Intake ID:
Facility ID: DTC
Provider Number:
Mgmt.Unit: 3SYR

ACTS Complaint/Incident Investigation Report

PROVIDER INFORMATION

Name: PLANNED PARENTHOOD OF THE NORTH COUNTRY, NE
Address:
City/State/Zip/County:
Telephone:

License #: 2201201R
Type: DTC
Medicaid #: 2201201R
Administrator:

INTAKE INFORMATION

Taken by - Staff: CERASANO, LISA J.
Location Received: P & A C - C H I P - C O
Intake Type: Complaint
Intake Subtype: State-only, licensure
External Control #:
SA Contact: BAIRD, COLLEEN D.
RO Contact:
Responsible Team: P & A C - C N Y R O - SYRACUSE
Source: State Survey Agency

Received Start: 10/17/2012 At 10:20
Received End: 10/17/2012 At 10:20
Received by: Hotline
State Complaint ID: 3561208001
CIS Number:

COMPLAINANTS

Name	Address	Phone	EMail
(Primary)			
Link ID:			

RESIDENTS/PATIENTS/CLIENTS - No Data

ALLEGED PERPETRATORS - No Data

INTAKE DETAIL

Date of Alleged Time: Shift:

Standard Notes: Case triaged as State Moderate.

Patient was seen at the on /12 for a exam. performed indicated of Estimated by date of last of 12 was
Patient seen at the on /12 for an
Procedure started at: 3.34 pm. Procedure end time: 4:00 pm. After first examination of of the physician decided to began at 4:05 pm and ended at 4:15pm. Final examination of of revealed all an estimated of Estimated loss of ml. Physician ordered 0.2mg and was administered by 1st LPN at 4:12 pm. It was after the procedure was completed that patient began to Physician ordered and 1st LPN administered at 4:22 pm a second dose of 0.2mg IM. Physician Physician instructed staff to call 911 for transfer to hospital. 2nd LPN called 911 at 4:25 pm. Medical Resident, with the assistance of 2nd LPN, started 1st LPN monitored patient ' s BP and pulse. BP would not register with electronic BP machine. 1st LPN documented that patient was alert but feeling Pulse was and The LPN was unable to count pulse since she was constantly talking to patient to keep her alert. Patient never lost consciousness. Ambulance arrived within 4 minutes of call. 2nd LPN notified Emergency room that patient would be arriving.

Extended RO Notes:
Extended CO Notes:

ALLEGATIONS

Category: Other Services
Subcategory: Outpatient Services
Seriousness: Moderate
Findings: Substantiated:State deficiencies related to the alleg are cited
Deficiencies Cited: State-T-2008-ORGANIZATION AND ADMINISTRATION. Operator. (751.2 (b))

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Deficiencies Cited: State-T-2056-ORGANIZATION AND ADMINISTRATION. (751.5 (a))

State-T-2114-ORGANIZATION AND ADMINISTRATION. (751.7 (d))

Details: Inadequate management of the patient during a

Findings Text:

Based on findings from document review and interviews, the care provided to Patient A in connection with a performed at the Planned Parenthood of North Country New York (PPNCNY) did not meet generally accepted standards of professional practice for patient safety. Up to date patient information and necessary equipment / supplies were not immediately available for the procedure and management of any complications that might occur. Also, during the emergency that did occur in this case, PPNCNY staff did not monitor VSs and apply oxygen per the facility's patient emergency procedures.

Findings include:

-- Review of Patient A's MR reveals the following information:

On 12, Patient A presented to PPNCNY for a An undated report in the MR indicates the patient's was and prior - it states the estimated was and and "please recheck at visit." The report does not include all measurements obtained for determining the and does not provide a clear explanation of why a repeat was necessary. The signature of the staff member who performed the is partially covered and not discernable.

Physician progress notes (dated one day later, 12) specifically describe or state the following information:

- An performed in the PPNCNY extension clinic on 12 indicated the was "Yesterday would then be and

- "Procedure began in usual fashion ... However, After decision was made to look at Also requested a #14 was retrieved + (and) initially no could be found to use with the While that was being sought, examined...clearly

- At the completion of the procedure with and were noted. Examination did not reveal a the was thought to be based on good and all accounted for. was given and was performed. but when ceased, again. At this time, emergency medical services (EMS) was called. A second dose o was given and continued. A medical resident established a and administration was initiated. (The MR lacks details about the i.e., name of the staff who it, used, the connected and rate of administration, as well as the amount prior to transport of patient to a hospital.)

Progress notes by licensed practical nurse (LPN) #1, dated 12, state "Attempted to assess vital signs, unable to get BP (blood pressure) with automatic BP cuff, ... pulse monitoring continued until arrival of Last vital sign recorded at 4:16 immediately post procedure - I was unable to count the rate of pulse as I was doing many other things at the same time such as moving equipment for the stretcher and talking to the patient."

LPN #2 documented 911 was called at 4:25 pm (arriving 4 minutes later), and that he/she called the emergency room to alert the staff the patient was on her way via ambulance.

-- The PPNCNY policy and procedure (P&P) titled Management of Emergencies," dated 01/2010, indicates that in an emergency situation the patient's vital signs must be documented every 3-5 minutes until the situation has stabilized or the client is transferred. The P&P also indicates that when occurs, oxygen will be provided by face mask at 10-12 liters/minute.

-- Per interview with LPN #1 on 04/08/13 at 1:00 pm, he/she could not read the report for Patient A because it was faxed and the copy was not good. He/she did not make any calls to obtain clarification. At the time of this case, the facility did not have a manual BP cuff, only a BP machine. The patient's pulse was too rapid to count and he/she was too busy talking to the patient to take the vital signs. LPN #1 could not explain why he/she did not put oxygen on the patient.

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-- During interview with Regional Manager (RM) #1 on 13 at 1:00 pm, he/she acknowledged that the facility did not have manual BP cuffs and that patient A's MR lacks details about the

-- In summary, in this case involving complication of

* Th report was visually difficult to read, did not contain complete information and also lacked the date of the procedure and the complete signature of the proceduralist.

* There is no indication the was rechecked at the visit as directed in the eport.

* Staff did not verify the availability of all necessary equipment prior to the start of the procedure.

* A manual BP cuff was not available for back up when the automated cuff did not work.

* The patient's VSs were not carefully monitored and recorded every 3-5 minutes during the emergency.

* Oxygen was not administered to the patient.

Based on findings from document review and interview, PPNCNY staff were not complying with the facility policy and procedure (P&P) regarding the performance of In reports of 2 examinations done by a NP in training (for , the reports lack evidence oversight was provided during the procedure and that the interpretation the NP provided was reviewed and finalized by a physician. Also, in 14 ultrasound reports reviewed in 6 medical records (MRs), complete details as well as the signature of an interpreting physician were lacking.

Findings include:

-- Per review of the facility P&P titled Services," dated 12/2011, it indicates an may only be performed by an affiliate-employed certified ... or an affiliate physician privileged in the performance of It also indicates that personnel interpreting and providing final reports for must be affiliate physicians.

Also, the P&P indicates that initial training for an must include a combination of direct observation of technique and submission of the to the program director (or designee) for review. It states that a minimum of 20 must be completed by the trainee.

-- Review of Patient F's MR reveals NP #2 performed 2 and signed the reports with the words "in training" after his/her signatures. There is no documentation indicating that another practitioner or physician observed the trainee or reviewed the interpretation the NP provided on the reports.

-- Review of the MRs for Patients A through F reveals the following lapses in the reports of 14 examinations performed by NPs who were PPNCNY-certifed

* 14 lack evidence the findings were interpreted by an affiliate physician (i.e., physician signatures are lacking);

* 2 lack the date of the procedure;

* 4 contain signatures that are either illegible or are covered by the which is glued to the report);

In the 14 reports, 7 pertain to examinations done for The following lapses are noted in those 7 reports:

* 2 lack information responding to the question of whether activity was detected;
* 1 lacks description of the number of present; and
* 2 lack the estimated

-- During interview with the VPPS on 03/26/13 at 12 p.m., he/she acknowledged PPNCNY did not have physicians interpreting the as required by PPNCNY's P&P (which is based on the Planned Parenthood Federation of America standards).

Based on findings from document review and interview, information recorded in PPNCNY medical records (MRs) was incomplete. The MR for Patient A lacks complete information regarding an that was during an emergency (see pertinent findings in tag T2031). Also, the US reports in Patient A's and 5 other patients' MRs lack complete information and legible signatures (see the findings in tags T2031 and T2056).

SURVEY INFORMATION

Event ID	Start Date	Exit Date	Team Members	Staff ID
LX5S11	11/05/12	11/05/12	Holgate, Mary Ellen	25327
			Baird, Colleen D.	21517

Intakes Investigated: Received: 10/17/2012)

SUMMARY OF CITATIONS:

Event ID	Exit Date	Tag
LX5S11	11/05/2012	
		State - Link to This Intake
		T2008-ORGANIZATION AND ADMINISTRATION. Operator.
		T2114-ORGANIZATION AND ADMINISTRATION.
		T2056-ORGANIZATION AND ADMINISTRATION.
		State - Not Related to any Intakes
		T0000-INITIAL COMMENTS

EMTALA INFORMATION - No Data

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ACTIVITIES

Type	Assigned	Due	Completed	Responsible Staff Member
Medical Records Requested	11/05/2012		11/05/2012	BAIRD, COLLEEN D.
Schedule Onsite Visit	11/05/2012		11/30/2012	BAIRD, COLLEEN D. HOLGATE, MARY ELLEN
Telephone Contact - Other	11/06/2012		11/06/2012	BAIRD, COLLEEN D.
Additional Information Requested	11/06/2012		11/06/2012	BAIRD, COLLEEN D.
Electronic Contact	11/13/2012		11/13/2012	BAIRD, COLLEEN D.
Telephone Contact - Other	11/19/2012		11/19/2012	BAIRD, COLLEEN D.
File Review	11/26/2012		11/26/2012	BAIRD, COLLEEN D.
Additional Information Requested	12/21/2012		12/21/2012	BAIRD, COLLEEN D.
Telephone Contact - Other	12/26/2012		12/26/2012	BAIRD, COLLEEN D.
Telephone Contact - Other	02/13/2013		02/13/2013	BAIRD, COLLEEN D.
Additional Information Requested	03/27/2013		03/27/2013	BAIRD, COLLEEN D.
Additional Information Requested	04/01/2013		04/01/2013	BAIRD, COLLEEN D.
Telephone Contact - Other	04/05/2013		04/05/2013	BAIRD, COLLEEN D.
Telephone Contact - Other	04/08/2013		04/08/2013	BAIRD, COLLEEN D.
Investigation Report Completion	04/10/2013		04/10/2013	GANCARZ, ROBERTA
Telephone Contact - Other	04/29/2013		04/29/2013	BAIRD, COLLEEN D.
Supervisory Review and Sign Off	04/29/2013		04/29/2013	GANCARZ, ROBERTA

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INVESTIGATIVE NOTES

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CONTACTS - No Data

AGENCY REFERRAL

Agency	Contact Name	Date Referred	Due Date	Agency Visit	Report Received	RO/SA
Island Peer Review Orgranization (IPRO)		12/19/2012			01/30/2013	S

LINKED COMPLAINTS - No Data

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

Reason for Restraint:
Cause of Death:

NOTICES

Notification:

Date	Type	Party	Method
10/17/2012	Acknowledgement to Complainant	Central Office	E-Mail

PROPOSED ACTIONS

Proposed Action	Proposed Date	Imposed Date	Type
State Only Actions	04/29/2013	04/29/2013	Federal
POC (No Sanction)	04/29/2013	04/29/2013	State

Closed: 01/13/2014 **Reason:** Paperwork Complete

END OF COMPLAINT INVESTIGATION INFORMATION