Planned Parenthood of Indiana and Kentucky, Georgetown Facility #160111181				
Response to ISDH Abortion Licensing Review conducted February 15, 2017				
Survey results received March 2, 2017				
Tag #	**Problem Identified**	**Corrective Action**	**Responsibility**	**Date of Correction**
26	Governing body failed to review Reports of Management Operations every 6 months	Board minutes updated to include section for Reports of Management Operations to ensure discussion is documented each board meeting, even if nothing new is reported	Executive Assistant & Board Liaison	4/15/2017
38	Governing board failed to have process for reporting licensed health professionals who fail to comply with state professional licensing requirements, document actions against licensed health professionals who fail to comply with clinic policies and procedures, and report information that statutes requires the abortion clinic to report to a state agency or law enforcement	Medical bylaws will be developed to include process for reporting licensed health professionals who fail to comply with state professional licensing requirements or clinic policies and procedures for one clinic	Vice President of Patient Services, Medical Director, Risk and Quality Manager	4/15/2017
46	Clinic administrator or designee failed to attend meetings of governing body and its committees and act as its representative at medical staff meetings	Clinic administrator to designate the Vice President of Patient Services to serve as representative at medical staff meetings	Health Center Manager, Director of Surgical Services, and Vice President of Patient Services	4/15/2017

60	Governing body did not ensure the criteria for selection for medical staff included competence and judgement for 1 of 4 physician credential files	Medical bylaws will be developed to include process for governing body approval of all physicians and review of physician competence and judgement; physician #4 in report has experience at other Planned Parenthood affiliate; Human Resources to obtain documentation from other affiliate to prove experience and competence; HR and Training to develop checklists for all new hires to keep in personnel file to ensure all documentation is obtained as needed	Vice President of Patient Services, Medical Director, Risk and Quality Manager; Human Resources	Bylaws by 4/15/2017 Checklist by 5/15/2017
96	QA Program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to all services, including those furnished by a contractor; currently lacking pharmacy and contracted occupational health	Quality measures to be developed to address pharmacy and contracted health services; these are to be included in the Report of Management Operations and reviewed by the Board of Directors and Quality Management and Infection Prevention Committee on quarterly basis; all measures to be summarized in written plan for clarity	Risk and Quality Manager	3/31/2017
144	Clinic did not maintain current job description and evaluation for 1 contracted housekeeping personnel	Facilities coordinator to obtain job description and staffing parameters from housekeeping contracted service to keep on file with contract, job description to be approved by Facilities Director; housekeeping service reviewed on vendor review log and discussed at quarterly Infection Control and Quality Management Meetings; annual evaluation of housekeeping service to be sent to housekeeping company for use in employee review/evaluation process; Risk and Quality Manager to schedule annual meeting via Outlook to send feedback to company	Facilities Coordinator	4/18/2017
206	Emergency supply logs were not completed for December 2016 and January 2017; not regularly reviewed by Medical Director, Pharmacist, or designated NP; 2 IV bags of LR expired 1/2017 and were on the emergency cart	Expired supplies have been removed and replaced in Emergency Cart; Health Center Manager will review emergency supply logs quarterly to ensure completion and remediate with staff if not completed; Health Center Manager will have Medical Director of Abortion Services review and sign log quarterly to oversee supplies	Health Center Manager, Director of Surgical Services, and Medical Director of Abortion Operations	To begin April 1, 2017 (Quarterly)

250	Cidex test strips expired 1/28/17 and were used for the 2 subsequent days before being caught	Incident report was created at time of incident and staff was re-educated by NP at the time the expired strips were discovered; expired strips were replaced immediately upon discovery; staff using strips completing log upon each use to ensure they are not expired; health center manager periodically checking all logs and supplies to ensure none are expired	Health Center Staff and Nurse Practitioner; Health Center Manager	Already completed; Health Center Manager checking logs on at least quarterly basis
318	Facility failed to ensure that a designated professional person with prescriptive authority or pharmacist who is responsible for the control of the drug stocks in the clinic	Facility to develop policy that clearly outlines designated professional person with prescriptive authority who is responsible for the control of the drug stocks in the clinic	Risk and Quality Manager	4/15/2017
324	Facility failed to have policies in place to ensure physician responsible for the patient is aware of adverse reactions and medication errors	Medical bylaws will be developed to include policy for reporting adverse reactions and medication errors to the physician responsible for the patient; Policy will be developed to ensure staff are aware that physician(s) involved should be notified in situations where patient has adverse reaction	Vice President of Patient Services, Medical Director, Risk and Quality Manager	4/15/2017
326	Facility failed to ensure the drug cabinets are accessible to authorized personnel only	Drug cabinets are all locked in this facility; Health Center Manager and Director of Surgical Services will ensure only authorized individuals have keys	Health Center Manager and Director of Surgical Services	4/15/2017
330	Clinic failed to have a current formulary that clearly lists which drugs are in the center	Formulary will be updated to ensure clarity for which centers have which medications	Risk and Quality Manager	4/15/2017
403	No condition in clinic or grounds may be maintained that may be conducive to harboring or breeding of insects, rodents, or other vermin; trash in parking lot	Trash to be removed from parking lot by 4-15-17 and reviewed/removed on a weekly basis by staff delegated by Health Center Manager	Facilities Coordinator; Health Center Manager	Trash removed by 4/15/17 and reviewed/removed weekly after

404	Facility failed to ensure monthly checks of equipment, supplies, and/or medications were conducted for 5 of 14 months Staff did not complete monthly emergency supply log, resulting in expired supplies on emergency supply cart	Facilities Coordinator responsible for maintenance or delegation of maintenance for all equipment; Facilities Coordinator to catalog all equipment and develop written procedure for equipment maintenance and operation available to all staff Director of Surgical Services reeducated staff member responsible for emergency supply checks at time of survey; expired supplies were removed from cart and replaced; Health Center Manager to verify regularly that logs are being completed	Facilities Coordinator; Health Center Manager	Policy to be developed by 3/31/2017 Policy to be implemented by 4/30/2017 Health Center Manager to review logs at least quarterly
408	The facility failed to provide documented maintenance of mechanical equipment/systems according to acceptable standards of practice or the manufacturer's recommended maintenance of 5 of 7 piece of equipment/systems; including heating, ventilation, air conditioning, emergency generator, and smoke detector systems	Facilities Coordinator responsible for maintenance or delegation of maintenance for all equipment; Facilities Coordinator to catalog all equipment and develop written procedure for equipment maintenance and operation available to all staff	Facilities Coordinator	Policy to be developed by 3/31/2017 Policy to be implemented by 4/30/2017
410	No operational & maintenance control records for heating, ventilation, air conditioning, emergency generator, fire alarm, smoke detector, & sprinkler system that indicated they were analyzed at least triennially	Facilities Coordinator responsible for maintenance or delegation of maintenance for all equipment; Facilities Coordinator to catalog all equipment and develop written procedure for equipment maintenance and operation available to all staff; policy to include review at least triennially	Facilities Coordinator	Policy to be developed by 3/31/2017 Policy to be implemented by 4/30/2017

414	Facility failed to have patient care equipment on an appropriate documented maintenance schedule for the cardiac monitor, centrifuge, defibrillator, emergency call system, patient exam light, scale, recovery chair, sterilizer, suction machine, surgical/exam table, and wheelchair	Facilities Coordinator responsible for maintenance or delegation of maintenance for all equipment; Facilities Coordinator to catalog all equipment and develop written procedure for equipment maintenance and operation available to all staff	Facilities Coordinator	Policy to be developed by 3/31/2017 Policy to be implemented by 4/30/2017
416	No evidence of preventive maintenance on the emergency call system, recovery chair, and US machine, and a wheelchair; no proof of annual maintenance on the AED and log from preventive maintenance vendor did not clearly indicate what was completed;	Facilities Coordinator responsible for maintenance or delegation of maintenance for all equipment; Facilities Coordinator to catalog all equipment and develop written procedure for equipment maintenance and operation available to all staff; policy to include review at least triennially	Facilities Coordinator	Policy to be developed by 3/31/2017 Policy to be implemented by 4/30/2017
418	Electrical current leakage checks not performed on equipment	Current PPINK preventive maintenance vendor (K&R) contract updated to include electrical current leakage checks on all applicable equipment to be completed annual with medical equipment inspections; policy to include review at least triennially	Facilities Coordinator	Next annual K&R inspection scheduled April 2017, electrical current leakage checks to be performed at that time

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T 000	INITIAL COMMENTS This visit was for a state licensure survey. Facility Number: 011118 Survey Date: 02-13-2017 to 02-15-2017 QA: 2/20/17 JLH IDR Committee held on 03/23/2017. Tag T426 changed to Tag T403. JL	T 000		
T 026	410 IAC 26-4-1 GOVERNING BODY 410 IAC 26-4-1(c)(3) (c) The governing body shall do the following: (3) Review, at least every six (6) months, reports of management operations, including, but not limited to, the following: (A) Quality assessment and improvement program. (B) Patient services provided. (C) Results attained. (D) Recommendations made. (E) Actions taken. (F) Follow-up. This RULE is not met as evidenced by: Based on document review and interview, the governing board failed to review the facility's quality assessment and improvement (QA&I) program at least once every 6 months. Findings include:	T 026		4/15/17

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T 026	Continued From page 1 1. Review of the governing board's minutes for calendar year 2016 indicated the facility's QA&I program was reviewed only on August 27. 2. In interview on 02-13-2017 at 11:45 am, employee #A2, Quality Resource Manager, confirmed there was only 1 governing board meeting in which review of the facility's QA&I had occurred and no other documentation was provided prior to exit.	T 026		
T 038	410 IAC 26-4-1 GOVERNING BODY 410 IAC 26-4-1(c)(8)(B) (c) The governing body shall do the following: (8) Establish the following: (B) A process for the following: (i) Reporting licensed health professionals who fail to comply with state professional licensing requirements as found in IC 25-22.5. (ii) Documenting actions against licensed health professionals who fail to comply with the clinic policies and procedures. (iii) Reporting information that statute requires the abortion clinic to report to a state agency or law enforcement agency.	T 038		4/15/17

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T 038	Continued From page 2 This RULE is not met as evidenced by: Based on document review and interview, the governing board failed to have a process for the following in 1 instance: a. Report licensed health professionals who fail to comply with state professional licensing requirements as found in IC 25-22.5 b. Document actions against licensed health professionals who fail to comply with clinic policies and procedures c. Report information that statute requires the abortion clinic to report to a state agency or law enforcement agency Findings include: 1. On 02-13-2017 at 9:15 am, employee #A2, Quality Resource Manager, was requested to provide a process the clinic would follow regarding reporting licensed health professionals who fail to comply with state professional licensing requirements as found in IC 25-22.5, documenting actions against licensed health professionals who fail to comply with clinic policies and procedures, and reporting information that statute requires the abortion clinic to report to a state agency or law enforcement agency 2. In interview on 02-15-2017 at 3:00 pm, employee #A2 indicated there was no such above-requested provision and nothing else was provided prior to exit.	T 038		

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T 046	Continued From page 3	T 046		
T 046	410 IAC 26-4-1 GOVERNING BODY 410 IAC 26-4-1(f)(4)(A) (f) If the governing body is not an individual who is also serving as the clinic administrator, the governing body shall do the following: (4) Require the following: (A) That the clinic administrator or a designee: (i) attend meetings of the governing body and its committees; and (ii) act as its representative at medical staff meetings. This RULE is not met as evidenced by: Based on document review and interview, there was no documentation of the clinic administrator or a designee attending 5 of 5 meetings of the governing body and its committees in calendar year 2016. Findings indicate: 1. Review of governing board minutes for calendar year 2016, indicated the clinic administrator or a designee was not present at meetings on January 20, March 16, June 1, August 27, and November 30. 3. In interview on 02-14-2017 at 3:35 pm, employee #A2, Quality Resource Manager, confirmed the above and no other documentation was provided prior exit.	T 046		4/15/17

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T 060	Continued From page 4	T 060		
T 060	410 IAC 26-4-2 GOVERNING BODY 410 IAC 26-4-2(d)(3) (d) In appointing or contracting with medical staff, the governing body shall do the following: (3) Ensure that criteria for selection for medical staff include the following: (A) Individual character. (B) Competence. (C) Education. (D) Training. (E) Experience. (F) Judgment. This RULE is not met as evidenced by: Based on document review and interview, the governing body did not ensure that criteria for selection for medical staff included competence and judgement for 1 of 4 physician credential files reviewed. Findings include: 1. Review of 4 physician credential files indicated file MD#4, Obstetrician/Gynecologist, did not have any documentation indicating the physicians's competence and judgement. Further file review indicated MD#4 was an initial appointment and there was no activity performed by the physician at the facility. thus the facility could not judge MD#4's competence and judgement. 2. On 02-13-2017 at 4:25 pm, employee #A2, Quality Resource Manager, was requested to	T 060		5/15/17

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T 060	Continued From page 5 provide any documentation such as recommendations or letters of reference from other sources who could attest to MD#4's competence and judgement. In interview on that date and time, employee #A2 indicated there was no such documentation and no other documentation was provided prior to exit.	T 060		
T 096	410 IAC 26-6-1 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 26-6-1(a)(1) The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to include 1 of 4 facility-provided services and 1 of 8 contracted services in its quality assurance and improvement (QA&I) program. Findings include: 1. Review of the facility's QA&I program indicated it did not include the facility-provided service of pharmacy and the contracted service of occupational health.	T 096		3/31/17

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T 096	Continued From page 6 2. In interview on 02-14-2017 at 2:50 pm, employee #A2 confirmed the above and no other documentation was provided prior to exit.	T 096		
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 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 maintain a current job description and evaluation for 1 contracted housekeeping personnel. Findings: 1. Review of the Janitorial Service Agreement, dated September 2006, indicated the following: A. Two (2) days cleanings per week. B. Work to be performed. 2. Review of personnel files indicated there was no file for staff member N #5, related to	T 144		4/18/17

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T 144	Continued From page 7 housekeeping services. 3. In interview on 2/15/2017 at 9:05 am am, with clinic staff members A #2 (Quality Resource Manager) and A #3 (VP Patient Services), confirmed that the individual who does the housekeeping for the clinic through this agreement, is also an employee of the clinic - (CNA-clinic staff member N #5). 4. In interview on 2/15/2017 at 11:10 am, with clinic staff member A #1 (Director of Surgical Services), the following was confirmed: A. That there is no contracted personnel file for this individual for role of contracted housekeeping personnel. B. That the housekeeping service company was contacted this am, with requested contracted personnel information- documents which then were not provided-sent; "they don't have a job description or file" for the individual. 5. No further documentation was provided prior to exit.	T 144		
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.	T 206		4/1/17

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T 206	Continued From page 8 This RULE is not met as evidenced by: Based on document review, observation and interview, the facility failed to ensure a safe and healthful environment that minimizes infection risk to patients in one instance. Findings: 1. Review of policy Emergency Medications and Supplies, last revised June 2016, indicated on page 13, "Assign designated licensed staff to perform monthly checks of the emergency box and document checks with a signature. Maintain a record of monthly checks." 2. On 2/15/2017 at approximately 12:00 pm, accompanied by clinic staff member A # 3 (VP Patient Services), during check of the clinic's Emergency cart, located in hall-area adjacent to the two procedure rooms, the following was found: A. In the bottom drawer of the Emergency cart two (2) 500 ml IV solution bags of Lactated Ringers had expired 1/2017. B. The monthly log lacked documentation for December 2016, January 2017, and thus far February 2017 for checks of contents. 3. In interview on 2/15/2017 at approximately 12:10 pm, with clinic staff member A # 3, confirmed the following: A. That the 2 IV bags of Lactated Ringers had expired 1/2017. B. That it is the responsibility of Nursing staff to check the cart monthly for contents and expired medications & items. C. That the medication room and emergency cart/box do not receive regular oversight from the Medical Director, a Pharmacist or a designated	T 206		

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T 206	Continued From page 9 Nurse Practitioner. 4. In interview on 2/15/2017 at approximately 3:30 pm, with clinic staff member A # 1 (Director of Surgical Services), confirmed the following: A. That the IV solution - bags were expired. B. That IV solution (Lactated Ringers) has been ordered to replace the expired; although not certain when will arrive. C. That it is the responsibility of Nursing staff to check the emergency cart montly for expired medications, IV solutions and supplies.	T 206		
T 250	410 IAC 26-11-2 INFECTION CONTROL PROGRAM 410 IAC 26-11-2(b) (b) Environmental surfaces and equipment not requiring sterilization that have been contaminated by blood or other potentially infectious materials must be cleaned then decontaminated in accordance with acceptable standards of practice and applicable state laws and rules (to include 410 IAC 1-4, Universal Precautions). This RULE is not met as evidenced by: Based on document review and interview the facility failed to ensure that equipment not requiring sterilization, must be cleaned then decontaminated in accordance with acceptable standards of practice in 18 instances. Findings:	T 250		4/30/17

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T 250	Continued From page 10 1. Review of Infection Control manual, last revised 11/2016, indicated in Chapter 2- Cleaning, Disinfection and Sterilization, on page 10, under Vaginal Probe - Ultrasound, indicated the following: A. "Clean probe per manufacturer's recommendation." B. "Cidex OPA Test Strips MUST be used before placing the clean probe in the solution." 2. Review of manufacturer's guidelines for Cidex OPA Solution Test Strips, on page 2, under PRECAUTONS:, indicated "Do not use any remaining strips 90 days after opening the bottle, or after expiration date stamped on the bottle." 3. Review of Cidex OPA logs for Ultrasound Room # 1, thus far calendar year 2017, indicated the following: A. That the Cidex test strips (Lot # 028949) had expired on 1/28/2017 B. That expired test strips were used to test Cidex OPA solution on 1/30 & 1/31/2017 (1). Total times expired test strips used = 18 (2). The expired test strips were used by clinic staff members N #1 (Health Care Assistant) and N #2 (Nurse Practitioner). 4. In interview on 2/2/13/2017 at 2:26 pm, with clinic staff member A # 1 (Director of Surgical Services), confirmed the following: A. That expired Cidex OPA test strips were used to test Cidex OPA solution for two days - 1/30 & 1/31/2017. B. That it is the responsibility of the assigned clinic staff to check strips/dates before testing and replace when expired. 5. In interview on 2/14/2017 at 9:47 am, with clinic staff member N #1, confirmed that expired	T 250		

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T 250	Continued From page 11 test strips had been used and not noticed until 2/2/2017, with then disposed of and new strips used.	T 250		
T 318	410 IAC 26-16-1 PHARMACEUTICAL SERVICES 410 IAC 26-16-1(1) 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: (1) A: (A) designated professional person with prescriptive authority; or (B) pharmacist; who is responsible for the control of drug stocks in the clinic. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure that a designated professional person with prescriptive authority adhered to the responsibility for the control of drug stocks for 1 facility. Findings include: 1. Review of a document entitled AGREEMENT FOR SERVICES, an agreement between abortion clinic facility #1 and contractor #1, dated July 1, 2010, indicated contractor #1 agrees to make available to abortion clinic #1 the services of MD#1 to perform medical director services.	T 318		4/15/17

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 _____	02/15/2017

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

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T 318	Continued From page 12 2. Review of a facility document entitled JOB TITLE: Medical Director, approved June, 2016, indicated the Medical Director assumes legal responsibility for ordering and distribution of drugs. 3. On 02-15-2017 at 10:30 am, employee #A3, Vice President Patient Services, was requested to provide documentation of MD#1 implementing the responsibility of ordering and distribution of drugs or any other documentation of MD#1 overseeing the pharmaceutical activity of clinic facility #1. 4. In interview at the above date and time, employee #A3 confirmed the above-stated AGREEMENT and JOB TITLE, and also indicated there was no above-requested documentation of MD#1 implementing the responsibility for ordering and distribution of drugs or any other documentation of MD#1 overseeing the pharmaceutical activity of clinic facility #1. No other documentation was provided prior to exit.	T 318		
T 324	410 IAC 26-16-1 PHARMACEUTICAL SERVICES 410 IAC 26-16-1(3)(B) 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: (B) Reporting of adverse reactions and medication errors to the: (i) physician responsible for the patient; and	T 324		4/15/17

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	011118	A. BUILDING: _____ B. WING _____	02/15/2017

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T 324	Continued From page 13 (ii) appropriate committee; and documented in the patient ' s record. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to have a policy (ies) to report adverse reactions and medication errors to the physician responsible for the patient in 1 instance. Findings include: 1. On 02-13-2017 at 9:15 am, employee #A2, Quality Resource Management, was requested to provide a facility policy (ies) to report adverse reactions and medication errors to the physician responsible for the patient. 2. Review of facility documents indicated there was no policy (ies) to report adverse reactions and medication errors to the physician responsible for the patient. 3. In interview on 02-15-2017 at 11:10 am, employee #A2 indicated there was no above-requested policy (ies) and no other documentation was provided prior to exit.	T 324		
T 326	410 IAC 26-16-1 PHARMACEUTICAL SERVICES 410 IAC 26-16-1(3)(C) 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:	T 326		4/15/17

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 _____	02/15/2017

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PLANNED PARENTHOOD OF INDIANA AND KENTUCI	8590 GEORGETOWN RD INDIANAPOLIS, IN 46268

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T 326	Continued From page 14 (C) Drugs must be accurately and clearly labeled and stored in specially designated, well-illuminated cabinets, closets, or storerooms and the following: (i) Drug cabinets must be accessible only to authorized personnel. (ii) Drug cabinets for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse must be permanently affixed compartments that are separately locked. (iii) Drug carts, if used, with controlled drugs as designated in item (ii) must be securely affixed when not in use. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure that drug cabinets are accessible to authorized personnel only for 1 facility. Findings: 1. Review of clinic job description titled: "Director of Surgical Services - Patient Services", indicated the following: A. That it is the job description for clinic staff member A # 1 (Director of Surgical Services) B. That there is no documentation included within area of "Essential Functions*", for access	T 326		

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	011118	A. BUILDING: _____ B. WING _____	02/15/2017

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

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T 326	Continued From page 15 to drug storage areas - access to medications. 2. In interview on 2/15/2017 at 11:45 am, with clinic staff members A # 2 (Quality Resource Manager) and A # 3 (VP Patient Services), both confirmed the following: A. That clinic staff member A #1, is the interim Clinic Office Manager, due to previous manager resigning approximately 2 weeks ago. B. That this clinic staff member is not a Registered Nurse. C. That this clinic staff member's job description does not include access to drug storage areas/medications. D. That the job description notes "Inventory control", although not specific to medications for clinic. 3. On 2/13/2017 at approximately 3:00 pm, while on tour of clinic, accompanied by clinic staff member A # 1, the following was found: A. That this clinic staff member (A # 1) is not a Registered nurse. B. That this clinic staff member had access to the secured medication room - located in the Pre-post area. C. That this clinic staff member was present for checking of medication room- cabinets- logs. 4. No further documentation was provided prior to exit. 5. Review of a facility document, a policy entitled ADMINISTRATIVE CHAPTER 7: PHARMACEUTICALS, section 7.1.3 Storage, approved June 2016, indicated "Access to pharmaceuticals dispensed from within patient care areas should be limited to health care providers responsible for dispensing these items." 6. In interview on 02-15-2017 at 11:15 am,	T 326		

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	011118	A. BUILDING: _____ B. WING _____	02/15/2017

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

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T 326	Continued From page 16 employee #A2, Quality Resource Manager, confirmed the above-stated facility policy. The employee was also requested to provide a written facility definition of health care provider. No written definition was provided. Therefore, it could not be determined which health care providers were responsible for dispensing pharmaceuticals. 7. Review of a facility document titled Narcotics Keys Daily Sign-Out/Return Log, approved June 2016, indicated health center managers, assistant managers, and licensed staff may access narcotics. 8. Neither of the above-stated facility documents (facility policy and log) indicated which clinic personnel can access non-narcotic drugs. 9. In interview on 02-15-2017 at 11:15 am, employee #A3, Vice President of Patient Services, indicated there were no facility policies as to who could access narcotics.	T 326		
T 330	410 IAC 26-16-1 PHARMACEUTICAL SERVICES 410 IAC 26-16-1(4) 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: (4) A formulary. This RULE is not met as evidenced by:	T 330		4/15/17

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	011118	A. BUILDING: _____ B. WING _____	02/15/2017

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

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T 330	Continued From page 17 Based on document review, observation and interview, the facility failed to ensure drugs were listed in the formulary for 4 Emergency drugs and 5 stock drugs. Findings: 1. Review of clinic's formulary, last reviewed March 2015, lacked documentation of: Emergency drugs (medications) of Epinephrine, Epi-pen, Methylergonovine and Benadryl and Stock drugs (medications) of Ibuprofen, Azithromycin, Benadryl, Epinephrine and Zovia. 2. On 2/13/2017 at 3:00 pm and on 2/14/2017 at 9:15 am, during tour(s), accompanied by clinic staff member A # 1 (Director of Surgical Services), it was observed the above drugs (medications) were in inventory for emergency use and stock (non-emergency) use. 3. In interview on 2/14/2017 at 1:30 pm, with clinic staff member A #2 (Quality Resource Manager), confirmed the following: A. That the above drugs (medications) are not listed - included in the clinic's formulary. B. That the formulary was last revised in June 2016.	T 330		
T 403	410 IAC 26-17-3 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-3(1) 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: (1) No condition in the clinic or on the grounds	T 403		4/15/17

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PLANNED PARENTHOOD OF INDIANA AND KENTUCI	8590 GEORGETOWN RD INDIANAPOLIS, IN 46268

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T 403	Continued From page 18 may be maintained that may be conducive to the harboring or breeding of: (A) insects, (B) rodents; or (C) other vermin. This RULE is not met as evidenced by: Based on observation, the facility failed to ensure that no condition on the clinic grounds be maintained that may be conducive to the harboring or breeding of insects, rodents and or other vermin in 1 instance. Findings include: 1. On 02-15-2017 at 1:50 pm, in the presence of employee #A1, Director of Surgical Services, it was observed there was considerable miscellaneous paper, refuse, a plastic bottle and an aluminum can, in the front parking lot and along a fence in the front parking area.	T 403		
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	T 404		4/30/17

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	011118	A. BUILDING: _____ B. WING _____	02/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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T 404	Continued From page 19 (C) employees. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure monthly checks of equipment, supplies and/or medications were conducted for 5 of 14 months. Findings: 1. Review of policy Emergency Medications and Supplies, last revised June 2016, indicated on page 13, "Assign designated licensed staff to perform monthly checks of the emergency box and document checks with a signature. Maintain a record of monthly checks." 2. Review of monthly "Emergency Drug Box" logs for calendar year 2016 and thus far 2017, indicated the following: A. That there are three (3) sheets for documentation for each month; includes: supplies, equipment and medications B. That no monthly check/documentation was found for December 2016, January 2017 and thus far February 2017, for first two sheets of monthly log - checks of equipment, supplies and medications. C. That no monthly check/documentation was found for the third sheet of monthly log - checks of medications, for October, November & December 2016, January 2017 and thus far February 2017. 3. In interview on 2/14/2017, at approximately 12:00 pm, with clinic staff member N # 4 (Registered Nurse), confirmed the following:	T 404		

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T 404	Continued From page 20 A. Monthly checks of emergency equipment, medications and supplies have not been completed as assigned. B. Is aware the emergency cart may contain expired items, based off log alone. C. That there is an Emergency cart and an emergency medication box - located in the medication room, and not actually an "emergency box", as noted on the monthly log sheet(s). D. That is assigned this responsibility, but due to staffing changes has been "pulled into different directions", and has not had time to complete the monthly checks.	T 404		
T 408	410 IAC 26-17-3 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-3(3)(B) 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: (B) All mechanical equipment (pneumatic, electric, sterilizing, or other) must be on a documented maintenance schedule of appropriate frequency in accordance with one (1) of the following: (i) Acceptable standards of practice. (ii) The manufacturer ' s recommended maintenance schedule. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to provide documented maintenance	T 408		4/30/17

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	011118	A. BUILDING: _____ B. WING _____	02/15/2017

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T 408	Continued From page 21 of mechanical equipment/systems according to acceptable standards of practice or the manufacturer's recommended maintenance schedule for 5 of 7 mechanical pieces of equipment/systems. Findings include: 1. Review of documents indicated there was no documented maintenance of mechanical equipment/systems according to acceptable standards of practice or the manufacturer's recommended maintenance schedule for the heating, ventilation, air conditioning, emergency generator and smoke detector systems. 2. In interview on 02-15-2017 at 2:45 pm, employee #A2, Quality Resources Manager,confirmed the above and no other documentation was provided prior to exit.	T 408		
T 410	410 IAC 26-17-3 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-3(3)(C) 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: (C) Operational and maintenance control records must be as follows: (i) Established and analyzed at least triennially. (ii) Readily available on the premises.	T 410		4/30/17

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 _____	02/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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T 410	Continued From page 22 This RULE is not met as evidenced by: Based on document review and interview, there were no operational and maintenance control records for 7 of 7 mechanical pieces of equipment/systems Findings include: 1. Review of facility documents indicated there were no operational & maintenance control records for heating, ventilation, air conditioning, emergency generator, fire alarm, smoke detector & sprinkler system that indicated were analyzed at least triennially. 2. In interview on 02-15-2017 at 2:45 pm, employee #A2, Quality Resources Manager, confirmed the above and no other documentation was provided prior to exit.	T 410		
T 414	410 IAC 26-17-4 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-4(1) All patient care equipment must be in good working order and regularly serviced and maintained as follows: (1) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with one (1) of the following: (A) Acceptable standards of practice. (B) The manufacturer ' s recommended maintenance schedule.	T 414		4/30/17

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T 414	Continued From page 23 This RULE is not met as evidenced by: Based on document review and interview, the facility failed to have patient care equipment on an appropriate documented maintenance schedule for 11 of 12 pieces of equipment, in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule. Findings include: 1. Review of facility documents indicated there was no documented maintenance schedule for a cardiac monitor, a centrifuge, a defibrillator, the emergency call system, patient exam light, patient scale, recovery chair, sterilizer, suction machine, surgical/exam table, and wheelchair. 2. In interview on 02-15-2017 at 2:45 pm, employee #A2, Quality Resources Manager, confirmed the above and no other documentation was provided prior to exit.	T 414		
T 416	410 IAC 26-17-4 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-4(2) All patient care equipment must be in good working order and regularly serviced and maintained as follows: (2) There must be evidence of preventive maintenance on all patient care equipment. This RULE is not met as evidenced by:	T 416		4/30/17

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	011118	A. BUILDING: _____ B. WING _____	02/15/2017

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

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T 416	Continued From page 24 Based on document review and interview, the facility failed to provide evidence of preventive maintenance on 5 of 12 pieces of patient care equipment. Findings include: 1. Review of facility documents indicated there was no evidence of preventive maintenance on the emergency call system, a recovery chair, an ultrasound machine, and a wheelchair. 2. In interview on 02-15-2017 at 2:45 pm, employee #A2, Quality Resource Manager, confirmed the above and no other documentation was provided prior to exit. 3. Review of the 2010 Cardiac Science Corporation AED (automated external defibrillator) manual indicated the facility was to perform ANNUAL MAINTENANCE to Check the integrity of the Pads and Circuitry via a series of tests. 3. Review of a document entitled K & R Annual Preventive Maintenance, dated 4-20-16, indicated some tests had been performed on an AED. However, it could not be determined all the tests specified by the manufacturer had been performed. Further review of the document indicated there was no reference to the tests being performed in accordance with the manufacturer's specification. 4. In interview, on 02-15-2017 at 2:30 pm, employee #A3, Vice President Patient Services, confirmed the above relative to the tests on the AED and no further documentation was provided prior to exit.	T 416		

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T 418	Continued From page 25	T 418		
T 418	410 IAC 26-17-4 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-4(3) All patient care equipment must be in good working order and regularly serviced and maintained as follows: (3) Appropriate records must be: (A) kept pertaining to: (i) equipment maintenance; (ii) repairs; and (iii) electrical current leakage checks; and (B) analyzed at least triennially. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to document electrical current leakage checks for 11 of 11 pieces of patient care equipment, nor a triennial analysis of the procedures to conduct preventive maintenance (PM) for 12 of 12 pieces of patient care equipment. Findings include: 1. Review of facility documents provided indicated there was no documentation of an electrical leakage check for a cardiac monitor, centrifuge, defibrillator, emergency call code system, patient emergency light, patient exam light, patient scale, recovery chair, suction machine, surgical/exam table, and an ultrasound machine.	T 418		4/30/17

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 418	Continued From page 26 2. Review of facility documents provided indicated there was no documentation of a triennial analysis of the procedures to conduct PM for a cardiac monitor, centrifuge, defibrillator, emergency call code system, patient emergency light, patient exam ;light, patient scale, recovery chair, suction machine, sterilizer, surgical/exam table, ultrasound machine, and a wheelchair. 3. In interview on 02-15-2017 at 2:45 pm, employee #A2, Quality Resource Manager, confirmed all the above and no other documentation was provided prior to exit.	T 418		