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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001157 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/01/2015 |
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| NAME OF PROVIDER OR SUPPLIER SENATE STREET SURGERY CENTER LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 1801 N SENATE BLVD INDIANAPOLIS, IN 46202 |
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| Q 000 Bldg. 00 | This visit was for a re-certification survey. Facility Number: 006622 Survey Date: 3-30-2015 to 4-1-2015 QA: cjl 04/15/15 | Q 000 | Agree | |
| Q 162 Bldg. 00 | 416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | <p>informed patient consent. (8) Discharge diagnosis. Based on policy review, medical record (MR) review and interview, the facility failed to ensure that the medical record was complete for 5 of 5 transfer medical records.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of policy and procedure, "Transfer of a Perioperative Patient" approved on July 2014 by the Board of Managers indicated: Under "Procedures" A. Obtain order from the physician. B. Call admitting facility and report of patient status. C. Complete the transfer paperwork.....the physician will need to sign the "Initiated Request to Transfer". Medical record review indicated that MR #28 did not have evidence of a physician order or the form "Initiated Request to Transfer" form. Medical record review indicated that MR #s 26, 27 and 28 did not have evidence of a physician order. Medical record review indicated that MR #s 25, 26, 27 and 28 did not have evidence of a physician signature. | O 162 | <p>On 04/15/2015, the QAPI/Infection Control Committee reviewed the deficits within this State tag. The plan to first educate the appropriate personnel regarding the Completion of Medical Records and Transfer Policies, followed by weekly audits completed at the Center to ensure consistent compliance with the regulations. The PACU Clinical Manager is responsible for the completion of this plan and the follow-up monitoring. The education was completed on 4/22/2015 by the PACU Clinical Manager.</p> | 04/22/2015 |

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| Q 201 Bldg. 00 | <p>5. At 1100 hours on 4/1/15, staff # 3, Clinical Specialty Coordinator and 4, Clinical Manager, PACU (post anesthesia care unit) verified that the above was not in the medical record.</p> <p>416.49(a) LABORATORY SERVICES If the ASC performs laboratory services, it must meet the requirements of Part 493 of this chapter. If the ASC does not provide its own laboratory services, it must have procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with Part 493 of this chapter. The referral laboratory must be certified in the appropriate specialties and subspecialties of services to perform the referral test in accordance with the requirements of Part 493 of this chapter. Based on document review and interview, the facility failed to have a written policy and procedure for describing how facility employees would perform urine pregnancy tests.</p> <p>Findings:</p> <p>1. Review of the facility's policies, procedures and other documents</p> | Q 201 | <p>The Clinical Manager of the preoperative department is responsible for the policies and procedures that pertain to that department. 1. The Preoperative Pregnancy testing Policy was revised to include the procedure for testing the urine. 2. The Policy revision will be taken to the Governing Board on Monday, April 27, 2015 for review and approval. 3. The Clinical Manager of the</p> | 04/27/2015 |

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| Q 220 Bldg. 00 | <p>indicated there were none describing how facility employees would perform urine pregnancy tests.</p> <p>2. In interview, on 3-30-2015 at 10:00 am, employee #A1, Clinical Director, indicated facility employees performed urine pregnancy tests.</p> <p>3. In interview, on 3-31-2015 at 3:40 pm, employee #A1 confirmed there were no written policies and procedures describing how facility employees would perform urine pregnancy tests and no other documentation was provided prior to exit.</p> <p>416.50 NOTICE - POSTING ... The ASC must also post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients waiting for treatment or by the patient's representative or surrogate, if applicable. Based on document review and interview, the posted patient rights did not contain 5 of 14 required elements.</p> <p>Findings:</p> <p>1. Review of a document entitled Patients Rights and Responsibilities, approved 7-28-2014, posted in the facility's reception area, indicated it</p> | Q 220 | <p>preoperative area will ensure all RNs who work in that area are familiar with and in compliance with the procedure. The Clinical Manager will monitor the RNs to ensure compliance is consistent.</p> <p>The Center's Clinical Managers are responsible for the completeness and correctness of all Patient Rights information in the facility. The 5 elements not contained in the posted Patient Rights and provided Patient Rights documents will be presented to the Governing Board on 04/27/2015 by the Clinical Director. The revisions to the patient package has been</p> | 04/27/2015 | |

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| | <p>lacked the following 5 patient rights:</p> <p>Specific names of the physician's who have a financial interest or ownership in the facility.</p> <p>The availability of the Indiana State Advanced Directive brochure.</p> <p>The patient has a right to be fully informed about a treatment or procedure and outcome before it's performed</p> <p>If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, that the rights of the patient may be exercised by the person appointed under State law to act on the patient's behalf. Or, if a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.</p> <p>The patient has a right to receive care in a safe setting, including free of contaminated</p> | | <p>completed and a temporary addition to the poster in the waiting room will be completed upon Board approval. A new Poster will be order and will replace the temporary addition. The Clinical Managers of the Center will monitor for compliance.</p> | |

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| Q 221 Bldg. 00 | <p>materials and unwanted visitors.</p> <p>2. In interview, on 4-1-2015 at 10:00 am, employee #A3, Clinical Specialty Coordinator, confirmed the above elements were not included in the posted patient rights and no further documentation was provided prior to exit.</p> <p>416.50(a) NOTICE OF RIGHTS An ASC must, prior to the start of the surgical procedure, provide the patient, or the patient's representative, or the patient's surrogate with verbal and written notice of the patient's rights in a language and manner that ensures the patient, the representative, or the surrogate understand all of the patient's rights as set forth in this section. The ASC's notice of rights must include the address and telephone number of the State agency to which patients may report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman.</p> <p>Based on document review and interview, the patient rights given to the patient or their representative verbally and in writing prior to surgery did not contain 3 of 14 required elements.</p> <p>Findings:</p> <p>1. Review of a document entitled Patients Rights and Responsibilities,</p> | O 221 | The Clinical Managers of the facility are responsible for the accuracy of the Patient Rights Poster and the verbal message and written documents provided to patients prior to their procedure. The following revisions were completed on 4/20/2015:1. If you would like information on Advance Directives, including a form to complete from the State | 04/27/2015 |

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| | <p>approved 7-28-2014, given to the patient or their representative verbally and in writing prior to surgery, indicated lack of the following patient rights:</p> <p>If requested by the patient, the Indiana State Advanced Directive brochure.</p> <p>If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, that the rights of the patient may be exercised by the person appointed under State law to act on the patient's behalf. Or, if a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.</p> <p>The patient has a right to receive care in a safe setting, including free of contaminated materials and unwanted visitors.</p> <p>2. In interview, on 4-1-2015 at 10:00 am, employee #A3, Clinical Specialty Coordinator, confirmed the above and no other documentation was provided prior</p> | | <p>Department of Health, please let us know and we will provide them for you. You can also find the information on the Indiana State Department of Health website, in.gov/isdh/files/advancedirective_s.pdf.2. If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, that the rights of the patient may be exercised by the person appointed under State law to act on the patient's behalf.3. The patient has a right to receive care in a safe setting, including free of contaminated materials and unwanted visitors.The Clinical Managers are responsible for monitoring the registration staff to ensure the proper verbal instructions are given as well as the written information and to ensure the Patient Rights information is in compliance with the Federal and State regulations. The Clinical Director is responsible for presenting the revisions stated to the Governing Board on 4/27/2015 for review and approval.</p> | |

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| Q 224 Bldg. 00 | <p>to exit.</p> <p>416.50(c)(1)(2)(3) ADVANCED DIRECTIVES The ASC must comply with the following requirements:</p> <p>(1) Provide the patient or, as appropriate, the patient's representative with written information concerning its policies on advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms.</p> <p>(2) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care.</p> <p>(3) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive.</p> <p>Based on document review and interview, the facility failed to have a policy of and description and availability of the State advanced directive brochure.</p> <p>Findings:</p> <p>1. Review of the facility's policies and procedures of a document entitled Patient Rights and Responsibilities, indicated no inclusion of a description and availability of the State advanced directive brochure.</p> | Q 224 | Then Clinical Managers of the Center have revised the Patient Rights and Responsibilities Policy to state "If you would like information on Advance Directives, including a form to complete from the State Department of Health, please let us know and we will provide them for you. You can also find the information on the Indiana State Department of Health website, in.gov/isdh/files/advancedirectives.pdf . The Clinical Director will present to the Governing Board on 04/27/2015 for review and | 04/27/2015 | | | |

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| Q 230 Bldg. 00 | <p>2. In interview, on 4-1-2015 at 10:00 am, employee #A3, Clinical Specialty Coordinator, confirmed the above and no further documentation was provided prior to exit.</p> <p>416.50(e)(2)& (3) EXERCISE OF RIGHTS BY OTHERS (2) If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.</p> <p>(3) If a State court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.</p> <p>Based on document review and interview, the facility failed to have a policy of those rights if the patient was incompetent, whether adjudged or not, and who could exercise the patient's rights.</p> <p>Findings:</p> <p>1. Review of a facility document entitled Patient Rights and Responsibilities, approved 7-28-2014, indicated it did not include</p> | O 230 | <p>approval. The Clinical Managers of the Center will educate the employees of the revision and monitor the employees in the registration area to ensure compliance with the revisions.</p> <p>The Clinical Managers of the Center have revised the Patient Rights and Responsibilities Policy to include the following: If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, that the rights of the patient may be exercised by the person appointed under State law to act on the patient's behalf. The policy also includes if not adjudged incompetent by the courts, the patient can select a representative of their choosing. The Clinical Managers of the Center will educate the Center's</p> | 04/27/2015 | |

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| Q 242 Bldg. 00 | <p>those rights if the patient was incompetent, whether adjudged or not, and who could exercise the patient's rights.</p> <p>2. In interview, on 4-1-2015 at 10:00 am, employee #A3, Clinical Specialty Coordinator, confirmed the above and no other documentation was provided prior to exit.</p> <p>416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines.</p> <p>Based on policy review, observation and staff interview, the ambulatory surgery center failed to ensure compliance with the dress code in the surgical suite; failed to use equipment that could be appropriately disinfected between patients in 4 out of 8 operating suites.</p> <p>Findings:</p> <p>1. Review of policy and procedure, Dress Code Peri-operative Domain, with date of 07/14, indicated:</p> | Q 242 | <p>employees of the revisions and monitor the appropriate employees for compliance. The Clinical Director is responsible for presenting the revisions to the Governing Board for review and approval on 04/27/2015.</p> <p>On 04/20/2015, the OR Clinical Manager reported the break in the Dress Code Policy to the Medical Director. The Center's policy was electronically provided to the Medical Director to distribute to the Medical Staff. Education to the OR personnel regarding the policy was also completed on 04/20/2015. Replacement pads were ordered by the OR Specialty Coordinator and the current affected pads were removed from the OR. The OR Clinical Manager will monitor</p> | 04/20/2015 | | | |

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| S 000 Bldg. 00 | <p>a. Under A-5, "All individuals in the restricted area will have jewelry removed or totally concealed under operating room apparel."</p> <p>2. At 0750 hours on 3/31/15, while observing a patient in OR room #6, it was observed that MD #1, had earrings present that were not confined within the surgical cap while a surgical procedure was in process. A positioning pad had the seam open exposing the form pad. Operating rooms # 3, 4 and 5 were toured. Positioning pads were observed to have cracks in their coverings in each room.</p> <p>3. At 1015 hours on 3/31/15, staff member #2, Nurse Manager, verified that the reusable positioners used during surgical procedures did not have surfaces intact in operating rooms #3, 4, 5 and 6.</p> <p>4. At 1500 hours on 4/1/15, staff member #1, the Director, verified that jewelry must be removed or concealed in the operating room.</p> <p>This vist was for a State licensure survey.</p> <p>Facility Number: 006622</p> <p>Survey Date: 3-30-2015 to 4-1-2015</p> | S 000 | all persons within the restricted areas for compliance with the Dress Code Policy. The Specialty Coordinator will do monthly checks of the positioning pads and remove from use any pads that are not completely intact. | |
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| S 106 Bldg. 00 | <p>QA: cjl 04/15/15</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(3)</p> <p>The governing body shall do the following:</p> <p>(3) Review the bylaws at least triennially.</p> <p>Based on document review and interview, the governing board failed to review its bylaws triennially.</p> <p>Findings:</p> <p>1. Review of the governing board bylaws indicated the most recent review of the bylaws was 4-25-2011.</p> <p>2. In interview, on 3-31-2015 at 4:30 pm, employee #A1, Clinical Director, confirmed the above and no further documentation was provided by exit.</p> | S 106 | The Governing Board bylaws will be presented to the Board of Managers on 4/27/2015 for review and approval. The Clinical Director is responsible for completing this requirement. The Clinical Director and the Administrative Assistant will set the triennial date in their calendars to prevent this oversight from reoccurring. | 04/27/2015 |
| S 162 Bldg. 00 | <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies</p> | | | |

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| | <p>and programs for the following:</p> <p>(G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care. Based on document review and interview, the facility failed to ensure current cardiopulmonary resuscitation (CPR) competence in accordance with facility policy for 1 (MD#4) of 6 physician credential files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Policy Number MS 2.02, entitled CARDIOPULMONARY RESUSCITATION (CPR) COMPETENCE FOR PHYSICIANS, approved July, 2014, indicated a current cardiopulmonary resuscitation certification in BLS, HST, ACLS, ACLS, NRP or PALS is required for all medical staff. 2. Review of 6 physician credential files indicated file MD#4, OB/Gyn practitioner, had no documentation of CPR competency 3. In interview on 3-31-2015 at 11:00 am, employee #A5, Coordinator of Medical Staff Credentialing, confirmed | S 162 | <p>The Clinical Director and the Clinical Managers are responsible to ensure the Center's policies comply with the Federal and State regulations and that the policies are followed as they are written. The policy regarding CPR, MS 2.02 for physicians has been revised to follow our current practice. The revision is as follows:</p> <p>Practitioners at the ASC are "licensed health professionals" who are not considered direct care providers of patient care therefore, they do not require documentation of CPR competence.</p> <p>The policy will be taken to the Governing Board on Monday, April 27, 2015 for final approval. The Center's Credentialing Specialist will monitor all Medical Staff for the appropriate credentials to ensure this is not repeated in the future.</p> | 04/27/2015 |

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| S 432 Bldg. 00 | <p>the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on observation and staff interview, the Infection Control Committee failed to ensure equipment could be appropriately disinfected between patients in 4 out of 8 operating suites.</p> <p>Findings:</p> <ol style="list-style-type: none"> At 0750 hours on 3/31/15, while observing a patient in OR room #6, it was observed that a positioning pad had the seam open exposing the form pad. Operating rooms # 3, 4 and 5 were toured. Positioning pads were observed to have cracks in their coverings in each room. | S 432 | On 04/20/2015, the Specialty Coordinator of the OR inspected all pads and removed from use all pads that were not intact and able to be properly disinfected. The OR Clinical Manager instructed all OR personnel to visually inspect all pads prior to use and not use if not completely intact. The Specialty Coordinator will inspect all pads monthly for holes or any break in the surface and remove from use if found. The OR Clinical Manager is responsible for the consistent practice mentioned above. | 04/20/2015 |

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| S 444 Bldg. 00 | <p>3. At 1015 hours on 3/31/15, staff member #2, Nurse Manager, verified that the reusable positioners used during surgical procedures did not have surfaces intact in operating rooms #3, 4, 5 and 6.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on policy review, observation and staff interview, the Infection Control Committee failed to ensure compliance with the dress code in the surgical suite.</p> <p>Findings:</p> <p>1. Review of policy and procedure, Dress Code Peri-operative Domain, with date of 07/14, indicated:</p> <p>a. Under A-5, "All individuals in the</p> | S 444 | The occurrence was discussed in the QAPI/Infection Control meeting on 04/15/2015 and the measures planned was discussed. On 04/20/2015, the OR Clinical Manager reported the break in the Dress Code Policy to the Medical Director. The Center's policy was electronically provided to the Medical Director to distribute to the Medical Staff. Education to the OR personnel regarding the policy was also | 04/20/2015 |

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| S 640 Bldg. 00 | <p>restricted area will have jewelry removed or totally concealed under operating room apparel."</p> <p>2. At 0750 hours on 3/31/15, while observing a patient in OR room #6, it was observed that MD #1, had earrings present that were not confined within the surgical cap while a surgical procedure was in process.</p> <p>3. At 1500 hours on 4/1/15, staff member #1, the Director, verified that jewelry must be removed or concealed in the operating room.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(1)</p> <p>(e) All entries in the medical record must be as follows:</p> <p>(1) Legible and complete. Based on policy review, medical record (MR) review and interview, the facility failed to ensure that the medical record was complete for 5 of 5 transfer medical records.</p> <p>Findings include:</p> <p>1. Review of policy and procedure, "Transfer of a Perioperative Patient" approved on July 2014 by the Board of</p> | S 640 | <p>completed on 04/20/2015. The OR Clinical Manager is responsible for monitoring all persons entering the restricted area for compliance with the policy.</p> <p>On 04/15/2015, the QAPI/Infection Control Committee reviewed the deficits within this State tag. The plan to first educate the appropriate personnel regarding the Completion of Medical Records Policy, followed by weekly audits completed at the Center to ensure consistent compliance with the regulations. The PACU Clinical Manager is responsible for the completion of this plan and the follow-up monitoring. The</p> | 04/22/2015 |

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| | <p>Managers indicated: Under "Procedures"</p> <p>A. Obtain order from the physician. B. Call admitting facility and report of patient status. C. Complete the transfer paperwork.....the physician will need to sign the "Initiated Request to Transfer".</p> <p>2. Medical record review indicated that MR #28 did not have evidence of a physician order or the form "Initiated Request to Transfer" form.</p> <p>3. Medical record review indicated that MR #s 26, 27 and 28 did not have evidence of a physician order.</p> <p>4. Medical record review indicated that MR #s 25, 26, 27 and 28 did not have evidence of a physician signature.</p> <p>5. At 1100 hours on 4/1/15, staff # 3, Clinical Specialty Coordinator and 4, Clinical Manager, PACU (post anesthesia care unit) verified that the above was not in the medical record.</p> | | education was completed on 4/22/2015 by the PACU Clinical Manager. | |

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| S 672 Bldg. 00 | <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(13)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(13) A copy of the transfer form, if the patient is referred to a hospital or other facility.</p> <p>Based on policy review, medical record review and interview, the facility failed to ensure that the transfer form was initiated on 1 of 5 medical records.</p> <p>Findings include:</p> <p>1. Review of policy and procedure, "Transfer of a Perioperative Patient" approved on July 2014 by the Board of Managers indicated: Under "Procedures" A. Obtain order from the physician. B. Call admitting facility and report of patient status. C. Complete the transfer paperwork.....the physician will need to sign the "Initiated Request to Transfer".</p> <p>2. Medical record review indicated that MR #28 did not have evidence of a physician order or the form "Initiated</p> | S 672 | On 4/22/2015, all RNs in the PACU department was educated the contents of the Transfer policy, including the need for an order from the physician, by the PACU Clinical Manager. The PACU Clinical Manager is responsible for monitoring the documentation when a transfer occurs to ensure consistent compliance. | 04/22/2015 |

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| | Request to Transfer" form. 3. At 1100 hours on 4/1/15, staff # 4, Clinical Manager, PACU (post anesthesia care unit) verified that the above was not in the medical record. | | | | |