California Department of Public Health

PRINTED: 09/10/2019
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA050000118	A. BUILDING: ______ B. WING ______	09/10/2019

NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD OF SANTA BARBAR

STREET ADDRESS, CITY, STATE, ZIP CODE: 518 GARDEN ST, SANTA BARBARA, CA 93101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
J 000	Initial Comments The following reflects the findings of the California Department of Public Health, Licensing and Certification, during an investigation of one Facility Reported Incident (FRI). FRI: CA00649646--Substantiated Representing the Department: HFEN 39106 The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility.	J 000	**a. What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice.** The patient was informed of the breach including the action we took to terminate employment with the employee involved in the incident. The patient was reassured that the copy of the identification and medical cards retrieved from her medical record would not impact her current employment or ability to be employed in another department. In fact, they were deleted. The patient verbalized appreciation for the swift action taken.	8/6/19
J 099	CCR TITLE 22 DIV5 CH7 ART6 -75055(b) Unit Patient Health Records (b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to protect the privacy of a patient (Patient 1) when an employee intentionally accessed the patient's electronic health record. This failure resulted in disclosure of information to another employee and the potential for misuse of the patient's information. Findings: The facility policy and procedure titled "General Security Compliance" dated 12/01/2018, indicates in part "As a covered entity under the Security Regulations, the facility works to protect against any reasonably anticipated uses or disclosures of	J 099 POC accepted 9/25/19 C. Werner	**b. How other patients having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken.** This was a unique situation with an action taken by one employee. We do not believe this will happen again. **c. What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur.** The employee involved in this incident was the Director of Revenue Cycle (DOR). In their role, they have access to patient medical records. However, they violated HIPAA policy when they used that access to retrieve information for the purpose of employment. The patient was concurrently an employee seeking a position in a different department. The DOR's employment was terminated for violating policy and using poor judgement.	8/2/19

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

2019 SEP 25 AM 5:5_ CA DEPT OF PUBLIC HEALTH

09/24/2019 TUE 17:16 FAX --- Gallina Weinreich 003/019

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA050000118	A. BUILDING: ______ B. WING ______	09/10/2019

NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD OF SANTA BARBAR.

STREET ADDRESS, CITY, STATE, ZIP CODE: 518 GARDEN ST, SANTA BARBARA, CA 93101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
J 099	Continued From page 1 such information that are not permitted or required by the Privacy Regulations". The facility policy and procedure titled "Uses and Disclosure of PHI based on an Authorization" dated 01/01/2019, indicates in part "A use or disclosure of PHI for purposes other than treatment, payment or healthcare operations must be accompanied by an Authorization signed by the patient..". During an interview on 8/14/19, at 11:30 a.m., the chief financial officer (CFO) indicated the director of revenue cycle (DRC) communicated on 8/1/19 that she needed clarification of the spelling of a prospective employee's first name. The DRC was directed to the human resources director (HRD) for assistance with this matter. The CFO further explained that later that same day, the DRC emailed the prospective employee's driver's license and insurance card to the CFO. The CFO indicated the DRC acknowledged accessing the prospective employee's (who had been a patient of the facility in the past) medical record to obtain a copy of the driver's license and health insurance card. During an interview on 8/14/19, at 1150 a.m., the chief operating officer (COO) confirmed the unauthorized access of Patient 1's electronic health record by the DRC on 8/1/19. The COO further confirmed there was not a legitimate reason for the DRC to have accessed the health record.	J 099	**d. A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, Director of Nursing, or other responsible supervisory personnel). How the facility plans to monitor its performance to ensure corrections are achieved and sustained. The plan of correction must be implemented, corrective action evaluated for its effectiveness, and it must be integrated into quality assurance system.** We do not believe this was a systemic problem. All employees go through intensive HIPAA training within the 1st week of employment and participate in an annual review. We believe this was a one-time occurrence involving one employee who used poor judgement. As a result, they are no longer employed with the agency. **e. Dates when corrective action will be completed. The corrective action completion must be acceptable to the Department. The deficient practice should be corrected immediately. This date shall be no more than 30 calendar days from the date the facility was notified of the non-compliance.** Coincidently, we were due for our annual HIPAA training. The HIPAA Privacy Officer and HIPAA Security Officer provided their training at all of our administrative and health center locations between the dates of August 20 – August 23, 2019 . Attached are the sign in sheets for each of those trainings and names of participants along with the	

SEP 25 AM 7:52
DEPT OF PUBLIC HEALTH
VENTURA DISTRICT OFFICE

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA630003541	A. BUILDING: ______ B. WING ______	C 07/24/2018

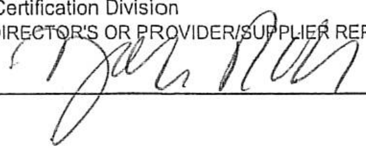
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF THOUSAND OAK	1200 W HILLCREST DR STE 100 THOUSAND OAKS, CA 91360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment The following reflects the findings of the California Department of Public Health, Licensing and Certifiacation, during the investigation of an Entity Reported Incident (ERI). ERI CA00595373 - Substantiated Representing the Department: 2675 - HFES	A 000		
	The investigation was limited to the investigation of the ERI and does not reflect the findings of a full inspection of the facility.		**a. What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice.**	
A 170	1280.15(a) Health & Safety Code 1280 a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined in Section 56.05 of the Civil Code and consistent with Section 1280.18. For purposes of this section, internal paper records, electronic mail, or facsimile transmissions inadvertently misdirected within the same facility or health care system within the course of coordinating care or delivering services shall not constitute unauthorized access to, or use or disclosure of, a patient's medical information. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars ($25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars ($17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that patient's medical	A 170	We were informed that Patient A's letter was received by a person who was not the intended recipient. We apologized for the error and she agreed to return the letter. Several phone calls were made to Patient A with the attempt to inform her of the breach. The patient did not reply. A letter was mailed informing patient of the breach. In addition, we have been working with Ventura's Public Health Department to locate the patient given that treatment for STD has not been attained. They have attempted phone calls and field visits without success. **b. How other patients having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken.** A report was run identifying all of the	7/6/18 7/13/18 8/1/18

CA DEPT OF PUBLIC HEALTH
2018 AUG 13 AM 11:2
LICENSING & CERTIFICATION VENTURA DISTRICT OFFICE

Licensing and Certification Division

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



TITLE: COO

(X6) DATE: 8/9/18

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA630003541	A. BUILDING: ____ B. WING ____	C 07/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF THOUSAND OAK	1200 W HILLCREST DR STE 100 THOUSAND OAKS, CA 91360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 170	Continued From page 1 information. For purposes of the investigation, the department shall consider the clinic's, health facility's, agency's, or hospice's history of compliance with this section and other related state and federal statutes and regulations, the extent to which the facility detected violations and took preventative action to immediately correct and prevent past violations from recurring, and factors outside its control that restricted the facility's ability to comply with this section. The department shall have full discretion to consider all factors when determining whether to investigate and the amount of an administrative penalty, if any, pursuant to this section. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure a patients' (Patient A) protected health information (PHI) was kept private, when Patient A's confidential information was sent by US postal service to the wrong recipient. This failure resulted in the unauthorized disclosure of Patient A's PHI and the potential for misuse of the information. Findings: During a telephone interview with the chief operating officer (COO) on 7/24/18, at 8:10 a.m., the COO stated, on 7/06/18 the facility received a phone call from an individual who stated she had received a letter addressed to her in the mail but the information inside had another patients name	A 170	patients who had letters mailed out regarding lab follow-up on the same day. Each patient was contacted to ensure they received letters intended for them. **c. What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur.** Call Center Director did an immediate review of procedures regarding abnormal lab follow up. He spoke with the Abnormal Lab Coordinator involved and reminded her that the process includes the mandatory double checking of the patient name and address on the envelope label, prior to placing the letter in the envelope. He also reinforced with the employee the need to handle only one patient letter and envelope at a time. This process was reviewed with all of the case management team. **d. A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, Director of Nursing, or other responsible supervisory personnel). How the facility plans to monitor its performance to ensure corrections are achieved and sustained. The plan of correction must be implemented, corrective action evaluated for its effectiveness, and it must be integrated into quality assurance system.**	7/9/18

2018 AUG 13 AM 8:23
CA DEPT PUBLIC HEALTH
LICENSING & CERTIFICATION DISTRICT OFFICE

California Department of Public Health

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF THOUSAND OAK	1200 W HILLCREST DR STE 100 THOUSAND OAKS, CA 91360

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A 170	Continued From page 2 and lab results (Patient A). The letter and lab result were related to a sexually transmissible disease. The COO explained that case management personnel had accidentally enclosed a letter and lab result intended for Patient A into the wrong envelope. According to the facility they were unable to contact Patient A by phone but sent a letter to inform her of the unintentional disclosure. The facility policy and procedure entitled "Notice of Health Information Privacy Practices" revised 11/2016, indicated in part "The privacy and security provisions of the Health Insurance Portability and Accountability Act ("HIPAA") requires us to: Make sure that health information that identifies you is kept private." The facility policy and procedure entitled "Case Management and Abnormal Follow-Up Policies and Procedure" revised 2/2016, indicated in part "Case management staff will handle medical records request and medical record release according to HIPAA guidelines."	A 170	The Call Center Director and Sr. Medical Services Director are responsible for monitoring and supervision of the case management team. They will provide an additional review of entire Case Management and Abnormal Follow-Up Policies and Procedures on 8/24/18. The training could not be scheduled earlier due to a few team members' scheduled vacations. The Risk and Quality Manager will be doing a quality follow up audit on 8/24/18 and quarterly thereafter. This new audit will be incorporated into the affiliate's Compliance, Quality and Risk Management 2018-2019 Work Plan. e. **Dates when corrective action will be completed. The corrective action completion must be acceptable to the Department. The deficient practice should be corrected immediately. This date shall be no more than 30 calendar days from the date the facility was notified of the non-compliance.** All corrective actions will be completed by August 24, 2018	

CA DEPT OF PUBLIC HEALTH
2018 AUG 13 AM 11:23
LICENSING & CERTIFICATION VENTURA DISTRICT OFFICE

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California Department of Public Health

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	CA630003541	A. BUILDING: ___ B. WING ___	C 12/30/2014

NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD OF THOUSAND OAK

STREET ADDRESS, CITY, STATE, ZIP CODE: 1200 W HILLCREST DR STE 100, THOUSAND OAKS, CA 91360

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D 000	Initial Comments The following represents the findings of the California Department of Health during a entity reported incident investigation. Complaint No.CA00420949 Representing the Department of Public Health Surveyor ID 2780 The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.	D 000		
D 070	T22 DIV5 CH7 ART4-75030(a)(1) Basic Services--Policies and Procedures (1) Description of the types and scope of services which the clinic will provide. This Statute is not met as evidenced by: Based on interview and record review the facility failed to implement it's written policy and procedure for scope of services when an abortion procedure was initiated on Client A whose pregnancy was beyond the gestational age of the clinics established limits. Findings: Review of the clinic's policy in the "Manual of Medical Standards and Guidelines", dated 12/14/12, revised 6/12, page 5 subhead "Client Selection" #2 indicates "...is pregnant and is not more than the gestational age limit of the affiliate program". This clinic was approved for abortion services up to 16 weeks gestation.	D 070	The majority of corrective actions outlined in this document occurred immediately following the incident. This was shared with the DPH surveyor when on site. Safeguards are now in place to ensure the deficient practice does not recur. PPSBVSLO's medical standards and guidelines are being updated (performed on an annual basis). The policy and procedure portion regarding our ability to perform procedures to 16 weeks gestational age remains unchanged.	

2015 MAR -6 PM 4:22
VENTURA DISTRICT OFFICE

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hrayinia Alegxxxx MD
TITLE: Medical Director
(X6) DATE: 3-6-15

Rec'd 3-11-15 KK

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA630003541	A. BUILDING: ____ B. WING ____	C 12/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF THOUSAND OAK	1200 W HILLCREST DR STE 100 THOUSAND OAKS, CA 91360

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D 070	Continued From page 1	D 070	The following corrective actions took place immediately following this incident:	
Date is 11/18 not 11/11	Review of client A's medical record on 12/18/14, revealed the following: Client A was seen on 11/11/14 for a surgical abortion. The procedure was started and the physician, realizing the gestational age was greater than 16 weeks, stopped the procedure. Client A was transported to a nearby hospital for completion of the procedure.		1) A debriefing with the clinic staff took place immediately following the incident. Attachment I shows the incident as the first agenda time on a staff meeting that had already been scheduled to take place that day after clinic.	11/18/14
	During an interview with the physician assistant (PA) on 12/18/14, at 1:45 p.m., the PA indicated she had performed the ultrasound on Client A prior to the procedure. The PA also indicated this was her first time using this particular ultrasound machine (Brand S). According to the PA, all of the other ultrasound machines in this and the other two associated clinics were a different brand (Brand G).		2) Three days later, a clinical debriefing took place with the staff and was lead by the medical Director (also the surgeon). During this meeting the incident was reviewed, outcomes discussed and Attachment II outlines the corrective actions to be implemented which would prevent a similar incident from occurring again. The emergency was handled appropriately with all staff carrying out their roles effectively.	11/21/14
	Further investigation revealed prior to the ultrasound being performed, the patient services representative routinely enters the clients stated last menstrual period date, into the (Brand S) ultrasound machine. This results in the Brand S ultrasound machine printing out two dates. The first line date is the calculated gestational age according to the patients stated last menstrual period. The second line date is the actual ultrasound calculated gestational age according to the ultrasound image. However, when using the G brand ultrasound there is only the first line date which with the G brand ultrasound is the actual ultrasound calculated gestational age.		3) On December 2, 2014 a Root Cause Analysis was performed by our Manager of Quality and Risk. Attachment III outlines the analysis followed by corrective action to be taken. Follow up on the recommendations were made on January 2, 2015 with most tasks completed. The remaining action item is the purchase of an ultrasound machine (same as Brand G) which was ordered on 2/19/15. We anticipate arrival within the next 2-3 weeks. Brand S machine was removed from abortion services on 11/21/14.	12/2/14 1/2/15
	The PA indicated she requested assistance from the nurse practitioner (NP) with the ultrasound because "She wasn't getting a clear picture". During an interview with the NP on 12/18/14, at 5:10 p.m., the NP indicated she took another ultrasound and after reviewing the image she			

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	CA630003541	A. BUILDING: ____ B. WING ____	C 12/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 070	Continued From page 2 stated she "Wasn't seeing the classic landmarks for the gestational age". The NP approached the MD to ask "If the image was OK ?" According to the NP when she was discussing the ultrasound image with the MD, she relayed to the MD,in error, the gestational age was the first line age printed on the ultrasound image, 13 weeks 1 day (which was actually the age calculated by the clients stated last menstrual period). The actual ultrasound calculated gestational age prints out on the second line when using the Brand S. In this case the actual ultrasound calculated gestational age was actually 21 weeks and 1 day. During a concurrent review of the ultrasound results and an Interview with the MD on 12/18/14, at 6 p.m.,The MD indicated prior to the procedure, when asked to look at the ultrasound, she was "only looking at the image" and was responding as to whether or not the image was "clear". The MD confirmed that two dates showed up on the ultrasound Brand S machine and the Brand S machine is the only ultrasound machine used which has a different system of printing out the gestational age.	D 070	4) As part of this incident review, it was determined that the PA appropriately consulted with the more experienced clinician. Both appropriately consulted with the physician. 5) On the day of the incident, the Medical Director (surgeon) appropriately was in communication with the receiving hospital physician before the patient arrived. Follow up with the same local physician took place the following day to obtain information on the patient outcome and current patient status. 6) In an effort to ensure that no other patients were effected by this incident, an audit was conducted on all patients receiving abortion service that same day. All tissue examinations matched gestational age obtained on ultrasound and were appropriately documented in EHR. As stated above, the ultrasound Brand S was removed service. Attachment IV. Quarterly gestational age audit added to QM Plan effective January 2015.	11/18/14 11/18/14 11/19/14 2/20/15

2015 MAR -6 PM 4:2_ VENTURA DISTRICT OFFICE

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
12/17/13	CA050000445	A. BUILDING: ____ B. WING ____	C 12/09/2013

NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD OF VENTURA

STREET ADDRESS, CITY, STATE, ZIP CODE: 5400 RALSTON ST, VENTURA, CA 93003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The following represents the findings of the California Department of Public Health-Licensing and Certification during a complaint investigation. Complaint No. CA00372073- Substantiated Representing the Department of Public Health Surveyor ID # 22363, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.	D 000	CA DEPT OF PUBLIC HEALTH 2013 DEC 19 AM 11:05 LICENSING & CERTIFICATION VENTURA DISTRICT OFFICE	
D 172	T22 DIV5 CH7 ART6-75053 Unusual Occurrences Unusual Occurrences. Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, deaths from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients, personnel or visitors shall be reported by the facility within 24 hours either by telephone (and confirmed in writing) or by telegraph to the local health officer and the Department. An incident report shall be retained on file by the facility for one year. The facility shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may require. Every fire or explosion which occurs in or on the premises shall be reported within 24 hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshal. This Statute is not met as evidenced by: Based on interview and record review, the facility (Clinic A) failed to report an unusual event which	D 172	Upon notification from DPH, of the requirement to notify them of Unusual Occurrences within 24 hours, our policy and procedure was updated. We have since shared these expectations with all health centers. In summary: 1. When there is an Unusual Occurrence, health center staff must immediately notify Clinical Services Administration. 2. Clinical Services Administration (specifically, the VP of Clinical Services) will send DPH a fax outlining the event with specific dates/times. 3. Clinical Services will follow up on Unusual Occurrences as we normally do with notification/ submission of documentation to our insurance carrier and Planned Parenthood Federation of America. 4. All occurrences are monitored by our internal quality management program. This is not a change. This type of DPH reporting does not change how we currently handle occurrences nor does it affect the outcome of patient care.	1/8/14

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: VP Clinical Svs (X6) DATE: 12/17/13

PRINTED: 12/10/2013
FORM APPROVED

California Department of Public Health

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12/17/13	CA050000445	A. BUILDING: ________ B. WING ________	C 12/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF VENTURA	5400 RALSTON ST VENTURA, CA 93003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 172	Continued From page 1	D 172		

threatened the health of one Patient (Patient A) to the California Department of Public Health (CDPH) within 24 hours of the occurrence.

Findings:

Patient A, a 23 year old female, was seen in the facility (Clinic A) on 9/18/13 for a planned abortion at approximately 15 weeks gestation (date per transactional ultrasound performed on 9/12/13).

The medical record was reviewed with administrative staff on 10/8/13. According to the record Patient A came to the facility for a planned surgical abortion which began at 11:32 a.m. The physician (Physician X) performing the abortion noted the following: "...complication occurred during procedure Bleeding-Amount 1000 cc. ..." According to Physician X's notes, the facility attempted to control the bleeding with medication suspecting uterine atony (a loss of tone in the uterine musculature. Normally, contraction of the uterine muscle compresses the vessels and reduces flow. This increases the likelihood of coagulation and prevents bleeds. Thus, lack of uterine muscle contraction can cause an acute hemorrhage). Patient A failed to respond to medication and the facility called 911.

The Paramedic Prehospital Ambulance Report was reviewed. According to the Paramedic notes, upon arrival Patient A had a blood pressure of 73/48 was confused, with slurred speech, pale and cool to touch. Patient A was taken to a local Hospital (Hospital B) Emergency Department (ED) by paramedics, arriving at 12:15 p.m., according to the Prehospital Ambulance Report.

Upon arrival to Hospital B at 12:15 p.m., the ED Physician noted Patient A to be in "Severe

CA DEPT OF PUBLIC HEALTH
2013 DEC 19 AM 11:09
LICENSING & CERTIFICATION VENTURA DISTRICT OFFICE

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
12/17/13	CA050000445	A. BUILDING: ______ B. WING ______	C 12/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF VENTURA	5400 RALSTON ST VENTURA, CA 93003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 172	Continued From page 2	D 172		

distress, cool, pale, and in hemorrhagic shock"(resulting from acute hemorrhage and characterized by hypotension, tachycardia, oliguria, and by pale, cold, and clammy skin.) Patient A was rapidly transfused with 6 units of blood and taken to surgery at 1:23 p.m. (according to the ED physician notes).

The operative report from the surgeon (Physician C) was reviewed. According to the report, "...After the procedure (Patient A) began having heavy vaginal bleeding and was transferred emergently to (Hospital B). Upon arrival (Patient A) was in hemorrhagic shock and had profuse vaginal bleeding...Massive transfusion protocol was begun and the patient was taken emergently to the operating room...examination of the uterus revealed a perforation (a hole made by boring or piercing; an aperture passing through or into something) of the left lateral lower portion of the uterus..because of the volume of bleeding and the location of the laceration...the decision was made to proceed with hysterectomy (a surgical operation to remove all or part of the uterus).
The California Department of Public Health (CDPH) was notified of the above unusual occurrence through an anonymous complainant on 10/4/13. CDPH entered Clinic A on 10/8/13, twenty days after the date of occurrence (9/18/13).
Clinic A staff were interviewed on 10/8/13 and stated they recognized the occurrence as unusual for their facility, management staff stated administrative staff were aware of the incident and it was administrative staff that reported any occurrences to the correct authority.
Administrative staff at Clinic A were interviewed on 10/30/13 by telephone. According to administrative staff, they were unaware unusual occurrences such as this should be reported to

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