STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011134	A. BUILDING: _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP FAMILY PLANNING CLINIC	3700 BROADWAY GARY, IN 46408

(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 000	INITIAL COMMENTS This visit was for a standard licensure survey. Facility Number: 011134 Survey Date: 12/9/2014 & 12/10/2014 Surveyors: ReBecca Lair, LCSW Medical Surveyor Jacqueline Brown, RN Public Health Nurse Surveyor Chris Greeney Medical Surveyor QA: claughlin 01/02/15	T 000		
T 024	410 IAC 26-4-1 GOVERNING BODY 410 IAC 26-4-1(c)(2) (c) The governing body shall do the following: (2) Ensure that: (A) clinic policies are followed so as to provide quality health care in a safe environment; and (B) the clinic complies with: (i) this article; (ii) IC 16-21; and (iii) IC 16-34.	T 024		

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T 024	Continued From page 1 This RULE is not met as evidenced by: Based on document review, medical record review, and staff interview, the governing body failed to ensure the clinic complies with article IC 16-34-2-1.1 due to lack of informing the pregnant woman at least eighteen (18) hours before the abortion, orally and in writing via Abortion Consent State Form 55320 for 5 of 5 (#1, 2, 3, 4, and 5) patient medical records reviewed. Findings: 1. IC 16-34-2-1.1: Sec. 1.1. (a) An abortion shall not be performed except with the voluntary and informed consent of the pregnant woman upon whom the abortion is to be performed. Except in the case of a medical emergency, consent to an abortion is voluntary and informed only if the following conditions are met: (1) At least eighteen (18) hours before the abortion and in the presence of the pregnant woman, the physician who is to perform the abortion, the referring physician or a physician assistant (as defined in IC 25-27.5-2-10), an advanced practice nurse (as defined in IC 25-23-1-1(b), or a midwife (as defined in IC 34-18-2-19) to whom the responsibility has been delegated by the physician who is to perform the abortion or the referring physician has orally informed the pregnant woman of the following: (A) The name of the physician performing the abortion. (B) The nature of the proposed procedure or treatment. (C) The risks of and alternatives to the procedure or treatment. (D) The probable gestational age of the fetus, including an offer to provide: (i) a picture or drawing of a fetus;	T 024		

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T 024	Continued From page 2	T 024		

(ii) the dimensions of a fetus; and
(iii) relevant information on the potential survival of an unborn fetus;
at this stage of development.
(E) The medical risks associated with carrying the fetus to term.
(F) The availability of fetal ultrasound imaging and auscultation of fetal heart tone services to enable the pregnant woman to view the image and hear the heartbeat of the fetus and how to obtain access to these services.
(2) At least eighteen (18) hours before the abortion, the pregnant woman will be orally informed of the following:
(A) That medical assistance benefits may be available for prenatal care, childbirth, and neonatal care from the county office of family and children.
(B) That the father of the unborn fetus is legally required to assist in the support of the child. In the case of rape, the information required under this clause may be omitted.
(C) That adoption alternatives are available and that adoptive parents may legally pay the costs of prenatal care, childbirth, and neonatal care.
(3) The pregnant woman certifies in writing, before the abortion is performed, that the information required by subdivisions (1) and (2) has been provided.

2. Document titled Abortion Consent State Form 55320 was reviewed on 12/10/14 at approximately 1:00 PM and confirmed, "By my signature below, I affirm the following: 1. This form is being completed at least eighteen (18) hours before the abortion."

3. Review of medical records on 12/10/14 at 10:45 AM, indicated patient:
A. #1 signed and dated the Abortion Consent

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T 024	Continued From page 3 State Form 55320 on 5/6/14 at 4:00 PM and had a surgical abortion on 5/6/14 between 4:00 PM and 4:15 PM. B. #2 signed and dated the Abortion Consent State Form 55320 on 6/17/14 at 3:40 PM had a surgical abortion on 6/17/14 between 5:31 PM and 5:42 PM. C. #3 signed and dated the Abortion Consent State Form 55320 on 2/19/14 at 10:50 AM had a surgical abortion on 2/19/14 between 11:49 AM and 12:00 PM. D. #4 signed and dated the Abortion Consent State Form 55320 on 6/18/14 at 10:48 AM had a surgical abortion on 6/18/14 between 11:21 AM and 11:31 AM. E. #5 signed and dated the Abortion Consent State Form 55320 on 3/3/14 at 10:30 AM had a surgical abortion on 3/3/14 between 10:59 AM and 11:12 AM. 4. Staff #3 (Medical Director) was interviewed on 12/10/14 at approximately 10:48 AM and 12:20 PM and confirmed the Abortion Consent State Form 55320 is given to the patient at least 18 hours prior to a surgical abortion and is also discussed verbally, but there is no documentation of this in the patient medical record.	T 024		
T 078	410 IAC 26-4-2 GOVERNING BODY 410 IAC 26-4-2(g)(3) (g) The governing body is responsible for services delivered in the clinic by contractors for medical services. The governing body shall ensure the following: (3) That the clinic maintains a list of all contracted services, including the scope and nature of the	T 078		

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T 078	Continued From page 4 services provided. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to maintain a list of contracted services which includes the scope of services provided. Findings: 1. Review of facility documents on December 9, 2014 at 2:15pm lacked evidence of a list of contracted services. 2. Interview with employee #A3 on December 10, 2014 at 10:45am verified the facility does not maintain a list of contracted medical services.	T 078		
T 084	410 IAC 26-5-1 ADMINISTRATION AND POLICIES 410 IAC 26-5-1(3) The clinic administrator is responsible for day-to-day operations of the abortion clinic to include, but not be limited to, the following functions: (3) Implementation of internal and external disaster and emergency preparedness plans with documentation of outcome. This RULE is not met as evidenced by:	T 084		

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T 084	Continued From page 5 Based on document review and interview, the facility failed to implement and document internal and external disaster and emergency preparedness plans with outcomes. Findings: 1. Review of facility documents on December 9, 2014 at 2:15pm lacked evidence of the implementation of internal and external disaster drills with documentation of outcome. 2. Interview with employee #A3 on December 10, 2014 at 10:45am verified the facility has not implemented internal and external disaster drills with documentation of outcome.	T 084		
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 ensure a process for the evaluation of all services, including services furnished by a contractor.	T 096		

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T 096	Continued From page 6 Findings: 1. Review of the Quality Assurance documentation on December 9, 2014 at 2:15pm lacked evidence that the facility had a process for the evaluation of all services, including services furnished by a contractor. 2. Interview with employee #A3 on December 10, 2014 at 10:45am confirmed the facility has not developed a process for the evaluation of all services, including services furnished by a contractor.	T 096		
T 100	410 IAC 26-6-1 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 26-6-1(a)(3) The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (3) All services performed in the clinic with regard to the following: (A) Appropriateness of diagnoses and treatments related to a standard of care. (B) Anticipated or expected outcomes. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure a process for the	T 100		

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T 100	Continued From page 7 evaluation of all sevices performed in the clinic with regard to appopriateness of diagnoses and treatments related to a standard of care and expected outcomes. Findings: 1. Review of the Quality Assurance Program on December 9, 2014 at 2:15pm lacked evidence that the facility had a process for evaluation of all services performed in the clinic with regard to appropriateness of diagnoses and treatment related to a standard of care and anticipated outcomes. 2. Interview with employee #A3 on December 10, 2014 at 10:45am verified the facility had no process for evaluation of all services performed in the clinic with regard to appropriateness of diagnoses and treatment related to a standard of care and anticipated outcomes.	T 100		
T 103	410 IAC 26-6-1 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 26-6-1(b) (b) The clinic shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows: (1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.	T 103		

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T 103	Continued From page 8 This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure appropriate action to address the opportunities for improvement found through the quality assessment and improvement program and failed to ensure documentation of action and outcome of action. Findings: 1. Review of the Quality Assurance Program on December 9, 2014 at 2:15pm lacked evidence that the facility had a process to ensure appropriate action to address the opportunities for improvement found through the quality assessment and improvement program and failed to ensure documentation of the action and outcome. 2. Interview with employee #A3 on December 10, 2014 at 2:15pm verified the facility does not have a process to ensure appropriate action to address the opportunities for improvement found through the quality assessment and improvement program and failed to ensure documentation of the action and outcome.	T 103		
T 140	410 IAC 26-8-1 PERSONNEL POLICIES AND RECORDS 410 IAC 26-8-1(a)(2) (a) The abortion clinic shall maintain current and accurate personnel records for all employees. Personnel records shall:	T 140		

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T 140	Continued From page 9 (2) include personal data to include: (A) education; (B) experience; (C) date of employment; (D) a copy of current license when required; (E) evidence of participation in job-related educational and training activities; and (F) health records of employees that relate to post offer and subsequent: (i) physical examinations; (ii) tests; and (iii) immunizations. This RULE is not met as evidenced by: Based on policy and procedure review, personnel record review, and staff interview, the facility failed to ensure post offer physical examinations for 2 of 2 (Staff #1 and 2) personnel records reviewed; and documentation of immunizations for 2 of 2 (Staff #1 and 2) personnel records reviewed. Findings: 1. Policy titled "Friendship Family Planning Clinic" reviewed/revised 7/2012, indicated under: A. Physicals section, "A post offer physical is required. Manitou testing: two-stage mantoux is required with initial employment and must be repeated yearly." B. Hepatitis section, "A series of 3 injections will be offered to a newly hired employee. The employee may elect to take these injections or refuse them." 2. Policy titled "Infection Control Program" reviewed/revised 7/2012, indicated under:	T 140		

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T 140	Continued From page 10 A. Policy section, "The Clinic shall maintain a planned systematic organization-wide approach to designing, identifying, surveillance, investigate, control and prevent infection of communicable diseases in patients and health care workers. B. Procedure section, point 5., "A system to monitor the immune system of employees exposed to communicable diseases." 3. Review of personnel records on 12/9/14 at 12:15 PM, indicated: A. Staff #1 (Medical Assistant, Recovery Room Assistant, and OR [Operating Room] Assistant) was hired 7/2009 and: a. lacked documentation of a post offer physical examination and immunizations or communicable disease history related to Manitou (TB), Hepatitis B, Rubella, Rubeola, and Varicella. b. had job descriptions in the personnel record for Recovery Room Assistant and OR Assistant. B. Staff #2 (Supervisor, Recovery Room Assistant, OR Assistant, and Scrub Tech) was hired 2/1981 and: a. lacked documentation of a post offer physical examination and immunizations or communicable disease history related to Manitou (TB), Hepatitis B, Rubella, Rubeola, and Varicella. b. had job descriptions in the personnel record for Recovery Room Assistant, OR Assistant, and Scrub Tech. 4. Staff #3 (Medical Director) was interviewed on 12/10/14 at approximately 10:48 AM and 12:20 PM and confirmed the above-mentioned personnel records were lacking documentation of a post offer physical examination and/or immunizations or communicable disease history. 5. Staff #1 was interviewed on 12/10/14 at approximately 12:20 PM and stated his/her job	T 140		

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T 140	Continued From page 11 title is Medical Assistant, which did not match the job descriptions in the personnel file. 6. Staff #2 was interviewed on 12/10/14 at approximately 12:20 PM and stated his/her job title is Supervisor, which did not match the job descriptions in the personnel file.	T 140		
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 policy and procedure review, personnel record review, and staff interview, the facility failed to ensure performance evaluations based on the job description for 2 of 2 (Staff #1 and 2) personnel records reviewed. Findings: 1. Policy titled "Friendship Family Planning Clinic" reviewed/revised 7/2012, indicated under:	T 144		

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T 144	Continued From page 12 A. Evaluations and Raises section, "An evaluation will be given at the end of the six-month probationary period and again at one year and yearly thereafter. Merit raises are based on evaluations." B. Employee Files section, point 6., "Current job descriptions." 3. Review of personnel records on 12/9/14 at 12:15 PM, indicated: A. Staff #1 (Medical Assistant, Recovery Room Assistant, and OR [Operating Room] Assistant) was hired 7/2009 and: a. lacked documentation of a six-month probationary period evaluation and again at one year and yearly thereafter. b. had job descriptions in the personnel record for Recovery Room Assistant and OR Assistant. B. Staff #2 (Supervisor, Recovery Room Assistant, OR Assistant, and Scrub Tech) was hired 2/1981 and: a. lacked documentation of annual evaluations. b. had job descriptions in the personnel record for Recovery Room Assistant, OR Assistant, and Scrub Tech. 4. Staff #3 (Medical Director) was interviewed on 12/10/14 at approximately 10:48 AM and 12:20 PM and confirmed the above-mentioned personnel records were lacking documentation of evaluations. 5. Staff #1 was interviewed on 12/10/14 at approximately 12:20 PM and stated his/her job title is Medical Assistant, which did not match the job descriptions in the personnel file. 6. Staff #2 was interviewed on 12/10/14 at approximately 12:20 PM and stated his/her job	T 144		

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T 144	Continued From page 13 title is Supervisor, which did not match the job descriptions in the personnel file.	T 144		
T 146	410 IAC 26-8-1 PERSONNEL POLICIES AND RECORDS 410 IAC 26-8-1(c)(2) (c) The clinic must do the following: (2) Ensure that all health care workers, including contract and agency personnel, for whom a license, registration, or certification is required: (A) maintain current license, registration, or certification; and (B) keep documentation of same. This RULE is not met as evidenced by: Based on personnel record review, document review, and staff interview, the facility failed to ensure personnel met job description qualifications for 1 of 1 (Staff #1) personnel record reviewed. Findings: 1. Review of personnel records on 12/9/14 at 12:15 PM, indicated: A. Staff #1 (Medical Assistant, Recovery Room Assistant, and OR [Operating Room] Assistant) was hired 7/2009 and: a. had job descriptions in the personnel record	T 146		

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T 146	Continued From page 14 for Recovery Room Assistant and OR Assistant. 2. Review of job description for Recovery Room confirmed, "Qualifications: A. Current license or certification." 3. Staff #2 (Supervisor, Recovery Room Assistant, OR Assistant, and Scrub Tech) was interviewed on 12/10/14 at approximately 10:48 AM and 12:20 PM and confirmed staff #1 assists staff #3 (Medical Director) during procedures. Staff #1 does not have a license or certification.	T 146		
T 152	410 IAC 26-8-2 PERSONNEL POLICIES AND RECORDS 410 IAC 26-8-2(3)(A) The clinic shall do the following: (3) Ensure that all employees, staff members, and contractors having direct patient contact are evaluated at least annually for tuberculosis as follows: (A) Any person with a negative history of tuberculosis or a negative test result must have a baseline two step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.	T 152		

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T 152	Continued From page 15 This RULE is not met as evidenced by: Based on policy and procedure review, personnel record review, and staff interview, the facility failed to ensure documentation of 2-step Mantoux testing for 2 of 2 (Staff #1 and 2) personnel records reviewed. Findings: 1. Policy titled "Communicable Disease Policy - Employees" reviewed/revised 7/2012, indicated under Tuberculosis Screening section, "At time of hire each employee will show proof of a baseline 2 step mantoux testing. The second step must be completed 1-3 weeks after the first skin test was administered, unless the individual has documentation that a TST has been applied any time in the previous 12 months and the result was negative...All employees with a negative skin test will then be required to be skin tested annually there after. With mantoux method or quantiferon-TB assay...All employees with a documented positive Mantoux test will be required to have one chest x-ray to exclude a diagnosis of tuberculosis, and a medical evaluation by a physician approving the employee to work before allowed to provide direct patient contact, or documentation of completed tuberculosis treatment." 2. Review of personnel records on 12/9/14 at 12:15 PM, indicated: A. Staff #1 (Medical Assistant, Recovery Room Assistant, and OR [Operating Room] Assistant) was hired 7/2009 and lacked documentation of 2-step Mantoux testing at time of hire and/or annually. B. Staff #2 (Supervisor, Recovery Room Assistant, OR Assistant, and Scrub Tech) was hired 2/1981 and lacked documentation of	T 152		

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T 152	Continued From page 16 Mantoux testing annually. 3. Staff #3 (Medical Director) was interviewed on 12/10/14 at approximately 10:48 AM and 12:20 PM and confirmed the above-mentioned personnel records were lacking documentation of 2-step Mantoux testing at time of hire and/or annually.	T 152		
T 164	410 IAC 26-8-3 PERSONNEL POLICIES AND RECORDS 410 IAC 26-8-3(a)(1) (a) The clinic must do the following: (1) Develop, implement, and maintain a policy and procedure for the orientation of new employees, contractors, and agency personnel providing direct care and services to patients. This RULE is not met as evidenced by: Based on policy and procedure review, personnel record review, and staff interview, the facility failed to implement policy and procedure for the orientation of new employees providing direct patient care for 2 of 2 (Staff #1 and 2) personnel records reviewed. Findings: 1. Policy titled "Friendship Family Planning Clinic" reviewed/revised 7/2012, indicated under: A. Orientation section, "All employees will receive a general orientation to the facility and	T 164		

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T 164	Continued From page 17 those policies and procedures that apply to their job description." 2. Review of personnel records on 12/9/14 at 12:15 PM indicated Staff #1 (Medical Assistant, Recovery Room Assistant, and OR [Operating Room] Assistant) was hired 7/2009 and personnel file lacked documentation of orientation and had job descriptions in the personnel record for Recovery Room Assistant and OR Assistant. 3. Staff #3 (Medical Director) was interviewed on 12/10/14 at approximately 10:48 AM and 12:20 PM and confirmed the above-mentioned personnel records were lacking documentation of orientation that applies to their job description.	T 164		
T 168	410 IAC 26-8-3 PERSONNEL POLICIES AND RECORDS 410 IAC 26-8-3(b) (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 policy and procedure review, personnel record review, and staff interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) competence for all health care personnel who provide direct patient care for 2 of 2 (Staff #1 and 2) personnel records reviewed.	T 168		

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T 168	Continued From page 18 Findings: 1. Policy titled "Friendship Family Planning Clinic" reviewed/revised 7/2012, indicated under: A. CPR (cardiopulmonary resuscitation) section, "All positions requiring hands on patient care require CPR certification on employment and certification must be renewed as certificate requires." 2. Review of personnel records on 12/9/14 at 12:15 PM, indicated: A. Staff #1 (Medical Assistant, Recovery Room Assistant, and OR [Operating Room] Assistant) was hired 7/2009 and: a. lacked documentation of current CPR certification; it expired 1/2011. b. had job descriptions in the personnel record for Recovery Room Assistant and OR Assistant. B. Staff #2 (Supervisor, Recovery Room Assistant, OR Assistant, and Scrub Tech) was hired 2/1981 and: a. lacked documentation of current CPR certification; it expired 1/2011. b. had job descriptions in the personnel record for Recovery Room Assistant, OR Assistant, and Scrub Tech. 3. Staff #3 (Medical Director) was interviewed on 12/10/14 at approximately 10:48 AM and 12:20 PM and confirmed staff #1 provides direct patient care and their personnel record lacked documentation of current CPR certification. 4. Staff #2 (Supervisor, Recovery Room Assistant, OR Assistant, and Scrub Tech) was interviewed on 12/10/14 at approximately 10:48 AM and 12:20 PM and confirmed staff #1 assists staff #3 (Medical Director) during procedures.	T 168		

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T 188	410 IAC 26-10-1 PATIENT CARE AND NURSING SERVICES 410 IAC 26-10-1(a)(3)(A) (a) All patient care services must: (3) require that: (A) patient care services rendered are: (i) reviewed and analyzed at regular meetings of patient care personnel; and (ii) used as a basis for evaluating the quality of services provided; and This RULE is not met as evidenced by: Based on policy and procedure review, document review, personnel record review, and staff interview, patient care services were not documented as being reviewed and analyzed at regular meetings of patient care personnel. Findings: 1. Policy titled "Care Coordination" reviewed/revised 7/2012 indicated, "To ensure that appropriate, quality care is being provided to clients...To establish that effective interchange, reporting, and coordination of client care does occur between members of the interdisciplinary team...Each staff shall meet with the Nursing Supervisor monthly or as necessary to review all areas of client needs...Ongoing care conferences shall be conducted to evaluate the client's status, progress, and any problems." 2. Job Description titled "Position: OR [Operating Room] Assistant" (lacking original approval	T 188		

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T 188	Continued From page 20 and/or revision/reapproval date) indicated, "General Duties: A. Attendance at all staff meetings." 3. Review of personnel records on 12/9/14 at 12:15 PM, indicated: A. Staff #1 (Medical Assistant, Recovery Room Assistant, and OR Assistant) was hired 7/2009. B. Staff #2 (Supervisor, Recovery Room Assistant, OR Assistant, and Scrub Tech) was hired 2/1981. 4. Staff #3 (Medical Director) was interviewed on 12/10/14 at approximately 10:48 AM and 12:20 PM and documentation of attendance at regularly scheduled staff meetings by the above-mentioned personnel was requested, as well as documentation of meeting minutes, and were not provided prior to survey exit.	T 188		
T 204	410 IAC 26-10-2 PATIENT CARE AND NURSING SERVICES 410 IAC 26-10-2(2) If the clinic employs licensed nurses, the clinic must ensure the following: (2) Nursing personnel meet annual inservice requirements as established by clinic and federal and state requirements. This RULE is not met as evidenced by:	T 204		

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T 204	Continued From page 21 Based on policy and procedure review, personnel record review, and staff interview, the facility failed to ensure nursing personnel meet annual in-service requirements per policy and procedure for 2 of 2 (Staff #1 and 2) personnel records reviewed. Findings: 1. Policy titled "Friendship Family Planning Clinic" reviewed/revised 7/2012, indicated under: A. In-service section, "This company will provide four in-services per year. If certification or license requires more than we provide it will be up to the individual to obtain those on her own." 2. Review of personnel records on 12/9/14 at 12:15 PM, indicated: A. Staff #1 (Medical Assistant, Recovery Room Assistant, and OR [Operating Room] Assistant) was hired 7/2009 and lacked documentation of in-services. B. Staff #2 (Supervisor, Recovery Room Assistant, OR Assistant, and Scrub Tech) was hired 2/1981 and lacked documentation of in-services. 3. Staff #3 (Medical Director) was interviewed on 12/10/14 at approximately 10:48 AM and 12:20 PM and confirmed the above-mentioned personnel records were lacking documentation of annual in-service requirements.	T 204		
T 206	410 IAC 26-11-1 INFECTION CONTROL PROGRAM 410 IAC 26-11-1(a)(1) (a) The clinic must do the following:	T 206		

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T 206	Continued From page 22 (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 and staff interview, the facility failed to ensure a safe and healthful environment that minimizes infection exposure risk to patients, health care workers, and persons who accompany patients due to a water leak throughout the patient care lower level area of the facility toured. Findings: 1. While on tour of facility on 12/10/14 at approximately 12:15 PM, accompanied by staff #3 (Medical Director), the following was observed throughout the lower level of the facility: A. fifty plus feet of black hose connected at several different lengths lying on the floor and traveling from room to room from a sump pump to a drain hole in the floor located in a utility closet. This hose was leaking water in several different spots, one of which created a puddle on the tile floor that could not be avoided while entering from the hallway to the procedure room. B. a strong odor of mildew, mold, and stagnant water. C. rust stains approximately 6 inches to 1 foot on the bottoms of the doors and/or walls. 2. Medical staff #3 (Medical Director) was interviewed on 12/10/14 at approximately 12:20 PM and confirmed a water pipe broke several	T 206		

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T 206	Continued From page 23 weeks ago and he/she fixed it and the basement has also flooded several times over the years.	T 206		
T 220	410 IAC 26-11-1 INFECTION CONTROL PROGRAM 410 IAC 26-11-1(e)(1) (e) The clinic must establish a committee to monitor and guide the infection control program in the clinic as follows: (1) The infection control committee must meet at least quarterly. This RULE is not met as evidenced by: Based on policy and procedure review and staff interview, the infection control committee failed to meet at least quarterly. Findings: 1. Policy titled "Infection Control Program" reviewed/revised 7/2012 indicated under Procedure section, point 4., "A written report of the quarterly meeting." 2. Staff #3 (Medical Director) was interviewed on 12/10/14 at approximately 10:48 AM and 12:20 PM and confirmed there is no documentation of quarterly infection control meetings.	T 220		
T 222	410 IAC 26-11-1 INFECTION CONTROL PROGRAM 410 IAC 26-11-1(e)(1)(A,B,C&D)	T 222		

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T 222	Continued From page 24 (e) The clinic must establish a committee to monitor and guide the infection control program in the clinic as follows: (1) The infection control committee must meet at least quarterly. (A) The person directly responsible for management of the infection surveillance, prevention, and control program as established in subsection (c). (B) The medical director. (C) A representative from the nursing staff (if the clinic employs a licensed nurse). (D) Representatives from other appropriate services within the clinic as needed. This RULE is not met as evidenced by: Based on policy and procedure review and staff interview, the infection control committee is lacking a representative from the medical director and other appropriate services. Findings: 1. Policy titled "Infection Control Program" reviewed/revised 7/2012 indicated under Procedure section, point 1., "The program will involve participation by the person directly responsible for managing the infection control program, the Medical Director, a representative from the nursing staff, any other representative from appropriate services within the clinic identified." 2. Staff #3 (Medical Director) was interviewed on	T 222		

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T 222	Continued From page 25 12/10/14 at approximately 10:48 AM and 12:20 PM and confirmed, a registered nurse is not employed at this facility and has not been since January 2014 and confirmed there is no documentation of quarterly infection control meetings.	T 222		
T 310	410 IAC 26-15-1 LABORATORY SERVICES 410 IAC 26-15-1(c) (c) The clinic must assure that all laboratory services provided to its patients are performed in a facility possessing a valid certificate, in accordance with 42 CFR 493 (excluding Subparts F, R, Q, and T) authorizing the performance of testing in the specialty or subspecialty of service for level of complexity in which the test is categorized. This RULE is not met as evidenced by: Based on document review, policy and procedure review, medical record review, and staff interview, the clinic failed to present a valid Clinical Laboratory Improvement Amendments (CLIA) certificate to assure all laboratory services provided to its patients are performed for the level of complexity in which the test is categorized for 5 of 5 medical records reviewed (patient #1, 2, 3, 4 and 5). Findings: 1. CLIA Certificate of Waiver, ID #15D1070179, effective 06/22/2013, expiration date 06/21/2015. 2. Label from Rh testing box titled "ALBAclone	T 310		

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T 310	Continued From page 26 Blood Grouping Reagent Anti-D Blend (Human/Murine Monoclonal IgM/IgG)", lot V117718 is a moderate complexity test according to the FDA (Food and Drug Administration) website. Serum pregnancy testing is also considered moderate complexity testing according to the FDA. 3. Policy titled "Laboratory Test Results Protocol" reviewed/revised 7/2012 indicated under Rh Testing and RhoGam section, "Every abortion patient will have her blood tested for the Rh factor (see CLIA Manual). Every woman who has Rh-negative blood will be given a form of RhO immune globulin (see Medication Protocols)." 4. Review of medical records on 12/10/14 at 10:45 AM, indicated patient: A. #1 had Rh factor testing and blood serum pregnancy testing completed on 5/6/14. B. #2 had Rh factor testing and blood serum pregnancy testing completed on 6/17/14. C. #3 had Rh factor testing and blood serum pregnancy testing completed on 2/19/14. D. #4 had Rh factor testing and blood serum pregnancy testing completed on 6/18/14. E. #5 had Rh factor testing and blood serum pregnancy testing completed on 3/3/14. 5. Staff #2 (Supervisor, Recovery Room Assistant, OR Assistant, and Scrub Tech) was interviewed on 12/10/14 at approximately 12:20 PM and confirmed the following patient testing is done here onsite: urine and blood serum pregnancy testing, hematocrit, and Rh factor testing. Staff #1 and 2 perform these lab tests.	T 310		
T 314	410 IAC 26-15-1 LABORATORY SERVICES	T 314		

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T 314	Continued From page 27 410 IAC 26-15-1(e) (e) All nursing and other clinic personnel performing laboratory testing must have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed. This RULE is not met as evidenced by: Based on policy and procedure review, personnel record review, and staff interview, the facility failed to ensure annual competency assessment of all clinic personnel performing laboratory testing with documentation of assessment maintained in the employee file for the procedures performed for 2 of 2 (Staff #1 and 2) personnel records reviewed. Findings: 1. Policy titled "Friendship Family Planning Clinic" reviewed/revised 7/2012, indicated under: A. Competency Evaluation of Skills section, "Will be done with orientation and yearly there after." B. Employee Files section, point 10., "Skills certification re-certified yearly." 2. Review of personnel records on 12/9/14 at 12:15 PM, indicated: A. Staff #1 (Medical Assistant, Recovery Room Assistant, and OR [Operating Room] Assistant) was hired 7/2009 and lacked documentation of competency evaluation of skills related to performing laboratory testing. B. Staff #2 (Supervisor, Recovery Room Assistant, OR Assistant, and Scrub Tech) was hired 2/1981 and lacked documentation of	T 314		

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T 314	Continued From page 28 competency evaluation of skills related to performing laboratory testing. 3. Staff #2 (Supervisor, Recovery Room Assistant, OR Assistant, and Scrub Tech) was interviewed on 12/10/14 at approximately 12:20 PM and confirmed the following patient testing is done here onsite: urine and blood serum pregnancy testing, hematocrit, and Rh factor testing. Staff #1 and 2 perform these lab tests and staff #3 (Medical Director) performs the ultrasounds. The above-mentioned personnel files are lacking documentation of competency evaluation of skills related to performing laboratory testing.	T 314		
T 354	410 IAC 26-17-2 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-2(c)(1) (c) For common administration and authorized visitor areas, the clinic shall be able to accommodate wheelchairs and provide the following: (1) A reception and information counter. The reception and information counter or desk shall be as follows: (A) Located to provide visual control of the entrance to the clinic. (B) Immediately apparent from the entrance.	T 354		

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T 354	Continued From page 29 This RULE is not met as evidenced by: Based on observation and interview, the facility was unable to accommodate wheelchairs in the lower level where the procedure and exam room was located. Findings include: 1. During an observational tour of the clinic between on 12/9/2014 between 12:15 P.M. and 12:50 P.M., it was noted that a procedure and exam room for the facility was on a lower level only accessible by stairs. 2. Interview with MA#1, the medical assistant present during the tour, indicated patients treated by the facility were seen by the Doctor in the room. MA#1 indicated the stairs were the only way to the procedure and exam room from the entrance and waiting area and the clinic was unable to accommodate individuals using wheelchairs.	T 354		
T 368	410 IAC 26-17-2 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-2(d)(1)(B) (d) Requirements for clinical facilities are as follows: (1) Procedure rooms shall be segregated and removed from general traffic flow and be a minimum of: (B) two hundred fifty (250) square feet, exclusive of vestibules, toilets, or closets for procedures that require conscious sedation.	T 368		

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(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 368	Continued From page 30 This RULE is not met as evidenced by: Based on observation and interview, the facility failed for 1 of 1 procedure room where conscious sedation was used, to ensure the procedure room was at least 250 square feet. Findings include: 1. During observation on 12/09/2014 between 12:15 P.M. and 12:50 P.M., one procedure room in the facility measured to be 11 feet 8 inches by 8 feet 4 inches. The square footage the procedure room was calculated at 97.22 square feet. 2. Interview with MA#1, the medical assistant present during the observation, indicated the facility used Stadol, (an injectable opioid pain medication used during surgical procedures which causes drowsiness and dizziness).	T 368		
T 370	410 IAC 26-17-2 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-2(d)(2) (d) Requirements for clinical facilities are as follows: (2) A hand washing station shall be included within each procedure room. This RULE is not met as evidenced by: Based on observation and interview, the facility	T 370		

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T 370	Continued From page 31 failed for 1 of 1 procedure room, to ensure hand washing station was present in the procedure room. Findings include: 1. During observation on 12/09/2014 between 12:15 P.M. and 12:50 P.M., one procedure room in the facility was noted not to have a hand washing sink within the room. 2. Interview with MA#1, the medical assistant present during the observation, indicated staff used sinks in other parts of the building for hand washing.	T 370		
T 374	410 IAC 26-17-2 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-2(d)(4) (d) Requirements for clinical facilities are as follows: (4) A separate recovery room or area shall be included and provide for the following: (A) A minimum clear area of two (2) feet, six (6) inches around three (3) sides of each recovery cart or lounge chair for work and circulation. (B) A method of providing privacy for each patient in the room or area. (C) A work station with the following: (i) A countertop. (ii) Space for supplies. (iii) Provisions for charting. (iv) A communication system.	T 374		

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T 374	Continued From page 32 This RULE is not met as evidenced by: Based on observation and interview, the facility failed to have a functioning recovery room for patients. The findings include: 1. During an observational tour of the clinic between on 12/9/2014 between 12:15 P.M. and 12:50 P.M., it was indicated by MA#1, the medical assistant present during the tour, that the recovery room was on the lower level. During the observation, it was noted that there had been water damage and a large black hose extended through the recovery room from one maintenance room to another maintenance room on the other side of the floor. There was a musty odor. There were no chairs arranged in the room available to sit and multiple cardboard boxes, supplies and other assorted items were stored, stacked on tables extending 5-6 feet above the floor throughout the room. 2. Interview with MA#1 indicated the room was being used for storage since the facility had not performed surgical procedures since July 1, 2014.	T 374		
T 394	410 IAC 26-17-2 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-2(e)(6) (e) Requirements for design standards are as follows: (6) The minimum nominal door width for patient use shall be three (3) feet.	T 394		

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T 394	Continued From page 33 This RULE is not met as evidenced by: Based on observation and interview, the facility failed for one of one bathroom door in the waiting area and 1 of 1 door to the facility's lab room, to ensure the nominal width of each doorway was at least 36 inches. Findings include: 1. During observation on 12/09/2014 between 12:15 and 12:50 P.M., the doorway to the bathroom located in the waiting/reception area measured 32 inches. During the same observation, the room the facility used for laboratory procedures had a door width of 30 inches. 2. Interview withMA#1, the medical assistant present during the observation indicated patients access both rooms.	T 394		
T 396	410 IAC 26-17-2 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-2(e)(7) (e) Requirements for design standards are as follows: (7) Each building shall have a [sic., at] least two (2) exits that are remote from each other.	T 396		

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T 396	Continued From page 34 This RULE is not met as evidenced by: Based on observation and interview, the facility failed to have two exits remote from each other in the level that was below grade. Findings include: 1. During observation on 12/09/2014 between 12:15 P.M. and 12:50 P.M., it was noted the procedure room and the recovery room were on the lower level of the facility, which was below grade. There were no windows present. Only one way of egress was observed from the lower level, which was a stairway at one end of building. This stairway exited to the upper level in front of the rear entrance of the building. 2. Interview with MA#1, the medical assistant present during the observation, indicated if an evacuation of the lower level was necessary, the stairs was the only way out from any of the rooms that were below grade.	T 396		
T 398	410 IAC 26-17-2 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-2(e)(8) (e) Requirements for design standards are as follows: (8) An approved antiscald device shall be provided on the hot water supply to all hand washing facilities limiting the water temperature to a maximum of one hundred ten (110) degrees Fahrenheit (forty-three (43) degrees Celsius).	T 398		

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T 398	Continued From page 35 This RULE is not met as evidenced by: Based on observation and interview, it could not be determined if the facility had anti-scald devices on the hot water supply to all hand washing facilities. The findings include: 1. During observation on 12/09/2014 between 12:15 and 12:50 P.M., an installed anti-scald device was not observed on the hot water supply. 2. Interview with MA#1, the medical assistant present during the observation, stated he/she "did not know if there was (an anti-scald device)" installed in the facility.	T 398		
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:	T 404		

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T 404	Continued From page 36 Based on observation and interview, the facility failed to maintain the facility to ensure no hazard existed to patients, visitors and staff. The findings include: 1. During observation on 12/09/2014 between 12:15 and 12:50 P.M., the following was noted: a. An office located on the main level was packed from wall to almost the ceiling with corrugated storage boxes, supplies, equipment and other assorted materials in such a way that the stored items filled the entire room, except for a small one foot wide path between the storage that snaked into the room. These items would be considered easily combustible and there was no sprinkler system, or fire suppression system except for a fire extinguisher that was sitting on the floor in the pathway. The door to the office was a sliding window with no mechanism to automatically close. b. A storage area adjacent to the office also was observed with combustible storage from floor to almost the ceiling throughout the room except for one small walkway. The wall separating this room from the common waiting area had a partial wall that did not extend to the ceiling. c. The lower level contained a procedure room, a recovery room area and two storage areas. Throughout the lower level, unused medical equipment, corrugated boxes and other assorted items were found in the recovery area as well as filling both storage areas. d. A long black hose extended on the floor throughout the lower level from one maintenance room to another maintenance room on the other	T 404		

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T 404	Continued From page 37 side of the building where drains and a sump pump was located. This hose extended through the recovery area and water could be heard passing through the hose. The floor was wet in areas where carpet and rugs existed and evidence of water splatter could be seen along the walls throughout the lower level. When walking off carpet or rugs onto the tile flooring, wet footprint tracks were visible. There was a musty odor throughout the lower level and a distinct sewage smell was present in the procedure room. Interview with the medical assistant during the observation indicated they had flooding problems on that level a few weeks ago. 2. Interview with MA#1, the medical assistant, indicated this building was used to store items from three other facilities owned by FD#1, the Facility Director. MA#1 indicated that patients had been seen for consultation in the procedure/exam room within the past week.	T 404		
T 420	410 IAC 26-17-4 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-4(4) All patient care equipment must be in good working order and regularly serviced and maintained as follows: (4) Defibrillators must be discharged at least in accordance with manufacturers ' recommendations, and a discharge log with initialed entries must be maintained.	T 420		

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T 420	Continued From page 38 This RULE is not met as evidenced by: Based on record review and interview, it could not be determined that a discharge log existed, or that the facility defibrillator had been discharged in accordance with manufacturer's directions. Findings include: 1. During review of facility documentation on 12/09/2014 between 11:50 A.M. and 2:45 P.M., there was no evidence found that the facility maintained a discharge log for its defibrillator. 2. Interview with CS#1, the clinic supervisor, at 1:40 P.M. indicated he/she was not aware of where those records were maintained.	T 420		
T 422	410 IAC 26-17-5 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-5 The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following: This RULE is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building was maintained clean and orderly.	T 422		

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T 422	Continued From page 39 The findings include: 1. During observation on 12/09/2014 between 12:15 and 12:50 P.M. the following was noted: a. An office located on the main level was packed from wall to almost the ceiling with corrugated storage boxes, supplies, equipment and other assorted materials in such a way that the stored items filled the entire room, except for a small one foot wide path between the storage that snaked into the room. These items would be considered easily combustible and there was no sprinkler system, or fire suppression system except for a fire extinguisher that was sitting on the floor in the pathway. The door to the office was a sliding window with no mechanism to automatically close. Ceiling tiles in this room had brown stains as if there had been past leaks. b. A storage area adjacent to the office also was observed with combustible storage from floor to almost the ceiling throughout the room except for one small walkway. The wall separating this room from the common waiting area had a partial wall that did not extend to the ceiling. Ceiling tiles in this room were also stained and discolored. c. The lower level contained a procedure room, a recovery room area and two storage areas. Throughout the lower level unused medical equipment, corrugated boxes and other assorted items were found in the recovery area as well as filling both storage areas. Ceiling tiles throughout the lower level also had evidence of water stains. d. A long black hose extended on the floor throughout the lower level from one maintenance room to another maintenance room on the other	T 422		

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T 422	Continued From page 40 side of the building where drains and a sump pump was located. This hose extended through the recovery area and water could be heard passing through the hose. The floor was wet in areas where carpet and rugs existed and evidence of water splatter could be seen along the walls throughout the lower level. When walking off carpet or rugs onto the tile flooring, wet footprint tracks were visible. There was a musty odor throughout the lower level and a distinct sewage smell was present in the procedure room. 2. Interview with MA#1, the medical assistant, indicated this building was used to store items from three other facilities owned by FD#1, the Facility Director. Interview with MA#1 during the observation indicated they had flooding problems on that level a few weeks ago. MA#1 indicated that patients had been seen for consultation in the procedure/exam room within the past week.	T 422		
T 436	410 IAC 26-17-6 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-6(a)(5) (a) A safety management program must include, but not be limited to, the following: (5) A written fire control plan that contains provisions for the following: (A) Prompt reporting of fires. (B) Extinguishing of fires. (C) Protection of the following: (i) Patients. (ii) Personnel. (iii) Guests. (D) Evacuation.	T 436		

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T 436	Continued From page 41 (E) Cooperation with firefighting authorities. (F) Fire drills. This RULE is not met as evidenced by: Based on record review and interview, the facility failed to ensure evidence it had conducted fire drills and trained staff regarding fire control policy and procedures. Findings include: 1. In review of the facility's Safety Management Program (updated July 2012) on 12/09/2014 at 2:00 P.M., the facility's written fire control plan indicated "The Safety Program is responsible for fire drills." 2. Interview with CS#1, the clinic supervisor, on 12/09/2014 at 2:05 P.M. indicated no evidence could be located to determine if the facility had conducted fire drills or trained staff how to respond to a fire emergency.	T 436		
T 438	410 IAC 26-17-6 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-6(a)(6) (a) A safety management program must include, but not be limited to, the following: (6) Maintenance of written evidence of regular inspection and approval by state or local fire control agencies in accordance with the following: (A) Clinic policy. (B) State and local regulations.	T 438		

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T 438	Continued From page 42 This RULE is not met as evidenced by: Based on record review and interview, the facility failed to ensure evidence of an inspection by local or state fire control agencies. Findings include: 1. During a review of the facility documentation on 12/09/2014, there was no evidence indicating the facility had inspection or approval by a local or state fire control agency. 2. Interview with CS#1, the clinic supervisor, on 12/09/2014 at 1:40 P.M. indicated the facility was unable to locate evidence of an inspection.	T 438		
T 440	410 IAC 26-17-6 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-6(a)(7) (a) A safety management program must include, but not be limited to, the following: (7) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.410 IAC 26-17-6	T 440		

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T 440	Continued From page 43 This RULE is not met as evidenced by: Based on record review and interview, the facility failed to ensure evidence of a a safety management program which included emergency and disaster preparedness coordination with appropriate community, state and federal agencies. Findings include: 1. During a review of the facility documentation on 12/09/2014, there was no evidence indicating the facility had attempted coordination of emergency management and preparedness with appropriate agencies. 2. Interview with CS#1, the clinic supervisor, on 12/09/2014 at 1:40 P.M. indicated the facility was unable to locate evidence of coordination.	T 440		
T 442	410 IAC 26-17-6 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-6(b) (b) The clinic must maintain adequate battery-powered lighting and sufficient equipment needed to provide for the: (1) completion of services; and (2) safety of patients and staff; in the event of a power loss. This RULE is not met as evidenced by: Based on observation and interview, the facility failed to ensure adequate battery-powered	T 442		

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T 442	Continued From page 44 lighting in the event of a power failure. Findings include: 1. During observation on 12/09/2014 between 12:15 P.M. and 12:50 P.M. with MA#1, the medical assistant, no emergency lights were found throughout either floor of the building. The lower level did not have windows. No emergency lighting was observed on either level. 2. Interview with CS#1, the clinic supervisor, on 12/09/2014 at 1:40 P.M. indicated there were no battery powered emergency lights.	T 442		
T 446	410 IAC 26-18-1 OTHER SERVICES 410 IAC 26-18-1(b) (b) The services must be as follows: (1) Under the direction of a qualified person or persons. (2) Staffed in accordance with written clinic policies and in compliance with the applicable state and federal rules. This RULE is not met as evidenced by: Based on policy and procedure review, medical record review, and staff interview, the facility is not staffed in accordance with written clinic policies related to the lack of a registered nurse. Findings: 1. Policy titled "Surgery Center Staffing"	T 446		

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FRIENDSHIP FAMILY PLANNING CLINIC	3700 BROADWAY GARY, IN 46408

(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 446	Continued From page 45 reviewed/revised 7/2012 indicated under: A. Policy section, "Adequate staff will be available to handle the patient care needs at all times." B. Procedure section, points 1., 3., 6., and 7., "A minimum of one registered nurse (R.N.) will staff Friendship Family Planning Clinic (FFPC)...Recovery Room care will be directed by a Registered Nurse licensed in the State of Indiana, CPR (cardiopulmonary resuscitation) certified, and IV (intravenous) certified...An R.N. must always be present while surgical procedures are being performed at FFPC...Two professional staff members will be present at FFPC until the last patient of the day is discharged. This will always include a R.N.; professional staff includes but is not limited to administrator, counselor, staff supervisor, or receptionist." 2. Review of medical records on 12/10/14 at 10:45 AM, indicated patient #: A. 1 had a surgical abortion on 5/6/14. B. 2 had a surgical abortion on 6/17/14. C. 3 had a surgical abortion on 2/19/14. D. 4 had a surgical abortion on 6/18/14. E. 5 had a surgical abortion on 3/3/14. 3. Staff #3 (Medical Director) was interviewed on 12/10/14 at approximately 10:48 AM and 12:20 PM and confirmed, a registered nurse is not employed at this facility and has not been since January 2014.	T 446		