Printed:
Due Date: 04/14/2014
Priority: Non-IJ Medium

Intake ID:
Facility ID:
Provider Number:
Mgmt.Unit:

ACTS Complaint/Incident Investigation Report

PROVIDER INFORMATION

Name:
Address:
City/State/Zip/County:
Telephone:

License #:
Type:
Medicaid #:
Administrator:

INTAKE INFORMATION

Taken by - Staff:
Location Received:
Intake Type: Complaint
Intake Subtype: State-only, licensure
External Control #:
SA Contact:
RO Contact:
Responsible Team:
Source:

Received Start: 2014 At 09:52
Received End: 2014 At 09:52
Received by: Hotline
State Complaint ID:
CIS Number:

COMPLAINANTS

Name	Address	Phone	EMail

Link ID:
Relationship : self
Confidentiality Requested : Y

RESIDENTS/PATIENTS/CLIENTS

Name	Admitted	Location	Room	Discharged	Link ID

ALLEGED PERPETRATORS - No Data

INTAKE DETAIL

Date of Alleged Time: Shift:

Standard Notes: Triaged as state MODERATE

DOB:

states she went to the on to have an abortion. She alleges on 14 she was admitted to for an in her and She alleges she the from the abortion.

4/14/14 Reassigned
5/20/14 Reassigned

Extended RO Notes:
Extended CO Notes:

ALLEGATIONS

Category: Infection Control
Subcategory: Infection Control Practices
Seriousness: Moderate
Findings: Unsubstantiated:Lack of sufficient evidence
Details:

Findings Text:

Printed: [redacted]

Due Date: 04/14/2014

Priority: Non-IJ Medium

Intake ID: [redacted]

Facility ID: [redacted]

Provider Number:

Mgmt.Unit: [redacted]

ACTS Complaint/Incident Investigation Report

SURVEY INFORMATION

Event ID	Start Date	Exit Date	Team Members	Staff ID
3QIS11	05/23/14	05/23/14	[redacted]	[redacted]

Intakes Investigated: [redacted] (Received: 01/14/2014)

SUMMARY OF CITATIONS:

Event ID	Exit Date	Tag
3QIS11	05/23/2014	

State - Not Related to any Intakes

T2069-ORGANIZATION AND ADMINISTRATION.

T0000-INITIAL COMMENTS

EMTALA INFORMATION - No Data

ACTIVITIES

Type	Assigned	Due	Completed	Responsible Staff Member
Medical Records Requested	04/17/2014		04/23/2014	[redacted]
Medical Records Requested	05/20/2014		07/08/2014	[redacted]
Additional Information Requested	05/20/2014		07/08/2014	[redacted]
Schedule Onsite Visit	05/23/2014	05/23/2014	05/23/2014	[redacted]
Investigation Report Completion	06/05/2014		06/06/2014	[redacted]

Printed:

Due Date: 04/14/2014

Priority: Non-IJ Medium

Intake ID:

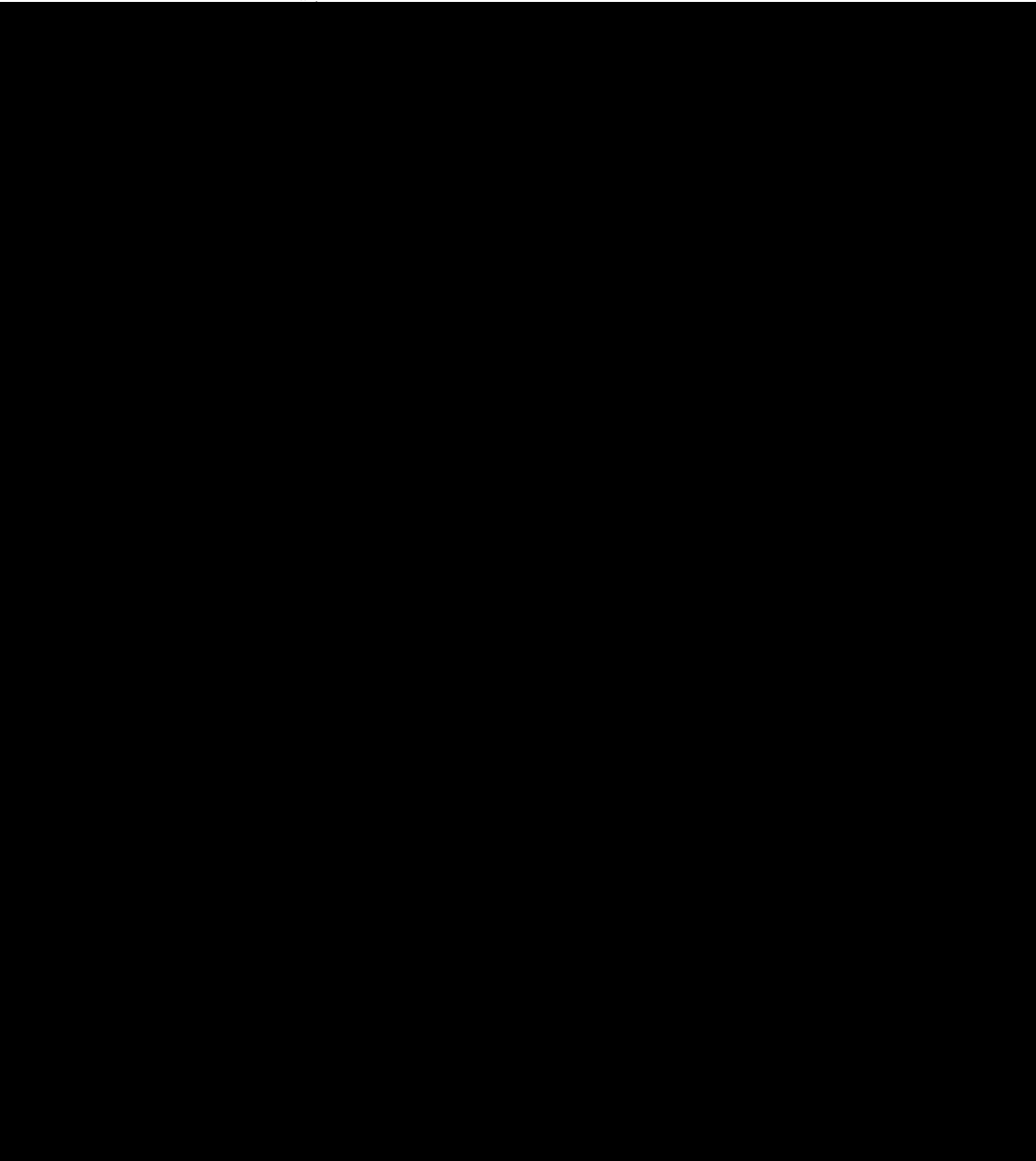
Facility ID:

Provider Number:

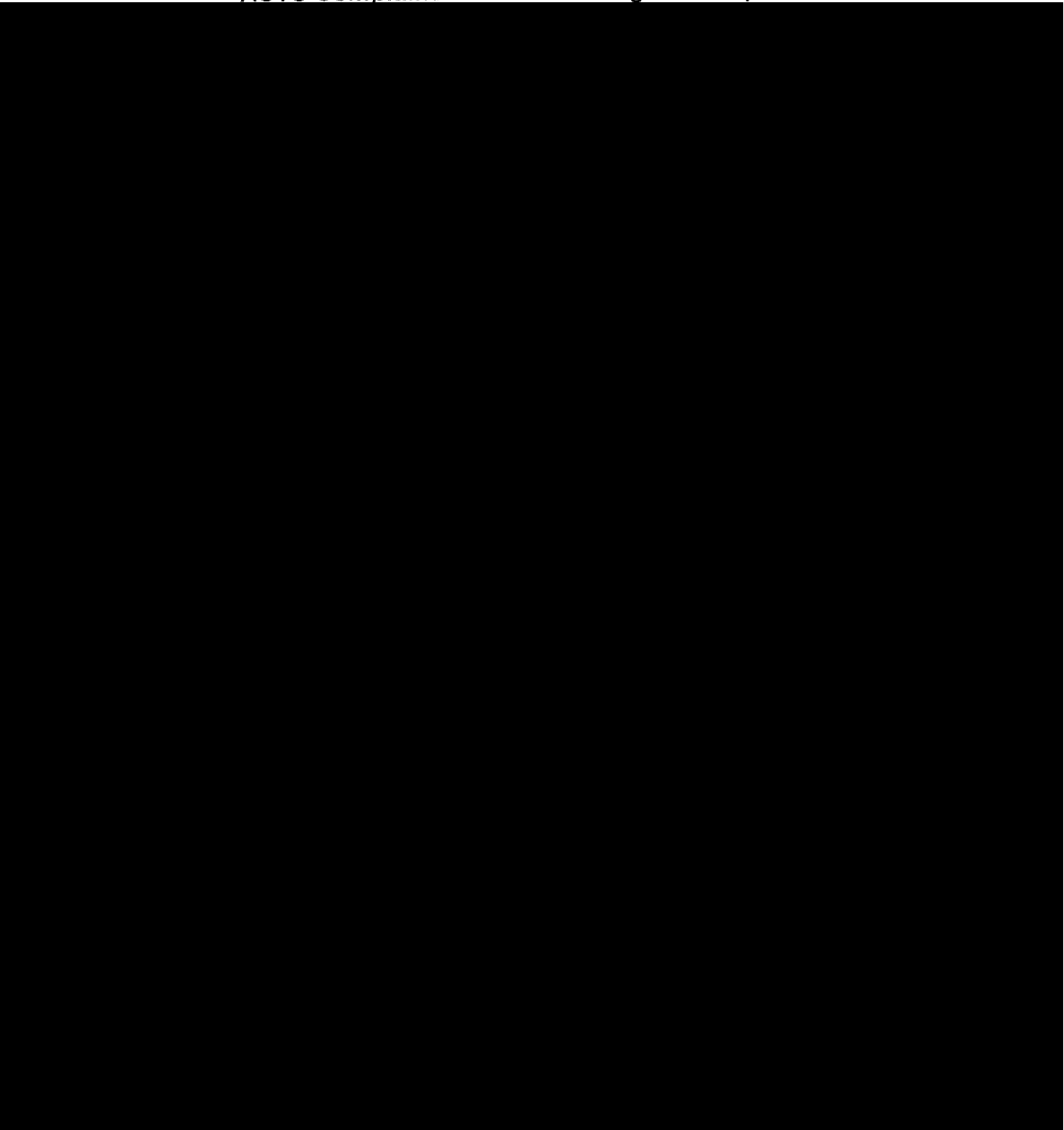
Mgmt.Unit:

ACTS Complaint/Incident Investigation Report

INVESTIGATIVE NOTES



ACTS Complaint/Incident Investigation Report



CONTACTS - No Data

AGENCY REFERRAL - No Data

Printed: [redacted]
Due Date: 04/14/2014
Priority: Non-IJ Medium

Intake ID: [redacted]
Facility ID: [redacted]
Provider Number: [redacted]
Mgmt.Unit: [redacted]

ACTS Complaint/Incident Investigation Report

LINKED COMPLAINTS - No Data

DEATH ASSOCIATED WITH THE USE OF RESTRAINTS/SECLUSION - No Data

Reason for Restraint:
Cause of Death:

NOTICES

Letters:

Created	Description
01/14/2014	CHIP GENERAL ACKNOWLEDGEMENT LETTER/Complainant

Notification:

Date	Type	Party	Method
01/14/2014	Acknowledgement to Complainant	Central Office	Written

PROPOSED ACTIONS

Proposed Action	Proposed Date	Imposed Date	Type
State Only Actions	07/03/2014		Federal
None	07/03/2014		State

Closed: 07/03/2014 **Reason:** Paperwork Complete

END OF COMPLAINT INVESTIGATION INFORMATION

NEW YORK
state department of
HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sue Kelly
Executive Deputy Commissioner

July 3, 2014

Re: Complaint #

Dear

This letter follows the completion of a complaint investigation. The allegation was related to a procedure performed at the and concerns related to infection control.

An unannounced onsite visit was made to the facility on 5/23/14. The investigation included a review of the patient's medical records, the facility's internal investigation, and facility policies and procedures. Information provided by the complainant was also considered.

Based on our review, a concern was identified related to the storage of clean supplies. The outcome of our investigation is reflected in the attached Statement of Deficiencies. However, since appropriate corrective measures have already been implemented, no further Plan of Correction is required.

This deficiency citation relates to non-compliance with the provisions of Title 10, NYCRR (Health) and does not preclude any additional administrative action by this Department.

Section 18 of the Public Health Law requires the Department of Health to provide Board members or trustees of voluntary facilities with notices of violations of Public Health Law or other regulations. A copy of the form transmitting the summary notice is attached. If you have any questions concerning this letter, please feel free to me at

Sincerely

Cc:

NEW YORK STATE DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES ABSTRACT

FACILITY:

TYPE OF SURVEY: Complaint Investigation

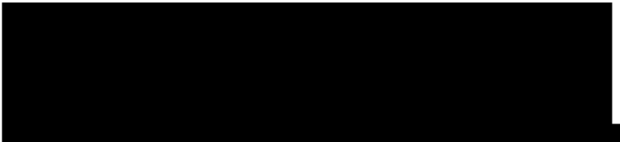
DATE OF SURVEY: July 3, 2014

On the date specified, staff of this office completed a survey of this health care facility for the purpose(s) indicated. Deficiencies were noted in the areas of operation identified below and/or on the reverse.

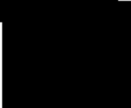
751.5 Organization and Adminstration

This Notice of Violation is provided to you in accordance with Section 18 of the New York State Public Health Law. Section 18 requires the Department of Health to send to each director or trustee of a facility notice of a violation of the Public Health Law or the Department's regulations, which could result in the revocation, cancellation, limitation, or suspension of the facility's operating certificate.

The full Statement of Deficiencies was sent to the facility Administrator and the Chairperson or other designated principal contact of the governing body, with the expectation that its contents would be made available to you. Please take time to secure it and review it. Each deficiency cited is a violation of State and/or Federal regulations and may result in the imposition of a fine and/or other penalty against the facility and/or the revocation, cancellation, limitation, or suspension of its operating certificate. As a member of the facility's governing body, you are responsible for completely correcting the identified deficiencies in a timely manner.



Hospital Program Director



cc: all board members

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA CERTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING ______ B. WING ______	05/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[redacted]

(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

T 000 INITIAL COMMENTS — T 000

PFI # [redacted]
OPERATING CERTIFICATE # [redacted]

NOTE: THE NEW YORK OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS (10NYCRR) DEFICIENCIES BELOW ARE CITED AS A RESULT OF COMPLAINT # [redacted] THE PLAN OF CORRECTION, HOWEVER, MUST RELATE TO THE CARE OF ALL PATIENTS AND PREVENT SUCH OCCURRENCES IN THE FUTURE. INTENDED COMPLETION DATES AND THE MECHANISM(S) ESTABLISHED TO ASSURE ONGOING COMPLIANCE MUST BE INCLUDED.

NO PLAN OF CORRECTION IS REQUIRED FOR THIS STATEMENT OF DEFICIENCIES AS THE FACILITY HAS INITIATED CORRECTIVE ACTION.

T2069 751.5 (a) (13) ORGANIZATION AND ADMINISTRATION. — T2069

Operating Policies and Procedures.
The operator shall ensure:
(a) the development and implementation of policies and procedures written in accordance with prevailing standards of professional practice which include but are not limited to:
(13) the operation, maintenance and security of the center.

This Regulation is not met as evidenced by:
Based on observation and interview the provider failed to implement policies and procedures regarding the storage of clean supplies.

Findings:

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING ______ B. WING ______	05/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE

(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
T2069	Continued From page 1	T2069		

On 5/23/14 a tour of the provider's clinic was conducted with the Chief Operating Officer and a nurse. At 15:20 clean supplies were noted in the dirty room. T

The Program, revised 12/ /12 " was reviewed. The " Program " P) addresses all areas of operations and the prevention of infection. The section pertaining to the cleaning and storage of supplies does not make specific reference to the location where clean supplies should be stored.

On 6/17/14 at 4:40 pm the provider's Director of was interviewed regarding provider policies procedures. The discussion focused on the P, and specifically the storage of clean supplies.

NEW YORK
state department of
HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sue Kelly
Executive Deputy Commissioner

July 3, 2014

Re:
Complaint #

Dear

This letter is to inform you of the results of the investigation of your complaint against the above referenced facility. The allegations related to care you received at the

This investigation included an onsite visit, interview of staff, a review of your medical record and a review of policies and procedures. The concerns identified in your complaint to the Department were reviewed. A concern was identified related to the storage of supplies. The Department will be working with the provider to ensure corrective measures are implemented.

Thank you for bringing your concerns to our attention.

Sincerely,

Printed: [redacted]
Due Date: 04/14/2014
Priority: Non-IJ Medium

INTAKE INFORMATION

Intake Number: [redacted]
Facility ID: [redacted]
Provider Number:
Mgmt.Unit: [redacted]

PROVIDER INFORMATION:

Name:
Address:
City/State/Zip/County:
Telephone:

License #:
Type:
Medicaid #:
Administrator:

INTAKE INFORMATION:

Intake Number:
Taken by - Staff:
Location Received:
Intake Type: Complaint
Intake Subtype: State-only, licensure
SA Contact:
RO Contact:
Responsible Team:
Source:

Received Start: 01/ 2014 At 09:52
Received End: 01/ 2014 At 09:52
Received by: Hotline
State Complaint ID:
CIS Number:
External Control #:

COMPLAINANTS:

Name	Address	Phone	EMail
Link ID: Relationship : self Confidentiality Requested : Y		H:	

RESIDENTS/PATIENTS/CLIENTS:

Name	Admitted	Location	Discharged	Room	Link ID
	/2013		/2013		

INTAKE DETAIL:

Date of Alleged Event: Time: Shift:

Standard Notes: Triaged as state MODERATE

DOB:

states she went to the on 13 to have an abortion. She alleges on 14 she was admitted to for an and She alleges she from the abortion.

4/14/14 Reassigned to
5/20/14 Reassigned to

Extended RO Notes:
Extended CO Notes:

ALLEGATIONS:

Category: Infection Control
Sub-category: Infection Control Practices
Seriousness: Moderate
Details:

Reason for Restraint
Cause of Death

END OF INTAKE INFORMATION

NEW YORK
state department of
HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sue Kelly
Executive Deputy Commissioner

May 20, 2014

Complaint ID#:
Patient:
D.O.B.

Dear

Pursuant to Article 28 of the Public Health Law and Section 400.3 of 10NYCRR, I hereby request a copy of the Admission History & Physical, physician and nurses notes surrounding /13 visit. In addition, please submit a copy of the facility's internal investigation into the matter.

Should you have any questions in regard to this request, I may be contacted at

Thank you for your cooperation.

Sincerely,

New York State Department of Health

PROTECTED HEALTH INFORMATION FAX

This transmission contains protected health information that you are required by law to maintain in a secure and confidential manner. Re-disclosure is prohibited. Failure to maintain confidentiality or re-disclosure without authorization could result in penalties as described in State and Federal law.

To:

Fax:

Date: 6/18/14

From:

Pages (including cover): 2

Re:

Comments:

Hi – addresses I have this to reflect the issues. This will be sent to all staff today. Please call if you have questions or other recommedations.

Thank you

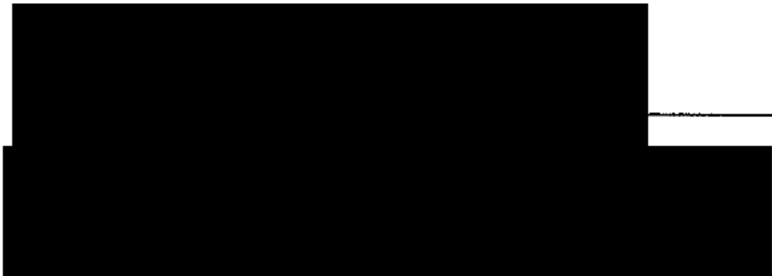
Warning: This message is intended only for the person listed above. The attached information is protected health information and considered privileged by law. If the reader of this fax is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is strictly prohibited. If you are not the recipient, please notify us and shred this information. Thank you for your cooperation.

CERTIFICATION

Pursuant to Section 4518 of the Civil Practice Law and Rules: This is to certify that, to the best of my knowledge, the attached is an exact copy of the original medical record which I have in my custody and control which may be released under the Public Health Law.

There are 38 pages contained in this certified copy, including the certification page.

The medical records were made and kept in the regular course of the business of the agency and is the regular course of the business of the agency to make such medical records (at or about the time of the events described in the medical records).



/ /13, / /13 & / /13
Date of Service

Team Facilitator or Designee

/ /14
Date

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

April 17, 2014

Re:

Dear

Pursuant to Article 28 of the Public Health Law and Section 400.3 of 10NYCRR, I hereby request the medical records for for her and 2014 department visits as well as the History & Physical for her 2014 admission. **This request is not as a result of a complaint against**

This submission should include physician and nursing progress notes, laboratory tests, physician orders, medication sheets and all other documents in the patient files. Any written explanation of the record may accompany the file but cannot be accepted in lieu of it.

Please return these records as soon as possible, to my attention. Should you have any questions in regard to this request, I may be contacted at

Thank you for your cooperation.

Sincerely,

Consultant Nurse