

**PLANNED PARENTHOOD OF
INDIANA AND KENTUCKY, INC
8645 CONNECTICUT ST
MERRILLVILLE, IN 46410**

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2019
--	--	---	--

NAME OF PROVIDER OR SUPPLIER
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY

STREET ADDRESS, CITY, STATE, ZIP CODE
**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 was for a State licensure survey. Facility Number: 011116 Survey Date: 3-13-2019 QA: 3/22/19	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 document review and interview, the facility failed to ensure the "Patient Visit Summary" was electronically signed, by the provider per facility policy, in twenty three (23) of thirty (30) instances. (Patient # 1, Patient # 3, Patient # 4, Patient # 6, Patient # 9, Patient # 11, Patient # 12, Patient # 13, Patient # 14, Patient # 15, Patient # 16, Patient # 17, Patient # 18, Patient # 19, Patient # 20, Patient # 21, Patient # 22, Patient # 23, Patient # 24, Patient # 25, Patient # 28, Patient # 29 & Patient # 30) Findings include: 1. Review of the facility policy titled, "Completing	T 132		

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

TITLE

(X6) DATE

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2019
--	--	---	--

NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD OF INDIANA AND KENTUCKY	STREET ADDRESS, CITY, STATE, ZIP CODE 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 132	<p>Continued From page 1</p> <p>and Signing of Medical Records", Reference Code PS20, creation date May 29, 2018, indicated "providers must electronically sign all visit summaries" within "120 business hours" (5 days) of the patient's encounter.</p> <p>2. The "Patient Visit Summary" lacked an electronic provider signature in the closed medical record (MR) for the following patient encounters:</p> <p>A. Patient # 1's encounter was on 08/29/2018. The summary was signed by the provider on 03/13/2019.</p> <p>B. Patient # 3's encounter was on 12/19/2018. The summary lacked the electronic physician signature.</p> <p>C. Patient # 4's encounter was on 01/16/2019. The summary lacked the electronic physician signature.</p> <p>D. Patient # 6's encounter was on 12/19/2018. The summary lacked the electronic physician signature.</p> <p>E. Patient # 9's encounter was on 08/22/2018. The summary lacked the electronic physician signature.</p> <p>F. Patient # 11's encounter was on 01/23/2019. The summary lacked the electronic physician signature.</p> <p>G. Patient # 12's encounter was on 01/16/2019. The summary lacked the electronic physician signature.</p> <p>H. Patient # 13's encounter was on 01/09/2019. The summary lacked the electronic physician signature.</p> <p>I. Patient # 14's encounter was on 12/28/2018. The summary lacked the electronic physician signature.</p> <p>J. Patient # 15's encounter was on 12/19/2018. The summary lacked the electronic physician signature.</p>	T 132		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2019
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD OF INDIANA AND KENTUCKY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 132	Continued From page 2 K. Patient # 16's encounter was on 12/12/2018. The summary lacked the electronic physician signature. L. Patient # 17's encounter was on 12/05/2018. The summary lacked the electronic physician signature. M. Patient # 18's encounter was on 11/21/2018. The summary lacked the electronic physician signature. N. Patient # 19's encounter was on 11/13/2018. The summary lacked the electronic physician signature. O. Patient # 20's encounter was on 11/07/2018. The summary lacked the electronic physician signature. P. Patient # 21's encounter was on 10/30/2018. The summary lacked the electronic physician signature. Q. Patient # 22's encounter was on 10/30/2018. The summary lacked the electronic physician signature. R. Patient # 23's encounter was on 10/30/2018. The summary lacked the electronic physician signature. S. Patient # 24's encounter was on 10/30/2018. The summary lacked the electronic physician signature. T. Patient # 25's encounter was on 10/30/2018. The summary lacked the electronic physician signature. U. Patient # 28's encounter was on 10/30/2018. The summary lacked the electronic physician signature. V. Patient # 29's encounter was on 10/30/2018. The summary lacked the electronic physician signature. W. Patient # 30's encounter was on 10/30/2018. The summary lacked the electronic physician signature.	T 132		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011116	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2019
NAME OF PROVIDER OR SUPPLIER PLANNED PARENTHOOD OF INDIANA AND KENTUCI		STREET ADDRESS, CITY, STATE, ZIP CODE 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 132	Continued From page 3 3. In interview on 03/13/2019 at approximately 4:45 pm with administrative staff member A # 1 (Area Service Director), confirmed "the physician should have signed the patient visit summary within five (5) days of the encounter as the policy indicated".	T 132		