDRESS OF THE A				
was aware of the requirement but it did not say		sanda o com a maria						
	the the facility should		•	ALL STORY SHAWAR				
	information was giver	1		P0000000000000000000000000000000000000				

SOD - State Form

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING:				
		007339	B. WING		04	04/25/2014	
NAME OF PE	ROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, STA	TE, ZIP CODE			
AARON WOMENS CENTER/WOMENS PAVILION 5607 SCHUMACHER HOUSTON, TX 77057							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
	· · · · · · · · · · · · · · · · · · ·		Control of the Contro				
						AAA PER KANTAN III KANTAN II KANTAN III KANT	
distribution of the control of the c							
under Stein Gereitstelle unseinen Steine Gereitstelle unseinen Steine Gereitstelle unseinen Steine Gereitstelle unseine Gereitstelle und der Steine Gereitstelle und der Gereitstelle und der Steine Gereitstelle und der Gereitstelle und der Gereitstelle un							
						IIII TA IA TA	
						47.1	
			o de care care care care care care care car				
			DISTRIBUTION OF THE PROPERTY O				
						and the state of t	
						Anadrija va An	
The state of the s			ACCUPATION AS STREET, ACCUPATION				
OR THE PARTY AND A			W COMMANDO COMPANIA DE COMPANI				
			MATERIAL PROPERTY AND ASSESSMENT				

SOD - State Form