STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011118	A. BUILDING: _____ B. WING _____	03/21/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	INITIAL COMMENTS The visit was for a State licensure survey. Facility Number: 011118 Survey Date: 3/20-21/19 QA: 03/28/2019	T 000		
T 222	410 IAC 26-11-1 INFECTION CONTROL PROGRAM 410 IAC 26-11-1(e)(1)(A,B,C&D) (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 document review and interview, the Infection Control (IC) committee failed to ensure the IC nurse attended quarterly meetings in accordance with committee meeting requirements for 2 of 4 quarterly meetings in	T 222		

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T 222	Continued From page 1 2018 (1st & 3rd Quarter 2018). Findings include: 1. Review of the Infection Control Manual (reviewed 12-18) indicated the following: "Membership of the PPINK Quality Management and Infection Control Committee includes...Abortion Site Infection Control Officers:..Meetings are held quarterly..." 2. Review of the Quality Management and Infection Control meeting minutes dated 5-16-18 (1st quarter 2018) and 11-19-18 (3rd quarter 2018) lacked documentation indicating an IC nurse was present. 3. On 3-21-19 at 1735 hours, the Vice President of Patient Services A2 confirmed the above.	T 222		
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 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	T 232		

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T 232	Continued From page 2 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. This RULE is not met as evidenced by: Based on observation, document review and interview, the facility failed to change the disinfection solution per manufacturer recommendations for one decontamination room. Findings include: 1. Review of facility, Infection Control Manual and OSHA (Occupational Safety and Health	T 232		

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T 232	Continued From page 3 Administration) Risk Exposure Plan, revised 04/2017, indicated all disinfectants must be prepared, changed, and discarded according to instructions on the package label. 2. Review of CIDEX OPA Solution label indicated do not reuse beyond 14 days or sooner... 3. On observation 3/25/2019, at approximately 5:29 pm, with N4 (Area Service Director) in the products of conception/decontamination room the following was observed. A blue bin approximately 10x10x20 inches with a lid, inside of cabinet. The bin was filled with fluid. The label on the bin indicated CIDEX OPA discard on 1/12/2016. 4. Interview on 3/25/2019, at approximately 5:29 pm, with N4 confirmed the above.	T 232		
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. (E) Cooperation with firefighting authorities. (F) Fire drills.	T 436		

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T 436	Continued From page 4 This RULE is not met as evidenced by: Based on document review and interview, the clinic failed to develop and maintain its written fire control plan for conducting fire drills for facility. Findings include: 1. Review of the Safety and Security Manual (approved 5-18) provided in response to a request for a fire drill policy/procedure included the clinic's fire response plan and lacked a provision indicating the process for conducting fire drills. 2. On 3-21-19 at 1438 hours, the Vice President of Patient Services A2 provided a copy of the annual Quality Plan Audit Calendar (or spreadsheet) and identified the entry for conducting a fire drill in the row titled Emergency Drills under the column titled September and confirmed a policy/procedure and/or additional documentation indicating the process for conducting fire drills was not available.	T 436		