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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF INDIANA AND KENTUCI	8645 CONNECTICUT ST MERRILLVILLE, IN 46410

(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: 011116 Survey Date: 11/19/2014 & 11/20/2014 Surveyors: ReBecca Lair, LCSW Medical Surveyor Linda Plummer, RN Public Health Nurse Surveyor Chris Greeney Medical Surveyor QA: claughlin 12/12/14	T 000		
T 132	410 IAC 26-7-2 MEDICAL RECORDS 410 IAC 26-7-2(b) (b) Entries in the medical record must be as follows: (1) Legible. (2) Complete. (3) Made by authorized individuals as specified in clinic and medical staff policies. (4) Authenticated and dated in accordance with this article. This RULE is not met as evidenced by: Based on policy and procedure review, medical record review, and staff interview, the facility failed to ensure the implementation of its policy related to completion and accuracy in the medical	T 132		

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records for 21 of 30 patients, and failed to ensure the authentication of the history and physical portion of the chart for 10 of 30 records reviewed.

Findings:
1. Review of the policy and procedure "Clinical Program Structure", I-A-1, PPINK revised May 2014, indicated:
a. On page 11, under section "VI. Maintaining Affiliate Medical Records", it read; "...Records must be 1. factual, complete, concise, and professional...".
b. On page 12, it read in item 9.: "...records are completely and accurately documented by only those staff who are authenticated on the signature cards maintained by the Human Resources. Department...".

2. Review of patient medical records indicated:
a. Pt. #1, on 11/13/14:
1. Was admitted to the RR (recovery room) at 8:39 AM and discharged at 8:55 AM.
2. Had a set of VS (vital signs) noted as taken at 9:38 AM.
b. Pt. #2, on 11/13/14:
1. Was admitted to the RR at 1:46 PM and discharged at 2:05 PM.
2. Had VS documented at 3:06 PM.
c. Pt. #3, on 11/13/14:
1. Had documentation of arrival to the RR at "1:12 AM" and discharge at "1159 AM". (Procedure start and stop times were noted at: "11:14 AM" and 11:28 AM".)
2. VS were documented at 11:45 AM, 12:40 PM and 12:55 PM, with the last two sets of VS being documented as being taken after the patient was discharged from the RR.
3. Lacked "Provider signoff" in the "Abortion History (Surgical and MAB [medical abortion])" and "Abortion (Surgical)" sections of the history

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and physical portion of the chart.
d. Pt. #5, on 11/6/14;
1. Had documentation of arrival to the RR at "1259 PM" and discharge at "1211 PM". (Procedure start and stop times were "11:41 AM" and "11:54 AM", as noted in the record.")
2. Lacked "Provider signoff" authentication in the "Abortion History (Surgical and MAB [medical abortion])" and "Abortion (Surgical)" sections of the history and physical portion of the chart.
3. Lacked completion in the area of POC (product of conception) regarding "Tissue exam consistent with documented gestational age" and "Discharge pt. from recovery room per protocol...".
e. Pt. #6, on 11/6/14:
1. Had documentation of procedure start time of "16:56 PM" and a stop time of "16:12 PM. (Arrival to the RR was noted at 5:15 PM and discharge as 5:35 PM.)
2. Had final VS noted at 6:15 PM.
3. Lacked completion in the area of POC (product of conception) regarding: "Tissue exam consistent with documented gestational age" and "Discharge pt. from recovery room per protocol...".
4. Lacked "Provider signoff" in the "Abortion History (Surgical and MAB [medical abortion])" and "Abortion (Surgical)" sections of the history and physical portion of the chart.
f. Pt. #7, on 10/16/14:
1. Was noted as being discharged from the RR at 4:10 PM, with a VS documented at "5:00 PM".
2. Lacked "Provider signoff" in the "Abortion History (Surgical and MAB [medical abortion])" and "Abortion (Surgical)" sections of the history and physical portion of the chart.
g. Pt. #8, on 10/16/14:
1. Was noted as being discharged from the RR at 4:23 PM, with a VS documented at "5:24 PM".

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T 132	Continued From page 3 2. Lacked documentation in the "Sedation Preference" section of the chart regarding whether the patient received "Local only" and/or "NSAID Only". 3. Lacked "Provider signoff" in the "Abortion History (Surgical and MAB [medical abortion])" and "Abortion (Surgical)" sections of the history and physical portion of the chart. h. Pt. #10, on 9/11/14: Lacked documentation in the "Sedation Preference" section of the chart regarding whether the patient received "Local only" and/or "NSAID Only". i. Pt. #11, on 9/11/14: Lacked documentation, in the "Procedure" section of the chart, indicating that the pre procedure check was completed due to lack of checking the boxes for: "Patient's name and/or ID (identification) band checked" and "Required CIIC's (consent forms) read/signed prior to procedure". j. Pt. #13, on 9/11/14: Lacked completion in the area of POC regarding "Tissue exam consistent with documented gestational age". k. Pt. #14, on 8/14/14: 1. Had a procedure start time noted as: "10:31 aM" and a stop time of "110:47 aM". 2. Had a RR room discharge time of 11:20 AM, with two sets of VS charted as taken after discharge at 12:56 PM and 1:02 PM. 3. Lacked "Provider signoff" in the "Abortion History (Surgical and MAB [medical abortion])" and "Abortion (Surgical)" sections of the history and physical portion of the chart. l. Pt. #15, on 8/14/14: 1. Lacked documentation, in the "Procedure" section of the chart, indicating that the pre procedure check was completed due to lack of checking the boxes for: "Patient's name and/or	T 132		

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ID (identification) band checked" and "Required CIIC's (consent forms) read/signed prior to procedure".
2. Was documented as being discharged at 4:00 PM, but had VS documented at 5:35 PM and 5:58 PM.
3. Lacked "Provider signoff" in the "Abortion History (Surgical and MAB [medical abortion])" and "Abortion (Surgical)" sections of the history and physical portion of the chart.
4. Lacked documentation in the "Sedation Preference" section of the chart regarding whether the patient received "Local only" and/or "NSAID Only".

m. Pt. #16, on 8/14/14:
1. Had a procedure start time noted as "15:58 PM" and a stop time of "6:08 PM".
2. Had an arrival to RR time of 4:14 PM and a discharge time of 4:41 PM, but had VS noted at 6:12 PM and 6:39 PM.

n. Pt. #17, on 10/30/14:
Had documentation of a start time of "8:25 AM", a stop time of "8:38 AM", a RR arrival time of "9:43 AM", and a discharge time of "937 AM", with VS noted at 10:06 AM.

o. Pt. #18, on 10/30/14:
Was documented as being discharged at 4:40 PM, with VS noted at 5:09 PM and 5:20 PM.

p. Pt. #20, on 7/31/14:
Lacked "Provider signoff" in the "Abortion History (Surgical and MAB [medical abortion])" and "Abortion (Surgical)" sections of the history and physical portion of the chart.

q. Pt. #21, on 10/30/14:
Had documentation of a procedure start time of "14:33 PM", and a stop time of "14:44 PM", with an arrival to the RR room noted at "349 PM" and a discharge time of "308 PM".

r. Pt. #23, on 10/24/14:
Lacked completion in the area of POC

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regarding "Tissue exam consistent with documented gestational age" and "Discharge pt. from recovery room per protocol...".

s. Pt. #24, on 10/24/14:

Had documentation of a procedure start time of "14:06 PM", and a stop time of "14:25 PM", with an arrival to the RR room noted at "131 PM" and a discharge time of "142 PM".

t. Pt. #25, on 10/24/14:

1. Had a procedure start time noted of "12:34 PM", and a stop time of "12:58 PM", with an arrival time to the RR at "2:06 PM" and a discharge time of "2:20 PM".

2. Lacked documentation that the patient "Verbalizes understanding of discharge instructions and medications".

u. Pt. #26, on 10/23/14:

1. Lacked "Provider signoff" in the "Abortion History (Surgical and MAB [medical abortion])" and "Abortion (Surgical)" sections of the history and physical portion of the chart.

2. Lacked documentation of the time of patient discharge from the RR.

v. Pt. #27, on 10/23/14:

Had documentation of arrival time to the RR at "447 PM" and a discharge time of "4:12 PM".

w. Pt. #28, on 10/23/14:

1. Lacked a procedure stop time in the "Procedure" portion of the medical record.

2. Lacked completion in the area of POC regarding "Tissue exam consistent with documented gestational age" and "Discharge pt. from recovery room per protocol...".

3. Lacked "Provider signoff" in the "Abortion History (Surgical and MAB [medical abortion])" and "Abortion (Surgical)" sections of the history and physical portion of the chart.

x. Pt. #29, on 10/23/14:

1. Lacked "Provider signoff" in the "Abortion History (Surgical and MAB [medical abortion])"

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T 132	Continued From page 6 and "Abortion (Surgical)" sections of the history and physical portion of the chart. 2. Had documentation that the patient was discharged at 9:31 AM with VS noted at 10:13 AM and 10:29 AM. y. Pt. #30, on 10/23/14: Had documentation that the patient was discharged at 10:33 AM with VS noted at 11:20 AM. 3. At 10:55 AM and 2:00 PM on 11/19/14, interview with staff member #42, the Quality Assurance Coordinator, indicated: a. The VS are incorrect in charts, and do not match procedure or RR times as the computers are set to indicate documentation on Indianapolis time (per their time zone), and not the NW Indiana time zone. b. Staff must remember to manually change the time of a notation to the NW time zone, from the Indianapolis time zone, which is a "default". c. Sometimes staff are forgetting to change the time, as noted in 2. above. d. No quality monitoring of wrong procedure times, RR times, and VS times has been performed. e. Physicians are to authenticate the "provider signature" areas of the history and physical portions of the charts on the day of the procedure.	T 132		
T 134	410 IAC 26-7-2 MEDICAL RECORDS 410 IAC 26-7-2(c) (c) Patient records for surgical abortions must document and contain, at a minimum, the following: (1) Patient identification.	T 134		

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T 134	Continued From page 7 (2) Appropriate medical history. (3) Results of the following: (A) A physical examination. (B) Diagnostic or laboratory studies, or both (if performed). (4) Any allergies and abnormal drug reactions. (5) Entries related to anesthesia administration. (6) Evidence of appropriate informed consent for procedures and treatments as required by IC 16-34-2- 1.1. (7) A report describing techniques, findings, and tissue removed or altered. (8) Authentication of entries by the physician or physicians and health care workers who treated or cared for the patient. (9) Condition on discharge, disposition of the patient, and time of discharge. (10) Discharge entry to include instructions to the patient or patient ' s legal representative. (11) A copy of the following: (A) The transfer form if the patient was referred to a hospital or other facility. (B) The terminated pregnancy report filed with the department. (12) Any report filed with a state agency or law enforcement agency pursuant to a statutory reporting requirement. This RULE is not met as evidenced by: Based on policy and procedure review, medical record review, and staff interview, the facility failed to ensure the implementation of policy related to the receipt of a medical history prior to the procedure for 11 of 30 medical records	T 134		

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reviewed (#3, 5, 6, 7, 8, 14, 15, 20, 26, 28, and #29); the evidence of appropriate informed consent for the procedure for 3 of 30 medical records reviewed (#7, #25 and #26); and to retaining a copy of the TPR (terminated pregnancy report) in the medical record for 3 of 30 medical records reviewed (#11, #12, and #13).

Findings:
1. Review of the policy and procedure "Surgical Abortion Services", VII-A-1, adopted July 2013 and revised August 2014, indicated:
a. On page 11, under "Medical Records", it read: "1. Indiana State Department of Health "Terminated Pregnancy Report" is filled out,...A copy of the Terminated Pregnancy Report form should be scanned into the electronic patient's chart...2. A copy of the State Mandated Information Consent (PL-187) must be scanned into the patient's electronic chart...".
b. On page 12, under "VII. Medical Screening and Evaluation", it read: "Medical History 1. A targeted medical history that includes screening...".

2. Review of patient medical records indicated:
a. Patients #11, #12, and #13 lacked having a copy of the TPR in their electronic medical record, as required by licensure rule and facility policy.
b. Patients #7, #25 and #26 lacked documentation of informed consent (form #55320) in their electronic medical record, as required by licensure rule and facility policy.
c. Patients #3, 5, 6, 7, 8, 14, 15, 20, 26, 28, and #29 lacked authentication by the physician that would indicate that a medical history was performed by the practitioner prior to their procedures.

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T 134	Continued From page 9 3. Interview with staff member #40, the regional director, at 10:45 AM on 11/20/14 indicated the patients listed in 2. above were lacking: copies of the TPR in their charts for patients #11, #12, and #13, the form 55320 in charts #7, #25, and #26 and authentication of the medical history for the patients listed in 2. c. above. 4. At 2 PM on 11/19/14, interview with staff member #42, the quality assurance coordinator, indicated that physicians are required to authenticate the medical history portion of the medical record the day of the procedure, prior to the procedure start time.	T 134		
T 184	410 IAC 26-10-1 PATIENT CARE AND NURSING SERVICES 410 IAC 26-10-1(a)(1) (a) All patient care services must: (1) meet the needs of the patient, within the scope of the service offered, in accordance with acceptable standards of practice; This RULE is not met as evidenced by: Based on policy and procedure review, medical record review, and staff interview, the facility failed to ensure the implementation of policy and standards of care related to the checking of VS (vital signs) in the procedure and recovery rooms for 23 of 30 medical records reviewed (Pts. #1, 2, 3, 5, 6, 7, 8, 10, 12 through #24, #27, and 28.). Findings: 1. Review of the policy and procedure "Analgesia and Sedation Services", I-F-1, with a	T 184		

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PPIN revised date of December 2012 and a PPINK adopted date of July 2013, indicated:
a. On page 21, it read in the "Client Discharge Criteria" section: "...4. PPINK recovery room a. Monitoring: 1. Blood pressure is to be taken one time prior to the patient leaving the surgical exam room,...2. Blood pressure and pulse are to be taken one time prior to the patient leaving the recovery room...".

2. Review of patient medical records indicated:
a. Pt. #1 had a procedure start time of 8:20 AM and a stop time of 8:34 AM with no VS documented during that time.
b. Pt. #2 had a procedure start time of "1319 PM" and a stop time of "1337 PM" with no VS documented during that time.
c. Pt. #3 had a procedure start time of 11:14 AM and a stop time of 11:28 AM with no VS documented during that time.
d. Pt. #5 had a procedure start time of 11:41 AM and a stop time of 11:54 AM with no VS documented during that time.
e. Pt. #6 had a procedure start time of "16:56 PM" and a stop time of "16:12 PM" with no VS documented during that time. (VS were documented at 5:20 PM and 6:15 PM which would not fit either of the times noted for start and stop.)
f. Pt. #7 had a procedure start time of 15:39 PM and a stop time of 15:54 PM with no VS documented during that time.
g. Pt. #8 arrived in the RR (recovery room) at 4:12 PM and was discharged at 4:23 PM with no VS documented during that time. (VS in the charted noted at 4:09 PM and 5:24 PM.)
h. Pt. #10 had a procedure start time of 8:44 AM and a stop time of 9:00 AM with no VS documented during that time.
i. Pt. #12 had a procedure start time of 4:57 PM

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and a stop time of 5:18 PM with no VS documented during that time.

j. Pt. #13 had a procedure start time of 4:33 PM and a stop time of 4:50 PM with no VS documented during that time.

k. Pt. #14 had a procedure start time of 10:31 AM and a stop time of "110:47aM" with no VS documented during that time. (Assuming stop time of 10:47 AM--VS noted at 10:14 AM, 11:17 AM, 12:56 PM, and 1:02 PM.)

l. Pt. #15 had a procedure start time of 3:16 PM and a stop time of 3:30 PM with no VS documented during that time, arrived in the RR at 3:35 PM and was discharged at 4:00 PM with no VS documented during that time. (VS noted at 2:14 PM, 5:35 PM, and 5:58 PM.)

m. Pt. #16 had a procedure start time of "15:58 PM" and a stop time of "6:00 PM" with no VS documented during that time, arrived in the RR at 4:14 PM and was discharged at 4:41 PM with no VS documented during that time. (VS noted at 11:30 AM, 6:12 PM, and 6:39 PM.)

n. Pt. #17 had a procedure start time of 8:25 AM and a stop time of 8:38 AM with no VS documented during that time.

o. Pt. #18 had a procedure start time of 3:50 PM and a stop time of 4:04 PM with no VS documented during that time, arrived in the RR at 4:09 PM and was discharged at 4:40 PM with no VS documented during that time. (VS noted at 1:20 PM, 5:09 PM, and 5:20 PM.)

p. Pt. #19 had a procedure start time of 12:31 PM and a stop time of 12:49 PM with no VS documented during that time.

q. Pt. #20 had a procedure start time of 3:17 PM and a stop time of 3:39 PM with no VS documented during that time. (VS noted at 10:43 AM only--pt. Transferred out from procedure room.)

r. Pt. #21 had a procedure start time of 2:33 PM

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PLANNED PARENTHOOD OF INDIANA AND KENTUCI	8645 CONNECTICUT ST MERRILLVILLE, IN 46410

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T 184	Continued From page 12	T 184		

and a stop time of 2:44 PM with no VS documented during that time, arrived in the RR at "3:49 PM" and was discharged at "3:08 PM" with no VS documented during that time. (VS noted at 12:20 PM and 3:00 PM.)

s. Pt. #22 had a procedure start time of 5:15 PM and a stop time of 5:29 PM with no VS documented during that time.

t. Pt. #23 had a procedure start time of 10:59 AM and a stop time of 11:14 AM with no VS documented during that time.

u. Pt. #24 had a procedure start time of 2:06 PM and a stop time of 2:25 PM with no VS documented during that time.

v. Pt. #27 had a procedure start time of 3:30 PM and a stop time of 3:43 PM with no VS documented during that time, arrived in the RR at "4:47 PM" and was discharged at "4:12 PM" with no VS documented during that time. (VS noted at 1:58 PM and 4:05 PM.)

w. Pt. #28 had a procedure start time of 2:07 PM with no stop time noted. Arrival to the RR was at 2:41 PM. No VS were noted while the patient was in the procedure room as VS were noted at 12:04 PM, 2:45 PM and 3:39 PM.

3. At 10:35 AM on 11/20/14, interview with staff members #40, the regional director, and #41, the director of special projects, indicated that, per facility policy, patients are to have their VS checked in the procedure room at least one time, and then at least one time in the recovery room prior to discharge.

4. At 10:55 AM and 2:00 PM on 11/19/14, interview with staff member #42, the Quality Assurance Coordinator, indicated:

a. The VS are incorrect in charts, and do not match procedure or RR times as the computers are set to indicate documentation on Indianapolis

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T 184	Continued From page 13 time (per their time zone), and not the NW Indiana time zone. b. Staff must remember to manually change the time of a notation to the NW time zone, from the Indianapolis time zone, which is a "default". c. Some staff members document in military time and others do not. There is no facility policy related to the correct documentation of time, so that it is unknown what is expected.	T 184		
T 194	410 IAC 26-10-1 PATIENT CARE AND NURSING SERVICES 410 IAC 26-10-1(b)(2) (b) Written patient care policies and procedures must be available to personnel and must include, but not be limited to, the following: (2) A provision for instruction or instructions to be given to the patient or the patient ' s legal representative regarding follow-up care and transportation needed by the patient on discharge following a surgical abortion to include at least the following: (A) Signs and symptoms of possible complications. (B) Activities allowed and to be avoided. (C) Hygienic and other postdischarge procedures to be followed. (D) Clinic emergency phone numbers available on a twenty-four (24) hour basis. (E) Follow-up appointment, if indicated. (F) Counseling regarding Rh typing. (G) Administration of Rh immune globulin, if indicated, unless: (i) the patient signs a waiver refusing the administration; or (ii) other arrangements for administration are documented.	T 194		

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This RULE is not met as evidenced by:
Based on policy and procedure review, medical record review, and staff interview, the facility failed to implement its policy regarding Rh counseling, for those who were Rh negative, for 1 of 3 medical records reviewed (pt. #3) and failed to document patients' post procedure instructions regarding hygiene for 30 of 30 medical records reviewed (#1 through #30).

Findings:
1. Review of the policy and procedure "Surgical Abortion Services", policy number VII-A1, "adopted" July 2013 and "revised" August 2014, indicated:
a. Under section "VII. Medical Screening and Evaluation", it read: "Laboratory Testing - must include...3. Rh typing - must be performed...Information regarding Rho (D) immune globulin must be given to the client in writing and must be documented in her medical record...".

2. Review of patient #3's medical record (MR) indicated the patient was Rh negative and received RhoGam. Patient #3's medical record lacked documentation of receiving counseling regarding Rh typing and RhoGam needed.

3. At 11:25 AM on 11/19/14, interview with staff member #42, the quality assurance director, indicated agreement that no counseling was documented for pt. #3 regarding Rh information.

4. Review of handouts, educational materials, and discharge instructions indicated hygiene

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T 194	Continued From page 15 instructions were not addressed in any of the written materials given to patients. 5. Review of the 30 medical records indicated that all were lacking documentation of education/instructions regarding hygiene post procedure. 6. At 1:45 PM on 11/19/14, interview with staff member #40, the regional director, indicated: a. There is nothing in writing regarding hygiene, other than not to douche. b. Staff instruct patients not to tub bathe for two weeks post procedure, but this is not on the written instructions given to patients, nor is it documented in the medical records that this education is being given.	T 194		
T 208	410 IAC 26-11-1 INFECTION CONTROL PROGRAM 410 IAC 26-11-1(a)(2) (a) The clinic must do the following: (2) Maintain a written infection control policy that provides for an active and effective clinic-wide infection control program. This RULE is not met as evidenced by: Based on review of the infection control plan/policy, and interview, the infection control committee/quality committee failed to approve its plan and policies on an annual basis. Findings: 1. Review of the document "Managing Infection	T 208		

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T 208	Continued From page 16 Prevention in Health Centers", from the "PPINK Infection Control Manual & OSHA Risk Exposure Plan" binder, adopted 7/2013, indicated: a. On page 1-1, it read: "...Ongoing Evaluation of Program...Therefore, all policies and procedures that compose the PPINK's Infection Prevention Program must be reviewed by the Quality Management and Infection Control (QMIC) Committee and the Risk and Quality Management (RQM) Committee on an annual basis or whenever new mandates are required." 2. At 12:20 PM on 11/20/14, interview with staff member #42, the quality assurance coordinator, indicated: a. There are no meeting minutes that indicate review and approval of infection policies occurred. b. It cannot be determined the last time that the infection prevention policies were approved, so that the policy, as listed in 1. above, was not implemented.	T 208		
T 214	410 IAC 26-11-1 INFECTION CONTROL PROGRAM 410 IAC 26-11-1(c) (c) The clinic must designate a person qualified by training or experience as responsible for the following: (1) Ongoing infection control activities. (2) The development and implementation of policies governing control of infections and communicable diseases. This RULE is not met as evidenced by:	T 214		

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T 214	Continued From page 17 Based on employee file review and staff interview, the facility failed to ensure that the designated staff member to hold the position of Infection Control Preventionist (ICP) had training or experience for that position, or that they had a job description with expectations for the position (staff member #30). Findings: 1. Review of the employee file for staff member #30 indicated: a. This staff member is a LPN (licensed practical nurse) who was hired 10/13/14 and is to act in the position of ICP. b. There is no education and training, beyond OSHA and other infection control education offered at the time of hire for all employees, indicating this staff person has qualifications to be the ICP. c. There was no job description in the file regarding this staff member being the ICP, or related to the duties expected of an ICP. 2. At 1:30 PM on 11/20/14, interview with staff members #40, the regional director, and #41, the director of special projects, indicated: a. Staff member #30 should have taken the organization's on line course for ICPs, but they have not yet signed up to do this. b. There is no job description, related to the ICP position, in the personnel file for staff member #30.	T 214		
T 232	410 IAC 26-11-1 INFECTION CONTROL PROGRAM 410 IAC 26-11-1(e)(2)(E) (e) The clinic must establish a committee to	T 232		

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T 232	Continued From page 18	T 232		

monitor and guide the infection control program in the clinic as follows:
(2) The infection control committee responsibilities must include, but are not limited to, the following:
(E) Reviewing and recommending changes in procedures, policies, and programs that are pertinent
to infection control. These include, but are not limited to, the following:
(i) Sanitation, including proper disposal of removed tissue.
(ii) Universal precautions, including infectious waste management.
(iii) Cleaning, disinfection, and sterilization.
(iv) Aseptic technique, invasive procedures, and equipment usage.
(v) Reuse of disposables.
(vi) A system for handling patients with communicable diseases.
(vii) A system, which complies with state and federal law, to monitor the immune status of
health care workers exposed to communicable diseases.
(viii) An employee health program to determine the communicable disease history of new
personnel as well as an ongoing program for current personnel as required by state and federal
agencies.
(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.
(x) A program of linen management.

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T 232	Continued From page 19 This RULE is not met as evidenced by: Based on policy and procedure review, document review, employee file review, and staff interview, the infection control committee failed to implement its policy related to the immune status of staff for rubella, rubeola, and varicella for 2 of 4 employee files reviewed (#31 and #32) and related to Hepatitis B for 2 staff who requested to receive the series of injections (#31 and #32). Findings: 1. Review of "Chapter 5 - Occupational Health", from the "PPINK Infection Control Manual and OSHA (Occupational Safety & Health Administration) Exposure Control Plan", adopted 7/2013, indicated: a. Under "Guidelines for Initial - Employment Health Screening", it read: "...Hepatitis B vaccine is recommended and will be offered to all employees and volunteers who are at risk of exposure to blood or body fluids (blood borne pathogens) within 10 days of onset of employment." b. Under "Recordkeeping", it reads: "...Personnel records for all staff must include a separate section of medical information including:...Copy of any tests [sic] results relating to immunity of the following infections: Rubella, Mumps, Rubeola, Hepatitis B, Pertussis, and Varicella...". 2. Review of the Personnel Policies in the "PPINK Infection Control Manual and OSHA Exposure Control Plan", in chapter 4., indicated: Under "Employee Groups One and Two Employees in groups one and two whose licensing or job duties places them in patient care situations in health centers will be offered the	T 232		

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T 232	Continued From page 20 Hepatitis B vaccine within 10 days of initial assignment and MUST receive complete infection control training prior to commencement of their duties. Employee Group One...Nurses...Health Center Assistants...". 3. Review of the welcome letters sent to employees indicated: In the section "Work Safety", it read: "Working in a PPINK health center requires you to bring some additional documentation for our records. On your first day of employment... you must bring:...Within 30 days of your start date, you must provide evidence of immunity to the following communicable diseases: Measles (Rubeola) Mumps German Measles (Rubella) Chickenpox (Varicella) Whooping cough (Pertussis) You can provide evidence of immunity by providing the Human Resources Department with copies of vaccination records or you can have your blood drawn to show serologic evidence of immunity (a titer). We can also accept a medical record if it shows that a laboratory confirmed you had the disease...". 4. Review of the document "Immunization, Health Care Workers January 2013 - Supplement to PPIN Infection Control Manual", indicated: a. Under "Policy", it read: "It is the policy of planned Parenthood of Indiana (PPIN) to minimize risks from communicable diseases and to ensure compliance with state and federal requirements regarding the health and safety of employees." b. Under section "C. Immunizations", it read: "Rubeola/Rubella/Mumps/Varicella/Pertussis - New Hires 1. Within 30 days of hire, staff will provide evidence of immunity to the following communicable diseases. a. Measles (rubeola) b. Mumps c. German Measles (rubella) d.	T 232		

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T 232	Continued From page 21 Chickenpox (varicella) e. Pertussis (whooping cough)...". 5. Review of employee health files indicated: a. Staff member #31, hired 4/19/13: 1. Lacked evidence of immunity to Rubella, Rubeola, and Varicella, as required per policy as stated in 4. above. 2. Had signed a request form for the Hepatitis B Vaccination on 4/19/13, but lacked documentation in the file for having begun the series. b. Staff member #32, hired 9/30/13: 1. Signed a form indicating that regarding "Measles/Mumps/Rubella (MMR) Immunity Status Acknowledgement", this staff member "...cannot produce proof of immunity...at this time" and "...I understand that I may continue to be at risk of acquiring these diseases...Furthermore, I understand that in event of exposure to this communicable disease(s) I will be excluded from duty or assigned alternative work...". The same language was signed in regard to "Varicella (chicken Pox) Immunity Status Acknowledgement". 2. Had signed a request form for the Hepatitis B Vaccination on 9/30/13, but lacked documentation in the file for having begun the series. 6. At 1:30 PM on 11/20/14, interview with staff member #40, the regional director, indicated: a. Facility infection control policies require some sort of proof of immunity to Rubella, Rubeola, and Varicella, as per 1. b., 3., and 4.b., above and not a signed document stating that employees are unaware of their immunization status. b. Facility infection control policy, and OSHA regulations, indicate that staff requesting the Hepatitis B series are to begin this within 10 days	T 232		

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T 232	Continued From page 22 of the written request. c. The facility is delinquent in beginning the Hepatitis B series for staff members #31 and #32, as they requested the series upon hire in 2013 and have yet to be started on the series.	T 232		
T 360	410 IAC 26-17-2 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-2(c)(4) (c) For common administration and authorized visitor areas, the clinic shall be able to accommodate wheelchairs and provide the following: (4) A conveniently accessible drinking fountain. This RULE is not met as evidenced by: Based on observation and interview, the facility failed to ensure a conveniently accessible drinking fountain within common administration and authorized visitor areas. Findings include: 1. During a tour of the facility on 11/19/2014 at 9:15 A.M., no water fountain was found present in the waiting area. 2. Interview with RD#1, the Regional Director, during the observation indicated the facility did not have a drinking fountain. RD#1 stated "We currently provide water on request."	T 360		

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T 426	Continued From page 23	T 426		
T 426	410 IAC 26-17-5 PHYS. PLANT,MAINT.,EQUIP.,ENVIR.,SAFETY 410 IAC 26-17-5(2) 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: (2) Refuse, biohazards, infectious waste, and garbage must be: (A) collected; (B) transported; (C) sorted; and (D) disposed of; by methods that will minimize nuisances or hazards in compliance with federal, state, and local laws and rules. This RULE is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure biohazard material stored and ready for disposal was labeled. Findings include: 1. Review of the facility's Infection Control Manual and OSHA (Occupational Health and Safety Administration) Risk Exposure Plan dated July 2013 indicated "Appropriate biohazard warning label is attached to any contaminated equipment, identifying the contaminated portions.....infectious materials are placed in designated leak-proof containers, appropriately	T 426		

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T 426	Continued From page 24 labeled, for handling and storage." 2. During observation on 11/19/2014 at 9:35 A.M. of a corridor that RD#1, the Regional Director stated was the "back door hallway", a large gray plastic storage cabinet was noted stationed along a wall near the rear door. There were no markings or labels on the cabinet, however it was padlocked. 3. Interview with RD#1 on 11/19/2014 at 9:35 A.M. indicated the facility stored biohazard refuse in the cabinet until a contracted company collected it for disposal. RD#1 confirmed the cabinet did not have any labels or signs indicating it contained biohazard material.	T 426		
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 This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure evidence of a safety management program which included emergency	T 440		

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T 440	Continued From page 25 and disaster preparedness coordination with appropriate community, state and federal agencies. Findings include: 1. A review on 11/19/2014 at 11:15 A.M. of the facility's "Safety and Security Manual" revised July 2011 indicated there was no documentation or instructions in the manual demonstrating coordination of emergency and disaster preparedness with any external agency. 2. Interview with QAC#1, the facility's Quality Assurance Coordinator on 11/19/2014 at 11:35 A.M. indicated the facility didn't have a written plan or procedure for coordinating emergency and disaster preparedness with appropriate community, state and federal agencies.	T 440		