STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

March 13, 2020

Jane Yousman, Manager
Planned Parenthood Of Connecticut Inc - Hilda Stan
1030 New Britain Avenue
West Hartford, CT 06133

Dear Jane Yousman:

Unannounced visits were made to Planned Parenthood Of Connecticut Inc - Hilda Stan concluding on January 9, 2020 by a representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation, with additional information received through January 9, 2020.

Attached is the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visits. The state violations cannot be edited by the provider in any way.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by March 23, 2020.

The plan of correction shall include:
(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;
(2) the date each such corrective measure or change by the institution is effective;
(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and
(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

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410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

DATE(S) OF VISIT: January 9, 2020

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

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violation and you may be provided with the opportunity to be heard. If the violation is not responded to by March 23, 2020 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

Please return your response to the Supervising Nurse Consultant via email at dph.flisadmin@ct.gov or right fax number 860-622-2655. Please direct your questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-8352. Please do not send another copy via US mail.

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

Respectfully,

Lisa A. DiLorenzo, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

LAD:mb

Complaint #25178

DATE(S) OF VISIT: January 9, 2020

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

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D56 (c) Administration (1) and/or (e) Professional Staff (7)(D)(f) and/or (f) Records and Reports (3) and/or (i) General (6).

1. Based on medical record review, review of facility documentation, review of facility policy, and interviews for one of three patients (Patient #1), the facility failed to document the correct procedure performed on the consent and did not document a complication during the surgery. The finding includes:
   a. Patient (P) #1 was admitted on 1/15/19 with a diagnosis of pregnancy at 16.1 weeks gestation. P#1 was scheduled for an "In-Clinic Dilation & Evacuation (D&E) Abortion" (removal of uterine pregnancy at 13 weeks or greater gestational age by mechanical method).
   Patient (P) #1's medical record identified the 9-page consent form explained the procedure, risks, and sedation (anesthesia) used during the procedure. The consent form was signed and dated on the day of the procedure by P#1, the physician, a witness, and the nurse anesthetist.
   The consent form (page 4) identified that the box for "In-Clinic Suction Abortion" (removal of uterine pregnancy less than 13 weeks gestational age by mechanical method) was marked off instead of the box for an "In-Clinic D&E Abortion". Further review of the consent form and the medical record identified although the signed consent indicated the wrong procedure, the patient underwent the correct procedure on 1/15/19, an "In-Clinic D&E" performed by Medical Doctor (MD) #1 and MD#2.
   Review of the medical record identified that an assessment note was written prior to the procedure which indicated that the procedure was completed without complication and the patient tolerated the procedure well however the medical record identified during the procedure a complication occurred which required the patient to be taken to the emergency room by ambulance and P#1 was admitted to the hospital for treatment.
   The facility failed to document the correct procedure performed on the consent and did not change the assessment documentation to reflect that complications occurred during the procedure.
   Interview with the Director of Clinical Medical Services on 1/9/20 at 10:00 AM indicated that the check box on the consent form should have been checked off correctly and was not. The Director of Clinical Medical Services indicated the assessment note, which indicated that the procedure was completed without complication and the patient tolerated the procedure well, is a computer-generated template in the electronic medical record. Initially the template answers the question with "yes" and if complications do occur during the procedure the MD must go into the electronic medical record and change the answer to the question to "No".
   Review of the Facility ' s Medical Records, Documentation, and Reporting Requirements policy directed that documentation must be performed in accordance with accepted professional standards and any applicable laws/regulations. It must be legible, factual, complete, concise, and professional.

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