	<u>tate Department of He</u>		7		O/al b Par	CHOVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN C	F CORRECTION	DERITO HORIZONIO	A. BUILDING:	· · · · · · · · · · · · · · · · · · ·			
		011118	B, WING		03	/29/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE			
		8590 GE	ORGETOWN RD				
PLANNED	PARENTHOOD OF INDI	ANA AND KENTUCY INDIANA	POLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
T 000	INITIAL COMMENTS		Т 000				
	This visit was for a st	ate Ilcensure survey.					
	Facility Number: 011	118					
	Survey Date: 03-27-2	2018 to 03-28-2018					
	QA: 4/02/2018	·					
T 004	410 IAC 26-2-7 LICE	NSE REQUIREMENTS	T 004				
	410 IAC 26-2-7				,		
	A license issued unde conspicuously posted open to patients.	er this article must be t on the premises in an area				-	
			17 17 17 17 17 17 17 17 17 17 17 17 17 1				
				•			
	This RULE is not me Based on observatio conspicuously post a	ot as evidenced by: n, the facility failed to current license for 1 facility.					
	Findings include:				ÿ		
	employee #A2, Vice Services, and emplo Manager, it was obs	yee #A5, Health Center erved in the waiting room current license posted. The observed to have an					
Indiana State	Department of Health DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE .		(X6) DATE	

If continuation sheet 1 of 10

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Indiana State Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDPLAN	OF CORRECTION	IDEIGH PICATION NOWBER:	A. BUILDING:		COMPLETED	
		011118	B. WING		03/29/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
m) ANNERD	DARCHTUOOD OF MO	ANA AND KENTUCK 8590 GEOF	RGETOWN RD	1		
PLANNED	PARENTHOOD OF INDI	INDIANAPO	DLIS, IN 4626	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE, COMPLET	
Т 134	Continued From page	:1	T 134	1		
T 134	410 IAC 26-7-2 MEDI	CALRECORDS	T 134			
	410 IAC 26-7-2(c)					
The state of the s	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,					

STATEMENT	Indiana State Department of Health TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		} ` `	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		011118	B. WNG		03/29/2018	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	TE, ZIP CODE		
PLANNED	PARENTHOOD OF INDI	IANA AND KENTLICK	RGETOWN RD POLIS, IN 46268	}		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLI	ETE
T 134	Continued From page	e 2	T 134			
	of thirty (30) medical documentation of appropriation of approvedures and transfer	review and interview, one (1) records reviewed lacked propriate informed consent reatments as required by IC ative Chapter 4: Consent, and Patient Education, last ated: The informed consent ace. It is the professional ary affiliate to provide each e information regarding the				
	3/28/2018 at 1000 ho #30 lacked documen He/she also indicate	4 Indicated in Interview on ours, that the medical record nation of the required form. d that since the forms are IR, that it may not have			A control of the cont	
T 144	410 IAC 26-8-1 PER RECORDS	SONNEL POLICIES AND	T 144			
	410 IAC 26-8-1(c)(1))				
	reporting responsibil	o the following: ent job descriptions with litles for all personnel and luations, based on the job				

Indiana State Department of Health

	r of deficiencies Of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		011118	B. WING		03/29/2018
NAME OF P	ROVIDER OR SUPPLIER		AODRESS, CITY, ST	•	
PLANNED	PARENTHOOD OF INDI	ANA AND KENTUC⊁	EORGETOWN RE APOLIS, IN 4626		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
T 144	Continued From page	3	T 144		
	description, for each e agency personnel.	employee and contract and			
		·			
		eview and interview, the its policy to conduct an			
	Findings Include:				
		oloyee Handbook, approved ted employees may receive se evaluation.			
	2. Review of 4 emplo indicated file P4, Nurs any documentation of evaluation.	e Practitioner, did not have			
	confirmed all the above policy was as indicate	resident Patlent Services, re, including the facility			
T 168	410 IAC 26-8-3 PERS RECORDS	ONNEL POLICIES AND	T 168		
	410 IAC 26-8-3(b)				

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	tate Department of He	alth							
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _						
			,						
		011118	B. WING		03/29/2018				
		CATHELET AL	DOCCC OITY STAT	TE ZID CODE					
NAME OF PE	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8590 GEORGETOWN RD								
PLANNED	PARENTHOOD OF INDI	ANA AND KENTUCI	POLIS, IN 46268						
			1	PROVIDER'S PLAN OF CORRECTION	(X5)				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE				
PREFIX TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	NATE DATE				
				DEFICIENCY)					
T 168	Continued From page	a 4	T 168						
1 100		•							
	(b) The clinic shall en	sure cardiopulmonary							
		competence in accordance							
		s of practice and clinic policy rkers including contract and							
	adency personnel wh	o provide direct patient care.							
	agency personner wi	o provide and or panetic early.							
	This RULE is not me								
		review and interview, the							
;	of ten (10) staff mem	that one (1) staff members							
	reviewed and 1 of 6 i	medical staff credential files							
		nented cardiopulmonary	1						
		competency per facility	,						
	policy.								
	, ,		-						
	Findings include;								
	1. Review of a facilit	y document titled PPINK							
	0417, CPR Certificat								
	4/21/2017, indicated								
	Purpose:								
	All staff participating	in patient care must be Basic							
	Life Support (BLS) C	ardiopulmonary	i e						
		d by the American Heart							
	Association.								
	Policy:								
		CPR certified at hire are							
	required to obtain ce	rtification prior to beginning							
	patient care.								
			1						
		el #N3's file, healthcare							
	assistant, who was h	nired 9/5/2017, and does							
		documentation of CPR							
1	training.		1						

Indiana State Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ 011118 03/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8590 GEORGETOWN RD PLANNED PARENTHOOD OF INDIANA AND KENTUCK INDIANAPOLIS, IN 46268 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX TAG (X6) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 5 T 168 T 168 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 #05, Human Resources, Indicated agreement with the finding that staff #N3's personnel file lacked documentation of CPR training. T 206 410 IAC 26-11-1 INFECTION CONTROL T 206 **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 falled to provide a safe and healthful environment that minimizes infection exposure and risk in 1 Instance. Findings include:

Indiana State Department of Health

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ate Department of He	alth			NO DATE CUDICY	
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED	
CONTECTION	1	A. BUILDING:			
	011118	B. WING		03/29/2018	
OVIDER OR SUPPLIER	STREET AU	ODRESS, CITY, STATE	E, ZIP CODE		
	8590 GE				
PLANNED PARENTHOOD OF INDIANA AND RENTOCY INDIANA					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE	
Continued From page	6	Т 206			
employee #A2, Vice Services, employee # and employee #A6, hobserved in an ultras strips being used to of Cidex, a chemical probes for ultrasound 2. Review of the marecommendation on instructions for Qualitest strip bottle indicanegative controls munewly opened bottle 3. On the above dawas requested to profollowing the above Procedures. The emposuch documentation 410 IAC 26-16-1 PH SERVICES 410 IAC 26-16-1(2) The clinic must proving and effective maccepted profession have the following: (2) Records of sto substances, including the above to substances, including the substances, including the substances, including the substances, including the substances in the substance in the su	President of Patient #A5, Health Center Manager, Health Care Assistant, it was ound room there were test Hetermine the effectiveness agent being used to disinfect it procedures. Introducer's Ithe insert package of Ity Control Procedures of the Ited testing of positive and Ited documentation of Ite and time, employee #A6 Ited documentation of Ite and time, employee indicated there was Iten hecause the Quality Item of performed, and no Item was provided prior to exit. ARMACEUTICAL Ited drugs and biologicals in a anner in accordance with Item of all scheduled Item of an accounting for all items	T 320			
	COVIDER OR SUPPLIER PARENTHOOD OF INDI SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page 1. On 03-27-2018 at employee #A2, Vice services, employee #A6, I observed in an ultrasstrips being used to of Cidex, a chemical probes for ultrasounce. 2. Review of the man recommendation on instructions for Qualitiest strip bottle indicates the properties of the properties of the properties. The employee was requested to profollowing the above-of Procedures. The employee of the procedures of the documentation of the procedures of the clinic must provide and effective maccepted profession have the following: (2) Records of sto substances, includir substances, includir	TOURIDER OR SUPPLIER PARENTHOOD OF INDIANA AND KENTUCE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA DESTRICT ADDRESS, CITY, STATE BET ADDR	OF DEFICIENCIES F CORRECTION CAT PROVIDER OF SUPPLIER CAT PROVIDER SUPPLIER CATE OF CORRECTION NUMBER: A SUILDING: B. WING B.	

Indiana State Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING_ 011118 03/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8690 GEORGETOWN RD PLANNED PARENTHOOD OF INDIANA AND KENTUCK INDIANAPOLIS, IN 46268 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X6) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) T 320 Continued From page 7 T 320 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.

Indiana State Department of Hea STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	8590 GF	DDRESS, CITY, STATE	; ZIP CODE			
PLANNED	PARENTHOOD OF IND	ANA AND KENTUCI	POLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
T 320	Continued From page	∍8	T 320				
	In interview on 03 employee #A2, Vice Services, confirmed a documentation was presented.	President of Patlent all the above and no other					
T 404	410 IAC 26-17-3 PH PLANT,MAINT.,EQU		T 404				
	410 IAC 26-17-3(2)						
	overall clinic environ maintained in such a well-being of patients	visitors; or					
	condition that may h	n, the facility created I	,				
	Findings include:						
	employee #A2, Vice Services, and emplo Manager, it was obs crash cart, there was unsecured by chain knocked over and by	yee #A5, Health Center erved in the hallway next to a s 1 small oxygen tank or holder. If the tank was					

FORM APPROVED 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 A. BUILDING: ___ B. WING 011118 03/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8590 GEORGETOWN RD PLANNED PARENTHOOD OF INDIANA AND KENTUC INDIANAPOLIS, IN 46268 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X4) ID PREFIX TAG (X5) COMPLETE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG T 404 Continued From page 9 T 404 people and/or property.