April 18, 2019

ATTN: DHI Complaint Unit
PO Box 26110
Santa Fe, NM 87505

Dear Complaint Dept.,

My complaint is against the license pertaining to:

PLANNED PARENTHOOD OF NEW MEXICO
701 SAN MATEO NE
ALBUQUERQUE NM 87108
License Number: 6574

also known as:
Planned Parenthood of the Rocky Mountains and Albuquerque Surgical Health Center

On February 12, 2016, Bianca Coons and Christopher Ruiz, parents of two young infants, went to Planned Parenthood of Albuquerque aka Albuquerque Surgical Health Center and Planned Parenthood of the Rocky Mountains at 701 San Mateo Blvd., NE, Albuquerque, New Mexico, and sought to have a Medically Assisted "MAB" or nonsurgical abortion due to the extreme poverty they were experiencing at the time and the inability to add a third child to their family of four.

A Patient Agreement was executed by the parties on February 12, 2016 for services to be provided by Planned Parenthood to Ms. Bianca Coons.

Dr. (Jane Doe) Han was the supervising physician in charge of Bianca Coons care along with the staff of CNP and RN's at the Planned Parenthood Albuquerque Surgical Center.

Ms. Coons was approximately 5 to 6 weeks into her pregnancy at the time she presented for the "M AB". She informed the staff she and her family were traveling from Idaho to New Mexico for this procedure so it could be done quickly before the fetus grew any bigger as Idaho had a wait period that would result in the baby being much more advanced in development. Her family had used all economic resources available to them at the time to pay the $400 fee for the abortion and to make the trip.

The prescribed regimen of Misoprostol was provided and Ms. Coons consumed the medication in front of PPRM staff and then was given instruction for further oral

administration. The family then returned to Boise, Idaho.

On February 13th, Ms. Coons was experiencing severe nausea, dizziness and felt very weak. She presented to the emergency room at St. Alphounsus Hospital in Boise Idaho and was seen and evaluated by Dr. Toby David. Following the evaluation and examination, the hospital staff informed Ms. Coons that her "baby was fine, in position with a strong heartbeat".

On February 13, 2016, the "on Call Nurse giving Report," identified as 'Kerry,' noted a call from Dr. Toby David from St. Alphounses Medical Center in Boise Idaho stating he was treating Ms. Coons for dehydration and wanted to make sure they should continue with Misoprostol.

"Kerry" noted her recommendations in the clinic call report of her call with Dr. Toby David, that she was "advised to still take Misoprostol and stay hydrated, call PRN if there are any further issues".

"Kerry" further noted on that record that "no further follow-up is indicated," a reference corroborated by comments to Ms. Coons that the abortion was working and would not fail. These statements were not grounded in any factual basis.

On February 15, 2016, Ms. Coons spoke with a "J. McKay, CNP", of Planned Parenthood of Albuquerque (PPRM), who noted Ms. Coons symptoms and advised Ms. Coons to follow up as scheduled and to provide a blood sample to determine HCG levels and proceed as determined by the HCG levels. Ms. Coons requested another MAB if pregnant but could not return to New Mexico from Idaho at the time nor did she have the funds to pay for any further procedures.

Ms. Coons agreed to, and did have, the bloodwork done as instructed which determined the pregnancy was still viable.

On February 16, 2016, "L. Trellion, RN ' spoke with Ms. Coons to follow up on her condition. Ms. Coons at that time reported " still feeling pregnant." RN Trellion informed Ms. Coons that occasionally another dose could be called in or arrangements made for a suction procedure if next blood work indicates the pregnancy is persisting.

The contract entered into between Coons and PPRM provided the PPRM would provide all necessary follow up report. The Contract referenced the provider as playing this role. In the contract the "provider," Planned Parenthood, was not defined or distinguished as between one Planned Parenthood agency and another.

Ms. Coons was instructed that she could return to New Mexico where another procedure would be paid for, however if she remained in Idaho, she would be responsible for the payment for any additional procedure(s) performed in Idaho.

Mr. Ruiz and Ms. Coons repeatedly informed PPRM, Albuquerque that they did not have additional funds for another procedure after the failed procedure and requested that Planned Parenthood include the additional treatment needed to complete the abortion in the cost of the original payments for the MAB since the first one had failed and the contract provided that PPRM would, as the provider, provide follow up to complete the abortion.

On March 3, 2016, "M. Coston, RN' from the Planned Parent Surgical Center spoke with Ms. Coons who informed her that she was still pregnant and did not have the funds for a second round of the abortion protocol. The fetus had now developed to somewhere around nine weeks. Ms. Coons could not morally sanction further action to terminate the fetus as this was the original reason she had travelled to New Mexico in consideration of her choice to terminate the fetus while it was relatively undeveloped at under 6 weeks.

Ms. Coons further informed RN Coston, that she was going to an OB- GYN, and, at this point, she felt impelled to keep the pregnancy after what had occurred.

On March 3, 2016, Planned Parenthood of Albuquerque sent Ms. Coons an MAB follow up letter informing her that Misoprostol can cause birth defects. No further arrangements to follow up with Ms. Coons were made.

As a result of the failed MAB, the child Mateo Kobe Ruiz was born on August 28, 2016.

RULES VIOLATED:

This is grounds for revocation of it's license according to http://164.64.110.239/nmac/parts/title07/07.011.0002.htm which is TITLE 7 HEALTH, CHAPTER 11 OUTPATIENT FACILITIES, PART 2 REQUIREMENTS FOR FACILITIES PROVIDING OUTPATIENT MEDICAL 7.11.2.17:

GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES: A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following:

A. failure to comply with any provision of these regulations;

D. misrepresentation or falsification of any information on application forms or other documents provided to the licensing authority;

F. failure to provide the required care and services as outlined by these regulations for the patients receiving care at the facility.

This Rule might have been violated:

7.11.2.25 E and F and I

It is unclear if they have health certificates (nurse and alleged doctor) and copy of current licenses and agreements /contracts with independant contractors of staff.

Ms. Coons patient rights were violated because she was poor.

It is questionable if this incident was report and if this rule was violated. Please look into this as this is privy to the public:

Please check if this was reported considering this Rule:

7.11.2.22 REPORTING OF INCIDENTS: All facilities licensed pursuant to these regulations must report to the licensing authority any serious incident or unusual occurrence which has, or could threaten the health, safety, and welfare of the patients or staff, such as but not limited to:

C. any serious human errors by staff members of the facility which has resulted in the death, serious illness, or physical impairment of a patient; or

Ms. Coons was injured as a result of the neglect of this licensed facility.

Another rule violated is:

7.11.2.24 PATIENT RECORDS: Each facility licensed pursuant to these regulations must maintain a medical record for each patient. Every record must be accurate, legible and promptly completed. Medical records must include at least the following:

A. ambulatory surgical centers:

(1) patient identification;

(2) significant medical history and results of physical examination;

(3) pre-operative diagnostic studies (entered before surgery), if performed;

(4) findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body;

(5) any allergies and abnormal drug reactions;

(6) entries related to anesthesia administration;

(7) documentation of properly executed informed patient consent; and

(8) discharge diagnosis;

B. diagnostic and treatment centers, rural health clinics, limited diagnostic and treatment centers:

(1) patient identification;

(2) patient consent forms (if applicable);

(3) pertinent medical history;

(4) assessment of the health status and health care needs of the patient;

(5) brief summary of the episode for which the patient is requiring care;

(6) disposition, and instructions to the patient;

(7) reports of physical examinations, diagnostic and laboratory test results, and consultative findings; and

(8) all physician's orders, reports of treatments and medication and other pertinent information necessary to monitor the patient's progress;

C. infirmaries:

(1) same as Paragraphs (1) through (8) of Subsection B of 7.11.2.24

NMAC above;

(2) nursing notes (for those patients requiring overnight care or observation); and

(3) medication chart (if applicable);

D. new or innovative outpatient service:

(1) same as Paragraphs (1) through (8) of Subsection B of 7.11.2.24 NMAC] above;

(2) any other information deemed necessary by the licensing authority after review and approval of the new or innovative service.

Ms. Coons Patient Rights were violated also. This Rule applies:

7.11.2.26 PATIENT RIGHTS:

A. All facilities licensed pursuant to these regulations shall support, protect and enhance the rights of patients as shown below:

(1) the right to efficient and equal service, regardless of their race, sex, religion, ethnic background, education, social class, physical or mental handicap, or economic status;

(2) the right of considerate, courteous and respectful care from all staff of the facility;

(3) the right of complete information in terms the average patient can reasonably be expected to understand;

(4) the right to informed consent and full discussion of risks and benefits prior to any invasive procedure, except in an emergency; alternatives to the proposed procedure must be discussed with the patient;

(5) the right to obtain assistance in interpretation for non-English speaking patients;

(6) the right to know the names, titles, and professions of the facility staff to whom the patient's speaks and from whom services or information are received;

(7) the right to refuse examination, discussion and procedures to the extent permitted by law and to be informed of the health and legal consequences of this refusal;

(8) the right of access to patient's personal health records;

(9) the right of respect for the patient's privacy;

(10) the right of confidentiality of the patient's personal health records as provided by law;

(11) the right to expect reasonable continuity of care within the scope of services and staffing of the facility;

(12) the right to respect for the patient's civil rights and religious opinions;

(13) the right to present complaints to the management of the facility without fear of reprisal;

(14) the right to examine and receive a full explanation of any charges made by the facility regardless of source of payment.

B. Facility staff shall be informed of and demonstrate their understanding of the policies on patient rights and responsibilities through orientation and in-service training activities.

C. Patient rights will be posted in the facility both in English and Spanish where they may be readily seen by the public.

D. The method by which a patient may register a complaint will be posted in the facility where it may be readily seen by the public.

Please revoke this facilities license according to this Rule as a result of their violations:

7.11.2.17 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES:

A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following:

A. failure to comply with any provision of these regulations;

F. failure to provide the required care and services as outlined by these regulations for the patients receiving care at the facility.

I would urge you according to 7.11.2.16 SUSPENSION OF LICENSE WITHOUT PRIOR HEARING in accordance with Section 24-1-5 (H) NMSA 1978, to take immediate action to protect human health and safety. Please revoke this license.

Planned Parenthood has violated 7.11.2.22 (REPORTING OF INCIDENTS) which is pertaining to this licensed facility not reporting to the licensing authority any serious incident or unusual occurrence which has, or could threaten the health, safety, and welfare of the patients such as but not limited to:

C. any serious human errors by staff members of the facility which has resulted in the death, serious illness, or physical impairment of a patient;

Planned Parenthood has violated the above requirements, laws, codes and regulations. The public's health is at risk everyday their doors are still opened for incompetent and negligent treatment.

Why couldn't Ms. Coons find out the full names of the pregnancy terminator physician name and all her nurses' names?

Planned Parenthood has committed negligence, misrepresentation and misprescription. It is unclear whether informed consent was full done.

Planned Parenthood has seemingly violated this Rule also: 7.11.2.25 E and F and I

It is unclear if they have health certificates (nurse and alleged doctor) and copy of current licenses and agreements /contracts with independant contractors of staff.

Ms. Coons patient rights were violated because she was poor.

Planned Parenthood has intentionally caused, or recklessly disregarded the risks of causing this emotional distress. They were negligent in causing Ms. Coons emotional distress. Planned Parenthood's acts were willful, wanton and in reckless disregard for the safety and well being of Ms. Coons.

If you need to contact Ms. Coons attorney his information is:

John McCall
500 Oak Street NE - Suite 108
Albuquerque, NM 87106
P: 505.256.1998
mccall.jo@gmail.com

While it is unknown how many previous complaints against this licensee exist I do know that I submitted one on July 12, 2018 which was closed and no investigation done because of the Planned Parenthood patient botch timeframe.

I would hope with this new complaint that you will revisit your decision to do nothing and be proactive as you are the eyes and ears for the public. Planned Parenthood is a direct threat to the public's health and safety as they have proven once again.

Thank you very much.