Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		
		014264	B. WING		11/07/2019
	ROVIDER OR SUPPLIER	STREET A 3511 LIN	DDRESS, CITY, STA COLNWAY WES BEND, IN 46628		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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 000	T 000 INITIAL COMMENTS		T 000		
	Complaint Number: IN Unsubstantiated; lack Complaint Number: IN Unsubstantiated; lack Complaint Number: I	N00308566 of sufficient evidence. N00304763 of sufficient evidence. N00304752 of sufficient evidence. N00312482 of sufficient evidence.			
Т9999	medical staff. This rule is not met as Based on document r Governing Body failed appointments or conti	ents to or contracts with s evidenced by; eview & interview the	T9999		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		014264	B. WING		1.	1/07/2019
	ROVIDER OR SUPPLIER /OMAN'S HEALTH ALLIA	NCE. INC	DDRESS, CITY, STATE COLNWAY WEST SEND, IN 46628			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
T9999	documentation of Govappointment or contra 2. On 11/06/19 at 161 there was no docume Board approving appointmedical staff for MD # ***410 IAC 26.5-5-2 (conduct of medical staff are acterior medical staff are acterecommendation of the staff are acterecommendation for a Staff for 3 of 5 medical #3, MD #4 & MD #5) Findings include; 1. Review of MD #3, I staff files lacked document in the staff are acterecommendation for a staff files lacked document in the staff for MD #3, MD #4 the staff for MD #3, MD #5 the staff for MD #3 the staff for MD	a #2's Credential files lacked verning Board approval of act to the medical staff. 5 hours staff #40 confirmed intation of the Governing bintment or contract to the #1 & #2 . d)(1) Appointment and aff: acting with medical staff, the do the following: ents to or contracts with the d upon the advice and he medical director. s evidenced by; eview & interview the d to provide a appointment to the Medical all staff files reviewed (MD to the Governing Board. MD #4 & MD #5's medical mentation of the Medical dation for appointment to the 5 hours staff #40 confirmed intation of the medical ag appointment to medical ag appointment to medical ag appointment to medical ag appointment to medical 4 & MD #5.	T9999			
	***410 IAC 26.5-5-2 (d)(3)(A)(F) Appointment and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		014264	B. WING		11	/07/2019
	ROVIDER OR SUPPLIER	NCE. INC	ADDRESS, CITY, STA	т		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
T9999	governing body shall Ensure that criteria fo include the following: Individual character. Judgment. This rule is not met as Based on document r failed to ensure the se included evidence of judgment for 4 of 5 m (MD #2, MD #3, MD # Findings include; 1. Review of MD #2, 3 lacked evidence that individual character & ***410 IAC 26.5-5-1(c Powers and Duties: Ensure that clinic poli reviewed at least trier This rule is not met as 1. Review of facility polacked documentation / approval. 2. On 11/06/19 at 154 there was no docume	aff: acting with medical staff, the do the following: r selection of medical staff sevidenced by; eview the Governing Body election of medical staff individual character & edical staff files reviewed 44 & MD #5). By 4 & 5's medical staff files selection was based on judgment. E)(7)(B) Governing Body: cies and procedures are: inially.	T9999			

Indiana State Department of Health

STATE FORM 6899 TFMV11 If continuation sheet 3 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY IPLETED	
		014264	B. WING		1	1/07/2019
	ROVIDER OR SUPPLIER	ANCE. INC	ADDRESS, CITY, STATE NCOLNWAY WEST BEND, IN 46628	, ZIP CODE		
(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 ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
T9999	Powers and Duties: Establish the followin A policy and procedu physicians concernin This rule is not met a Based on document governing board faile procedure for commu- concerning a patient Findings include; 1. Review of the facil lacked documentation for communication wi patient emergency. 2. On 11/06/19 at 158 there was no policy a communication with p patient emergency.	g: re for communication with g a patient emergency. s evidenced by; review & interview the d to establish a policy and unication with physicians emergency for 1 facility. ity policy & procedures n of a policy and procedure ith physicians concerning a	T9999			
	the following:	op, implement, and maintain ealth care worker practice but not limited to, the				
		review & interview the facility icy & procedure for health				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
	014264	B. WING		11/	07/2019
NAME OF PROVIDER OR SUPPLIER WHOLE WOMAN'S HEALTH ALLIANG	3511 LIN	ADDRESS, CITY, STATE ICOLNWAY WEST BEND, IN 46628	E, ZIP CODE		
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
for health care worker p addressing criminal history. 2. On 11/06/19 at 1650 the facility lacked a polic care worker practice procriminal history. ***410 IAC 26.5-10-1(b) The medical director mu Make recommendations the appointment of med This rule is not met as e Based on document rev Medical Director failed to recommendation for app Staff for 3 of 5 medical s #3, MD #4 & MD #5) to Findings include; 1. Review of MD #3, MD staff files lacked docume Director's recommendation medical staff.	policy & procedures f a policy and procedure ractice problems ory. hours staff #41 confirmed by & procedure for health oblems addressing (2) Medical staff services ast do the following; to the governing body on ical staff. evidenced by; iew & interview the o provide a pointment to the Medical staff files reviewed (MD the Governing Board. 0 #4 & MD #5's medical entation of the Medical ion for appointment to the hours staff #40 confirmed ation of the medical appointment to medical	T9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		014264	B. WING		11	/07/2019
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT	•		
WHOLE W	/OMAN'S HEALTH ALLIA	NCE, INC	NCOLNWAY WEST I BEND, IN 46628			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Т9999	Continued From page	e 5	Т9999			
	The medical director of There is a provision for take a verbal order. This rule is not met as Based on document or medical director failed procedure for persons verbal order was deverbal order was deverbal into the procedure for persons verbal order was deverbal order. Findings include;	review & interview the				
	lacked documentation for personnel authorize	n of a policy and procedure zed to take a verbal order.				
		15 hours staff #41 confirmed procedure for personnel perbal order.				
	administration The clinic must estable and guide the infection clinic as follows: The infection control of must include, but are Reviewing and recomprocedures, policies,	and programs that are control. These include, but following:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED	
		014264	B. WING		11	1/07/2019
	ROVIDER OR SUPPLIER	ANCE. INC	ADDRESS, CITY, STATE NCOLNWAY WEST BEND, IN 46628	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Т9999	Continued From pag	e 6	Т9999			
	policy & procedure o for 1 facility. Findings include; 1. On 11/07/19 at 10	he facility failed to have a n the reuse of disposables 15 hours staff #40 confirmed ve policy & procedure on the				
	control administration The clinic must estable and guide the infection clinic as follows: The infection control must include, but are Reviewing and recor procedures, policies, pertinent to infection are not limited to, the An employee health communicable disea as well as an ongoine	committee to monitor on control program in the committee responsibilities a not limited to, the following: mmending changes in and programs that are control. These include, but				
	This rule is not met a	ns evidenced by; the the facility failed to ensure				
	it had developed, impolicies addressing thistory of new person	olemented & maintained the communicable disease nnel as well as an ongoing personnel for 1 facility.				
	Findings include;					
	1. On 11/07/19 at 10	20 hours staff #40 confirmed				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		014264	B. WING		11	/07/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE	•	
WHOLE W	VOMAN'S HEALTH ALLIA	NCE. INC	ICOLNWAY WEST			
	T	SOUTH	BEND, IN 46628			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
T9999	Continued From page	e 7	Т9999			
	the communicable dis	re policies that addressed sease history of new an ongoing program for				
	services The clinic must provice safe and effective may accepted professional have the following; Written policies and primplemented, maintain personnel, including, following; Reporting of adverse errors to the: physician responsible This rule is not met as	reactions and medication for the patient s evidenced by; e facility failed to have				
	implemented, maintai reactions and medica physician for 1 facility	ned for reporting of adverse tion errors to the patient's				
	the facility did not hav addressing the report	5 hours staff #40 confirmed re a policy & procedure ing of adverse reactions and he patient's physician.				
	services The clinic must provice	(3)(B)(i) Pharmaceutical le drugs and biologicals in a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7.1. 20.125			
		014264	B. WING		11/	07/2019
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STA	TE, ZIP CODE		
WHOLE W	OMAN'S HEALTH ALLIA	ANCE. INC	INCOLNWAY WES H BEND, IN 46628	Т		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
T9999	have the following; Written policies and p implemented, maintai personnel, including, following; Instructions to the pat home medication is th prescribing physician. This rule is not met as Based on interview th clinic had developed, and made available to procedures which ado patients on the use of the responsibility of th facility. Findings include; 1. On 11/07/19 at 105 the facility did not hav addressed that instruc of take home medicat the prescribing physic ***410 IAC 26.5-16-11 The clinic must provic safe and effective ma accepted professiona have the following; A formulary. This rule is not met as	or ocedures developed, ined, and made available to but not limited to, the tient on the use of take he responsibility of the sevidenced by; he facility failed to ensure the implemented, maintained, or personnel policy & dressed instructions to fake home medication is he prescribing physician for 1 to hours staff #40 confirmed a policy & procedure that ctions to patients on the use tion is the responsibility of cian. (4) Pharmaceutical services the drugs and biologicals in a inner in accordance with all practice. The clinic must	T9999			
	clinic had a formulary					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		014264	B. WING		11	/07/2019
NAME OF P	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STA			
WHOLE V	VOMAN'S HEALTH ALLIA	NCE. INC	LINCOLNWAY WES [*] FH BEND, IN 46628	Γ		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
Т9999	Continued From page	9	Т9999			
	Findings include; 1. On 11/07/19 at 103 requested to provide formulary & none was	· ·				
	not limited to, the follomaintenance of writte inspection and approve	t program must include, but owing: in evidence of regular val by state and local fire ecordance with the following:				
	This rule is not met as	s evidenced by;				
	it maintained docume	the facility failed to ensure intation of evidence of diapproval by state and local sility.				
	Findings include;					
	requested to provide	5 hours staff #40 was evidence of regular trol & none was provided by				
	not limited to, the follo Emergency and disas coordinated with appr and federal agencies.	t program must include, but owing: ster preparedness copriate community, state,				
	Findings include; 1. On 11/07/19 at 091 requested to provide inspection for fire conexit. ***410 IAC 26.5-17-6 A safety management not limited to, the following the following forms and disast coordinated with apprentice.	5 hours staff #40 was evidence of regular trol & none was provided by (a)(7) Safety t program must include, but owing: ster preparedness copriate community, state,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED	
		014264	B. WING		11	/07/2019
	ROVIDER OR SUPPLIER	ANCE. INC	ADDRESS, CITY, STATE NCOLNWAY WEST BEND, IN 46628	;, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
Т9999	Continued From pag	e 10	Т9999			
	that emergency & discoordinated with an a and federal agencies	ne facility failed to ensure the saster preparedness was appropriate community, state for 1 facility.				
	emergency & disaste coordinated with an a	25 hours documentation of preparedness that was appropriate community, state was requested from staff ded prior to exit.				
	Personnel policies ar The abortion clinic sh accurate personnel re Personnel records sh data that includes: (I in job-related educati health records of em	Sec. 1. (1) (a) 2(E) (F) (i) (iii) and records. nall maintain current and ecords for all employees. nall: (2) include personal E) evidence of participation on and training activities, (F) ployees that relate to post to the post of the property of the				
	facility failed to provide packaging training for and S4) who package and failed to ensure 6	review and interview, the de take home medication r 2 of 2 staff members (S3 e take home medications documentation of Post offer zations for 5 of 5 personnel 2, S3, S4, S5).				
	Findings include:					
	Review of personr lacked training on me	nel files for staff S3 and S4 edication packaging.				
		/2019, at approximately 3:11 indicated S3 and S4				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		014264	B. WING		11/07/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WHOLE W	OMAN'S HEALTH ALLIA	INCE. INC	DLNWAY WES ND, IN 46628	Т	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
T9999	Continued From page	e 11	T9999		
	packaged medication	s for patients to take home.			
		el files S1, S2, S3, S4 and ation of Post offer Physical			
	4. Interview on 11/06/staff #40 confirmed podocumentation of posimmunizations.				

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