

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0031

Outpatient Clinic

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:
Connecticut Public Health Code Section 19-13-D54

Planned Parenthood of Southern New England of New Haven CT d/b/a Planned Parenthood of Southern, New England, Inc. is hereby licensed to maintain and operate a Family Planning Clinic.

Planned Parenthood of Southern New England, Inc. is located at 969 West Main Street, Waterbury, CT 06702.

This license expires **June 30, 2019** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, July 1, 2015. RENEWAL



Jewel Mullen, MD

Jewel Mullen, MD, MPH, MPA
Commissioner

STATE OF CONNECTICUT

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Jewel Mullen MD

Jewel Mullen, MD, MPH, MPA
Commissioner

In accordance with Section 19a-491 and/or Section 19a-506 of the Connecticut General Statutes, application is hereby made for a license to operate the following (please check the appropriate box that applies):

- | | |
|--|---|
| <input type="checkbox"/> Assisted Living Services Agency | <input type="checkbox"/> Infirmary Operated by an Educational Institution |
| <input type="checkbox"/> Children's Hospital | <input type="checkbox"/> Maternity Home |
| <input type="checkbox"/> Chronic and Convalescent Nursing Home | <input type="checkbox"/> Maternity Hospital |
| <input type="checkbox"/> Chronic Disease Hospital | <input type="checkbox"/> Outpatient Clinic/Primary Care/Dental |
| <input checked="" type="checkbox"/> Family Planning Clinic | <input type="checkbox"/> Outpatient Dialysis Unit |
| <input type="checkbox"/> General Hospital | <input type="checkbox"/> Outpatient Surgical Facility |
| <input type="checkbox"/> Home Health Care Agency | <input type="checkbox"/> Residential Care Home |
| <input type="checkbox"/> Homemaker-Home Health Aide Agency | <input type="checkbox"/> Rest Home with Nursing Supervision |
| <input type="checkbox"/> Hospice/19a-495-5a & 19-13-D1(C) | <input type="checkbox"/> In-Patient Hospice Unit |
| <input type="checkbox"/> Hospital for Mentally Ill Persons | <input type="checkbox"/> Well Child Clinic |

4. Bed Capacity Requested (if applicable). If submitting this application for multiple levels of care, please list the bed capacity for each level of care being requested.

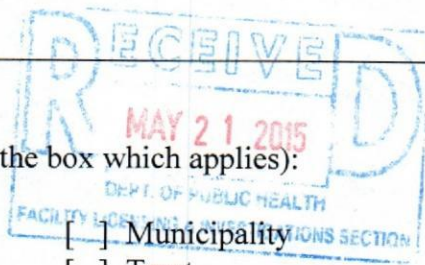
<u>Level of Care</u>	<u>Beds/ Hemodialysis Stations</u>	<u>Bassinets (if applicable)</u>
N/A	_____	_____
_____	_____	_____
_____	_____	_____

5. Disclose the **legal entity which owns/operates the facility**. (Note: The license will be issued to this entity.)

Planned Parenthood of Southern New England
Licensee

345 Whitney Ave. New Haven CT 06511 (203) 865-5158
Business Address City State Zip Code Telephone

Same
Mailing Address (if applicable)



6. Is the above named legal entity a (please check the box which applies):

- | | |
|--|---|
| <input type="checkbox"/> Individual/Sole proprietor | <input type="checkbox"/> Municipality |
| <input type="checkbox"/> General Partnership | <input type="checkbox"/> Trust |
| <input type="checkbox"/> Limited Partnership | <input type="checkbox"/> Profit Corporation |
| <input type="checkbox"/> Limited Liability Company | |
| <input type="checkbox"/> Other: _____ | |
| <input checked="" type="checkbox"/> Non-profit Corporation | |

7. Please disclose the name, business address and telephone number of the Agent for Service for the Licensee.

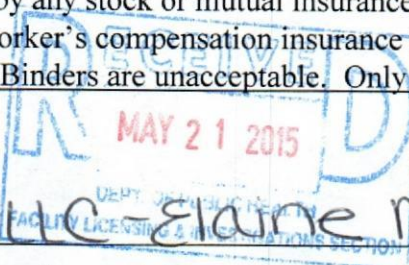
Judy Tabar 345 Whitney Ave (203) 865-5158
Name Address Telephone

NEW HAVEN, CT 06511

- 8. Attach an organizational chart which reflects the current ownership structure of the licensee and the licensee's relationship with the facility/agency.
- 9. Respond to the specific question that reflects the ownership structure of the licensee. **The Licensee is the legal entity which will be issued the license to operate.**
 - A. If the Licensee is a **general partnership, limited partnership or limited liability company**, complete Form 1 (attached).
 - B. If the Licensee is a **trust**, complete Form 2 (attached) for the Licensee.
 - i. Attach a list including the name, address and telephone number of all trustees.
 - C. If the Licensee is a **corporation (profit or non-profit)**, complete Form 3 (attached) for the Licensee. Complete a separate Form 3 for each additional corporate entity having 10% or greater ownership interest in the Licensee.
 - i. If the corporation is incorporated in a state other than Connecticut, please attach a Certificate of Good Standing from the Secretary of State of the state of incorporation.
 - ii. Attach a list including the name, address and telephone number of all officers and all directors of the corporation.
- 10. Attach a current copy of the facility's Certificate of malpractice and public liability insurance. (Note: Information Pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.). Please note that All Behavioral Health levels of care, except hospitals, and RCH facilities are exempt from the malpractice requirement.
- 11. Attach evidence of current compliance with the worker's compensation insurance coverage requirements in the form of one of the following:
 - A. a certificate of self-insurance issued by a worker's compensation commissioner pursuant to Section 31-284 of the Conn. General Statutes; or
 - B. a certificate of compliance issued by the Insurance Commissioner pursuant to Section 31-286 of the Conn. General Statutes; or
 - C. a Certificate of Insurance issued by any stock or mutual insurance company or mutual association authorized to write worker's compensation insurance in this state. (Note: Information pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.)

12. Ownership of Real Property

Russell Holdings LLC - Elaine Merrell
 Name
909 West Main Street Waterbury, CT 06708
 Business Address City State Zip Code Telephone



(203) 753-1070

FOR OFFICE USE ONLY

CHECK # _____

AMOUNT \$ _____

DATE RECEIVED _____

INITIALS _____

13. Annual Fire Marshal's Certificate of Inspection Form (attached) must be completed by the Local Fire Marshal. **NOTE: Hospitals must have a separate Fire Marshal's Certificate of Inspection completed for each building on the hospital's campus and each satellite listed on the hospital's license. Additional forms may be copied if necessary. Each completed Fire Marshal's Certificate of Inspection that is submitted must have an original signature. (Not applicable for Homemaker Home Health and Home Health Agencies).**

14. Affidavit of Owner:
I attest that the information provided within this application is true and accurate and that any changes in the information submitted will be reported to the Department as required by law.

Judy Tabak
Signature

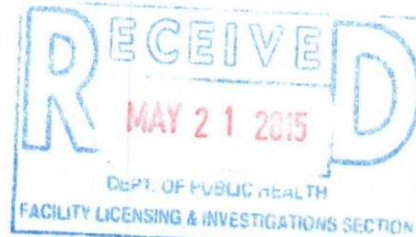
5/18/15
Date Signed

Check one as applicable:

- Individual/Sole Proprietor
- General/Managing Partner
- President of Corporation
- Secretary of Corporation
- Municipal Officer
- Trustee
- Member of the LLC

State of Connecticut)

County of New Haven)



ss May 18 20 15

Personally appeared before me the above named Judy Tabak and made oath to the truth of the statements contained in his/her answers to the foregoing questions.

Sally Hellerman
 Notary Public
 Justice of the Peace
 Town Clerk
 Commissioner of the Superior Court

My Commission Expires:
(If Notary Public)





CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
01/15/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Marsh USA, Inc. 1166 Avenue of the Americas New York, NY 10036 Attn: healthcare.accounts@marsh.com Fax: 212-948-1307 109210-WC-5-5-15-16 NEW,C WC	CONTACT NAME: PHONE (A/C, No, Ext): E-MAIL ADDRESS:	FAX (A/C, No):	
	INSURER(S) AFFORDING COVERAGE		NAIC #
INSURED PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC., AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. 345 WHITNEY AVENUE NEW HAVEN, CT 06511	INSURER A : N/A		N/A
	INSURER B : ACE American Insurance Company		22667
	INSURER C : N/A		N/A
	INSURER D :		
	INSURER E :		
INSURER F :			

COVERAGES **CERTIFICATE NUMBER:** NYC-006791908-03 **REVISION NUMBER:** 6

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC					EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COM/OP AGG \$ \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$					EACH OCCURRENCE \$ AGGREGATE \$ \$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N <input checked="" type="checkbox"/> N <input type="checkbox"/> Y	RSC C48128865	01/01/2015	01/01/2016	X WC STATUTORY LIMITS OTH-ER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101- Additional Remarks Schedule, if more space is required)
EVIDENCE OF COVERAGE.



CERTIFICATE HOLDER PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC. 345 WHITNEY AVENUE NEW HAVEN, CT 06511	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE of Marsh USA Inc. Ricki Fitzsimmons <i>Ricki Fitzsimmons</i>
--	---

RECEIVED
R/7
NOV 19 1974
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

ORGANIZATION CHART

Planned Parenthood of Southern New England, Inc.

BOARD OF DIRECTORS

^

Planned Parenthood of Southern New England Inc.

^

Planned Parenthood of Southern New England Inc.

EXAMPLE

Please refer to Renewal Application to complete this form

Start at the bottom of this page going up.

ORGANIZATION CHART

Please put name of the facility here

(Name of the Facility)

BOARD OF DIRECTORS

(On a separate page. Please attach a list of the board of Directors)

PLEASE PUT THE NAME OF THE (Licensee) here

^

Page 2, Line 4 of the renewal application (LICENSEE)

PLEASE PUT NAME OF THE FACILITY HERE

^

Page 1, Line 1 of the renewal application (D/B/A)

**Planned Parenthood of Southern New England
d/b/a Planned Parenthood of Southern New England**

Organizational Chart

Board of Directors 2014-2015

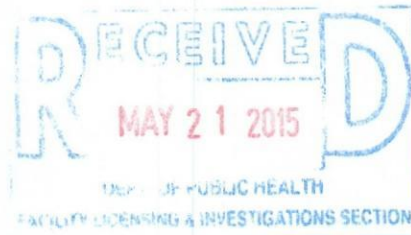
Officers:

Simone Joyaux, Chair
Gayle Capozzalo, Vice Chair
Karen Dubois Walton, Secretary
Leigh Bonney, Treasurer
Fahd Vahidy, Assistant Treasurer

Board of Directors:

Natalie Adsuar, M.D.
Adriana Arreola-Joseph
Bridget Baird
Erica Buchsbaum
Chris Corcoran
Holland Dunn
Siw de Gysser
Susann Mark
Donna Moffly
John R. Morton, M.D.
Francis Padilla
Amelia Renkert-Thomas
Susan Ross

Internal Org. Chart



Department of Public Safety
Division of Fire, Emergency & Building Services
Office of State Fire Marshal



STATE OF CONNECTICUT

On 5/5/2015, the Office of the Waterbury Fire Marshal conducted an inspection of Planned Parenthood located at 969 West Main St in Waterbury to determine the degree of compliance with the fire safety requirements of Connecticut General Statutes Chapter 541 as authorized by Section 29-305 of the statutes. This facility was evaluated as a CHAPTER 39 EXISTING BUSINESS OCCUPANCIES as classified by the CONNECTICUT FIRE SAFETY CODE. As a result of this inspection, the following conditions were found:

- I. At the time of inspection, no code violations were identified. Certificate of approval recommended.
- II. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. An acceptable plan of correction was submitted. (See attached information) Certificate of approval recommended.
- III. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. No approved plan of correction was submitted. (See attached information) Certificate of approval NOT recommended.
- IV. Based on the extreme hazard to public safety discovered at the time of this inspection, this office is currently seeking an injunction from the court through our Town/City Attorney for the purpose of closing or restricting usage of this facility by the public. (See attached information) Certificate of approval NOT recommended.

Thomas J. Squall DFM
Fire Marshal

5/12/15
Date

City or Town: WATERBURY



STATE OF CONNECTICUT
 DEPARTMENT OF PUBLIC HEALTH
 FACILITY LICENSING & INVESTIGATIONS SECTION

FORM 3

FACILITY/AGENCY NAME: _____

Form 3 must be completed if the facility/agency or Real Property Owner is owned/operated by a corporation (profit or non-profit). Please copy additional sheets if necessary.

For each stockholder with a 10% or greater ownership interest in the Licensee, provide the information requested below. If no owner owns 10% or more of the total shares, please indicate the two largest stockholders. **Please complete a separate form for each legal entity listed below that is not an individual.**

This information is for:

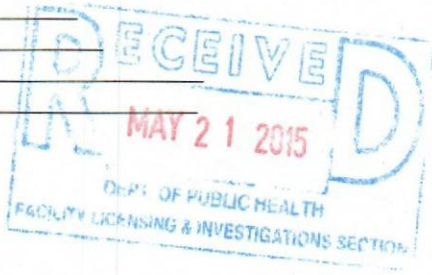
Licensee attached
 Real Property Owner _____

1. Name: _____
 Address: _____
 Telephone: _____
 Stockholder's percentage of ownership: _____
 Stockholder's occupation with the owner: _____

2. Name: _____
 Address: _____
 Telephone: _____
 Stockholder's percentage of ownership: _____
 Stockholder's occupation with the owner: _____

3. Name: _____
 Address: _____
 Telephone: _____
 Stockholder's percentage of ownership: _____
 Stockholder's occupation with the owner: _____

4. Name: _____
 Address: _____
 Telephone: _____
 Stockholder's percentage of ownership: _____
 Stockholder's occupation with the owner: _____





STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

LICENSURE APPLICATION - ADDITIONAL INFORMATION REQUIRED

OUTPATIENT CLINICS, WELL CHILD CLINICS AND
FAMILY PLANNING CLINICS

Please respond to all of the following questions:

1. Planned Parenthood of Southern New England
Facility "d/b/a" (doing business as) Name
969 West Main St. Waterbury CT 06708 (203) 574-2051
Business Address City State Zip Code Telephone

2. Check the appropriate box/boxes describing the services to be provided by the clinic:
 Primary Care Family Planning
 Well Child Clinic Abortion Procedures
 Dental Mental Health Services

Be advised that mental health services does NOT include Substance Abuse Services.

3. Alicia Caban
Administrator (Your name needs to appear as it is shown on your Professional License).

4. Timothy Spurrell, MD
Medical Director Dental Director (if applicable)
(Your name needs to appear as it is shown on your Professional License).

5. Days & Hours of Operation: M-11:00-10:30 W-8:30-4:00 F-8:30-4:00
T-12:15-10:30 TH-8:30-4:00
You MUST notify this agency when ANY change to the noted day/time changes. We accept email and fax.

6. Please provide a list of services that will be provided.

7. Business Fax Number: (203) 573-0315

8. Business Email Address: Alicia.Caban@ppsne.org

9. Business Cell Phone Number with Texting capabilities of the Administrator: _____

Alicia Caban 5/14/15
Signature of Administrator Date Signed



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
02/12/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

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PRODUCER Marsh USA, Inc. 1166 Avenue of the Americas New York, NY 10036 Attn: healthcare.accounts@marsh.com Fax: 212-948-1307 109210-NIPT-CAS-15-16	CONTACT NAME: _____	
	PHONE (A/C, No, Ext): _____	FAX (A/C, No): _____
E-MAIL ADDRESS: _____		
INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A : N/A		N/A
INSURER B : National Union Fire Ins. Co. of Pittsburgh, PA		19445
INSURER C :		
INSURER D :		
INSURER E :		
INSURER F :		

COVERAGES **CERTIFICATE NUMBER:** NYC-007010554-01 **REVISION NUMBER:** 0

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC					EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$					EACH OCCURRENCE \$ AGGREGATE \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y/N If yes, describe under DESCRIPTION OF OPERATIONS below					WC STATUTORY LIMITS OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
B	MEDICAL PROFESSIONAL CLAIMS-MADE COVERAGE		6793286 *Program Retro Date: 11/1/76'	01/01/2015	01/01/2016	PER CLAIM \$1,000,000 AGGREGATE \$3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
 EVIDENCE OF COVERAGE FOR HEALTH CENTER



CERTIFICATE HOLDER PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND 969 WEST MAIN STREET WATERBURY, CT 06708	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE of Marsh USA Inc. Ricki Fitzsimmons <i>Ricki Fitzsimmons</i>
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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
12/31/2014

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PRODUCER Marsh USA, Inc. 1166 Avenue of the Americas New York, NY 10036 Attn: healthcare.accounts@marsh.com Fax: 212-948-1307	CONTACT NAME: PHONE (A/C, No, Ext): E-MAIL: ADDRESS:		FAX (A/C, No):
	INSURER(S) AFFORDING COVERAGE		NAIC #
109210-NIP-CAS-15-16 NEW,C GLPL	INSURER A: New Hampshire Insurance Company		23841
INSURED PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC. AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. 345 WHITNEY AVENUE NEW HAVEN, CT 06511	INSURER B: National Union Fire Ins. Co. of Pittsburgh, PA		19445
	INSURER C:		
	INSURER D:		
	INSURER E:		
		INSURER F:	

COVERAGES	CERTIFICATE NUMBER: NYC-005757681-27	REVISION NUMBER: 11
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THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> SIR: \$100,000 GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC			082695195	01/01/2015	01/01/2016	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$ <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE						EACH OCCURRENCE \$ AGGREGATE \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below		N/A				<input type="checkbox"/> WC STATU-TORY LIMITS <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
B	MEDICAL PROFESSIONAL CLAIMS-MADE COVERAGE			6793286 Program Retro Date: 11/1/76	01/01/2015	01/01/2016	PER CLAIM \$1,000,000 AGGREGATE \$3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

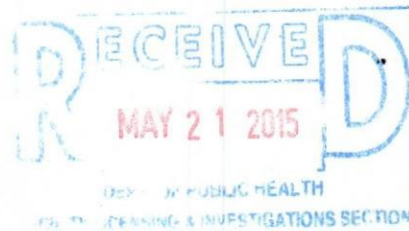
RECEIVED
MAY 21 2015
DEPT. OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

CERTIFICATE HOLDER PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND ATTN: LOUIS DENEGRÉ 345 WHITNEY AVENUE NEW HAVEN, CT 06511	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE of Marsh USA Inc. Ricki Fitzsimmons <i>Ricki Fitzsimmons</i>
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Planned Parenthood of Southern New England

Services available:

- Well women's health care
- Well men's health care
- Cervical cancer screening
- Breast exams
- Sexually transmitted infection testing and treatment
- HIV testing
- Birth control services
- Pregnancy testing
- Options counseling
- Pre-conception care
- Medication abortion services
- Health and sexual health education services
- Hepatitis and HPV services
- Transgender services
- Primary Care



LICENSING INSPECTION REPORT

Name and Address of Entity
PPSNE - Waterbury
969 West Main St
Waterbury CT 06702

Signature of DHSR Staff
[Signature] must consult

Licensure Category :
Food Service/Caric

Licensed Capacity : 0031 Census : _____

Licensed Capacity : _____ Census : _____

Date(s) of Onsite Inspection : 10/28/15

Date(s) Additional Information Obtained: _____

Personnel Contacted : Alicia Cason, Care manager Ronnie Dubrown, com

REVIEW/FINDINGS/PROCESS (complete all applicable)

Licensing Inspection: Initial Renewal Other: _____

Revisit for the Purpose of _____

See Complaint Investigation # _____

See Reportable Event Investigation # _____

See Certification file.

Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were identified at the time of this inspection.

See violation letter dated _____

Citation # _____ was issued to this facility as a result of this inspection.

Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were not identified at the time of this inspection.

Citation # _____ was verified as corrected. _____ was notified that the licensee was no longer required to post Citation (see narrative).

Citation # _____ was not corrected (see narrative).

Narrative Report / Additional Information Attached.

Referral(s) to: _____

REPORT SUBMITTED BY [Signature]

DATE OF REPORT 11/9/15

Approval for Issuance of License granted by : Loan Drayton 11-9-15
Supervisor / Title Date

FACILITY: PPSWE - Waterbury

DATE(S) of VISIT: 10/28/15 Page 2 of 2

OUTPATIENT CLINICS OPERATED BY CORPORATIONS/MUNICIPALITIES
LICENSING INSPECTION NARRATIVE REPORT
(P.H.C. Section 19-13-D45)

I. An unannounced visit was made to the above facility, by a representative of the Division of Health Systems Regulation, for the purpose of conducting a licensing inspection.

II. An entrance conference was held.

III. The following was conducted:

- a. Facility inspection ✓
- b. Observation of patient care
- c. Personnel files review ✓
- d. Quality assurance program (audits) review ✓
- e. Fire drill log/disaster plan review ✓
- f. New or revised agency policies and procedures review ✓
- g. Clinical record review ✓
- h. In-service training/staff meeting documentation ✓
- i. CLIA certificate/waiver *hse*

*(1) lidacaine should open
(2) MED REFRIG in Dirty utility Room
Blood specimen controls
in MED REFRIG.*

IV. An exit conference was provided. ✓

V. Violations of the Public Health Code of the State of Connecticut were/were not identified as a result of this inspection.

SIGNATURE: *[Signature]*

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

April 8, 2016

Alicia Caban, Center Manager
Planned Parenthood Of Connecticut Inc - Waterbury
969 West Main Street
Waterbury, CT 06702

Dear Ms. Caban:

An unannounced visit was made to Planned Parenthood Of Connecticut Inc - Waterbury on October 28, 2015 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing inspection.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visit.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by April 22, 2016 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

A handwritten signature in cursive script that reads "Loan D. Nguyen".

Loan Nguyen M.S.N., R.N., C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section



Phone: (860) 509-7400 • Fax: (860) 509-7543
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Affirmative Action/Equal Opportunity Employer

DATE(S) OF VISIT: October 28, 2015

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES
WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D48 Professional staff (b) (1) and/or 19-13-D51 Pharmaceuticals (3) and/or 19-13-D52 Maintenance.

1. Based on review of the agency documentation, surveyor observation and interview with agency personnel, the agency failed to maintain compliance with infection control and safety requirements. The findings include:

- a. During a tour of the agency with the Manager on 10/28/15, a multi-dose vial of Lidocaine 50ml for injection was found open, less than half full, stored in the medication refrigerator in the dirty utility room.

Interview and review of the surveyor observation with the Manager on 10/28/15 failed to identify the documentation on the vial of the date the vial was opened, and/or the date the vial should be discarded.

The agency policy on storage of multi-dose vials directed the documentation of the discard date as 28 days after opening, unless otherwise directed by the manufacturer;

During the tour of the agency on 10/28/15, the medication refrigerator was holding a vial of Hepatitis B vaccine, 20 doses of Fluvirin prefilled syringes, a syringe of Rho immune globulin, 10 vials of Gardasil, a vial of Lidocaine and a vial of Epinephrine.

Interview and inspection of the medication refrigerator with the Manager on 10/28/15 indicated that the medication refrigerator was stored in the dirty utility room under the sink counter where soiled equipment (speculums and probes) were washed, and under the counter holding the sterilizer, and failed to identify a clean and/or appropriate environment to store the medication refrigerator;

Interview and inspection of the medication refrigerator with the Manager on 10/28/15 identified two purple top blood specimen tubes containing blood used as quality control blood samples for the Rh factor testing device, and failed to identify the maintenance of quality control blood samples in a tightly sealed container in the refrigerator.



Planned Parenthood of Southern New England

969 West Main Street
Waterbury, CT 06708
p: 203.574.2051 · f: 844.560.1148
www.ppsne.org

*See my notes
12/9/16
Alicia Caban*

June 28, 2016

Attached is the plan of corrective actions for the violation found during the unannounced inspection of the Waterbury Health Center on October 28, 2015.

1. Violation – Section 19-13-D48 Professional Staff (b) (1) and/or 19-13-D51 Pharmaceuticals (3) and or 19-13-D52 Maintenance.

a. Response – The Manager reviewed the policy and procedure for storage of pharmaceuticals – Administrative Chapter 7: Pharmaceuticals of the Manual of Standards and Guidelines, with staff at a staff meeting on November 3, 2015. The Manager is responsible for ensuring the policy and procedure are as followed.

During the tour it was found the medication refrigerator was stocked with medications and stored in lab refrigerator.

b. Response – The vial of Lidocaine that was found open was discarded on October 28, 2015. Vaccines including and not limited to, prefilled syringes and vials of Gardasil, Lidocaine and Rho immune globulin were moved from the lab refrigerator to a refrigerator in a clean and appropriate environment in the clinician workspace. These medications were moved on October 29, 2015.

During the interview and inspection of the medication refrigerator with the Manager, two purple top blood specimen tubes were found containing blood used as quality control blood samples for Rh factor testing device and failed to identify the maintenance of quality control blood samples in a tightly sealed container.

c. Response - Purple top blood specimen tubes have been labeled as quality controls for Rh factor testing with expiration date and are now stored in a tight sealed container in the refrigerator in the dirty lab. An Advanced Clinical Assistant will monitor refrigerator temperature as well as medication storage. This change was effective October 29, 2015. The Manager is responsible for ensuring this process is followed.

I hope this plan of corrective actions answers the violation found during your visit of October 28, 2015. Please do not hesitate to contact me if you have further questions.

Best regards,

Alicia Caban -

Center Manager - Waterbury

Alicia Caban

