Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011118	A. BUILDING: _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCK	8590 GEORGETOWN RD INDIANAPOLIS, IN 46268

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T 000	INITIAL COMMENTS This visit was for a state licensure survey. Facility Number: 011118 Survey Date: 03-27-2018 to 03-28-2018 QA: 4/02/2018	T 000		
T 004	410 IAC 26-2-7 LICENSE REQUIREMENTS 410 IAC 26-2-7 A license issued under this article must be conspicuously posted on the premises in an area open to patients. This RULE is not met as evidenced by: Based on observation, the facility failed to conspicuously post a current license for 1 facility. Findings include: 1. On 03-27-2018 at 2:50 pm. in the presence of employee #A2, Vice President of Patient Services, and employee #A5, Health Center Manager, it was observed in the waiting room area there was not a current license posted. The license posted was observed to have an expiration date of 06-30-2017.	T 004		

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T 134	Continued From page 1	T 134		
T 134	410 IAC 26-7-2 MEDICAL RECORDS 410 IAC 26-7-2(c) (c) Patient records for surgical abortions must document and contain, at a minimum, the following: (1) Patient identification. (2) Appropriate medical history. (3) Results of the following: (A) A physical examination. (B) Diagnostic or laboratory studies, or both (if performed). (4) Any allergies and abnormal drug reactions. (5) Entries related to anesthesia administration. (6) Evidence of appropriate informed consent for procedures and treatments as required by IC 16-34-2- 1.1. (7) A report describing techniques, findings, and tissue removed or altered. (8) Authentication of entries by the physician or physicians and health care workers who treated or cared for the patient. (9) Condition on discharge, disposition of the patient, and time of discharge. (10) Discharge entry to include instructions to the patient or patient ' s legal representative. (11) A copy of the following: (A) The transfer form if the patient was referred to a hospital or other facility. (B) The terminated pregnancy report filed with the department. (12) Any report filed with a state agency or law enforcement agency pursuant to a statutory reporting requirement.	T 134		

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T 134	Continued From page 2 This RULE is not met as evidenced by: Based on document review and interview, one (1) of thirty (30) medical records reviewed lacked documentation of appropriate informed consent for procedures and treatments as required by IC 16-34-2-1.1. 1. PPINK Administrative Chapter 4: Consent, Informed Consent and Patient Education, last revised 6/2016, indicated: The informed consent process must take place. It is the professional and legal duty of every affiliate to provide each patient with adequate information regarding the nature of the proposed services. 2. Medical record #30 lacked documentation of a signed abortion informed consent certification, State Form 55320. 3. Staff member #O4 indicated in interview on 3/28/2018 at 1000 hours, that the medical record #30 lacked documentation of the required form. He/she also indicated that since the forms are scanned into the EMR, that it may not have gotten scanned in.	T 134		
T 144	410 IAC 26-8-1 PERSONNEL POLICIES AND RECORDS 410 IAC 26-8-1(c)(1) (c) The clinic must do the following: (1) Maintain current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on the job	T 144		

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T 144	Continued From page 3 description, for each employee and contract and agency personnel. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to follow its policy to conduct an annual evaluation on 1 of 4 employees files reviewed. Findings include: 1. Review of the Employee Handbook, approved February 2015, indicated employees may receive an annual performance evaluation. 2. Review of 4 employee personnel files indicated file P4, Nurse Practitioner, did not have any documentation of a current annual evaluation. 3. In interview on 03-28-2018 at 10:30 am, employee #A2, Vice President Patient Services, confirmed all the above, including the facility policy was as indicated in the Employee Handbook, and no other documentation was provided prior to exit.	T 144		
T 168	410 IAC 26-8-3 PERSONNEL POLICIES AND RECORDS 410 IAC 26-8-3(b)	T 168		

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T 168	Continued From page 4 (b) The clinic shall ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and clinic policy for all health care workers including contract and agency personnel who provide direct patient care. This RULE is not met as evidenced by: Based on document review and interview, the clinic failed to ensure that one (1) staff members of ten (10) staff member's personnel files reviewed and 1 of 6 medical staff credential files reviewed, had documented cardiopulmonary resuscitation (CPR) competency per facility policy. Findings include; 1. Review of a facility document titled PPINK 0417, CPR Certification Policy, approved 4/21/2017, indicated the Following; Purpose: All staff participating in patient care must be Basic Life Support (BLS) Cardiopulmonary Resuscitation certified by the American Heart Association. Policy: All staff who are not CPR certified at hire are required to obtain certification prior to beginning patient care. 2. Nursing Personnel #N3's file, healthcare assistant, who was hired 9/5/2017, and does patient care, lacked documentation of CPR training.	T 168		

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T 168	Continued From page 5 3. Review of medical staff credential files indicated file MD#6 Medical Director, a direct patient care provider, did not have any documentation of current CPR competency, per facility policy. 4. In interview on 3/28/2018 at 1050 hours, employee #A7, Human Resources Generalist, confirmed all the above and no other documentation was provided prior to exit. 5. In interview on 3/28/2018 at 1200 hours, staff member #O5, Human Resources, indicated agreement with the finding that staff #N3's personnel file lacked documentation of CPR training.	T 168		
T 206	410 IAC 26-11-1 INFECTION CONTROL PROGRAM 410 IAC 26-11-1(a)(1) (a) The clinic must do the following: (1) Provide a safe and healthful environment that minimizes infection exposure and risk to the following: (A) Patients. (B) Health care workers. (C) Persons who accompany patients. This RULE is not met as evidenced by: Based on observation, document review and interview, the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk in 1 instance. Findings include:	T 206		

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T 206	Continued From page 6 1. On 03-27-2018 at 3:25 pm in the presence of employee #A2, Vice President of Patient Services, employee #A5, Health Center Manager, and employee #A6, Health Care Assistant, it was observed in an ultrasound room there were test strips being used to determine the effectiveness of Cidex, a chemical agent being used to disinfect probes for ultrasound procedures. 2. Review of the manufacturer's recommendation on the insert package of Instructions for Quality Control Procedures of the test strip bottle indicated testing of positive and negative controls must be performed on each newly opened bottle of CIDEX OPA Solution. 3. On the above date and time, employee #A6 was requested to provide documentation of following the above-stated Quality Control Procedures. The employee indicated there was no such documentation because the Quality Control Procedures were not performed, and no other documentation was provided prior to exit.	T 206		
T 320	410 IAC 26-16-1 PHARMACEUTICAL SERVICES 410 IAC 26-16-1(2) The clinic must provide drugs and biologicals in a safe and effective manner in accordance with accepted professional practice. The clinic must have the following: (2) Records of stock supplies of all scheduled substances, including an accounting for all items purchased and dispensed.	T 320		

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T 320	Continued From page 7 This RULE is not met as evidenced by: Based on document review and interview, the facility failed to follow its policy for accounting of scheduled substances in 67 of 90 instances, and failed to document the Medical Director Review of the log used for the accounting in 9 of 9 instances. Findings include: 1. Review of facility policy titled Health Center Logs, REFERENCE CODE: PS04, approved 11-29-2017 indicated staff must follow the instructions on each log. 2. Review of 9 facility documents titled CONTROL SUBSTANCE LOG, dated 1/31/18 through 3/4/18, indicated the following: Instructions: Must be completed every procedure day by 2 staff members (2 licensed staff members, 1 licensed staff member and the health center manager or assistant manager) for all control substances. An unlicensed staff member may only complete the count if a licensed staff member, Health Center Manager, or Assistant Manager is not on site. Provider and Health Center Manager should review log monthly and document review by signing and dating below. 3. Further review of the 9 facility documents titled CONTROL SUBSTANCE LOG indicated: 90 daily entries - 23 were initialed by 2 licensed staff members and 67 were initialed by only 1 licensed staff member 9 log pages were not signed indicating the Provider had reviewed.	T 320		

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T 320	Continued From page 8 4. In interview on 03-27-2018 at 2:35 pm, employee #A2, Vice President of Patient Services, confirmed all the above and no other documentation was provided by exit.	T 320		
T 404	410 IAC 26-17-3 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-3(2) The condition of the physical plant and the overall clinic environment must be developed and maintained in such a manner that the safety and well-being of patients is assured as follows: (2) No condition may be created or maintained that may result in a hazard to: (A) patients; (B) authorized visitors; or (C) employees. This RULE is not met as evidenced by: Based on observation, the facility created 1 condition that may have resulted in a hazard to patients, authorized visitors, or employees. Findings include: 1. On 03-27-2018 at 3:15 pm in the presence of employee #A2, Vice President of Patient Services, and employee #A5, Health Center Manager, it was observed in the hallway next to a crash cart, there was 1 small oxygen tank unsecured by chain or holder. If the tank was knocked over and broke the head off the compressed cylinder, it could result in harm to	T 404		

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T 404	Continued From page 9 people and/or property.	T 404		