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

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D 172	Continued From page 1 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	D 172		

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D 172	Continued From page 2 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	D 172		

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