

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/29/2012
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NAME OF PROVIDER OR SUPPLIER GLEN LEHMAN ENDOSCOPY SUITE	STREET ADDRESS, CITY, STATE, ZIP CODE 550 N UNIVERSITY BLVE, SUITE 4100 INDIANAPOLIS, IN 46202
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 012607</p> <p>Survey Date: 2-27/29-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 03/06/12</p>	S0000	Survey completed on 2-27/29-12.	

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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S0310	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the facility failed to include a monitor and standard for 1 directly-provided service in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include a monitor and standard for directly-provided nursing services.</p> <p>2. On 2-27-12 at 3:10 pm, employee #A2 was requested to provide documentation of inclusion of the above activity. No documentation was provided prior to exit.</p>	S0310	<p>In regard to the Glen Lehman Endoscopy Suite's QAPI Program, a nursing monitor and standard was identified. Monitor: Monitor and audit nursing medical record doumentation monthly. The standard will be 40 records, or 5% of the monthly patient volume will be audited. A "concurrent medical record review" form has been developed for this purpose. The purpose of the medical record audit is to ensure completeness and accuracy. Start Date: Monday, March 26, 2012 Responsible Person: Linda DiPalmo, Clinical Manager GLES</p>	03/26/2012			

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S0614	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(2)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(2) A unit record system of filing should be utilized. When this is not practicable, a system must be established by the center to retrieve, when necessary, all divergently located record components.</p> <p>Based on document review, the facility failed to have a policy describing the unit record procedure used by the facility to file medical records.</p> <p>Findings:</p> <p>1. On 2-29-12 at 10:15 am, employee #A2 was requested to provide a policy describing the unit record procedure which was used by the facility to file medical records. No documentation was provided prior to exit.</p>	S0614	<p>The GLES Policy ADM 3.01 was reviewed and revised to indicate the documentation, collection, scanning, storing, and maintenance of both paper and electronic medical records by Indiana University Health Information Management (HIM) Department. Changes Noted:Part IV. DefinitionsHealth Information Management (HIM): Through a Service Level Agreement, HIM is responsible for collecting, scanning, storing and maintaining patient medical records, which includes paper and electronic documentation. Part VI. Procedure, the following sections were added to the policy:A. The Glen Lehman Endoscopy Suite (GLES) has a Service Level Agreement (SLA) with the Indiana University Health Information Management Department to collect, scan, store, and manage the GLES medical records, both</p>	03/15/2012			

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			<p>paper and electronic. B. The GLES paper records, which include the anesthesia records, discharge summary, patient procedural consent, and the financial consent will be picked up daily by a HIM courier and taken to the IU Health Shadeland Facility for scanning. After scanning, the medical record will be available to retrieve electronically from the Cerner System. C. Other portions of medical record will be completed electronically, either in the Cerner or Provation System, stored, and then made available for retrieval. D. - H. were present in the policy and note the HIM process for medical records.</p>	

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S0616	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(3)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(3) The center shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry must be authenticated in accordance with the center and medical staff policies.</p> <p>Based on document review and interview, the facility failed to follow its policy to protect the security of all record entries.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Policy Number CLR 6.00 entitled CONTENT OF MEDICAL RECORDS, indicated under section V.D.3 that any practitioner who uses a computer signature to authenticate entries must sign a statement that he or she is the only one who has the computer code or password and is the only one who will use it. The signed statement must be on file in the responsible departments. 2. On 2-29-12 at 10:15 am, employee #A2 was requested to provide 	S0616	<p>In regard to Policy Number CLR 6.00 noting "The center shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry must be authenticated in accordance with center and medical staff policies." Action: A 'Responsibility Statement Information Security and Confidentiality Statement' was revised for the Glen Lehman Endoscopy Suite. The revised form will be reviewed and approved at the Medical Staff meeting on Friday, March 16, 2012. The Clinical Manager, Linda DiPalmo, will begin obtaining signatures on the revised form following the Medical Staff meeting on March 16. Signatures for all available</p>	03/29/2012			

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	documentation of signed statements by all practitioners who used computer signatures. Upon interview, the employee indicated there was no documentation per facility policy.		physicians will be obtained and completed by April 6, 2012. Responsibility: Linda DiPalmo, Clinical Manager GLES.#9 was added to the above statement form. #9. "To guarantee author identification and record maintenance that ensures the integrity of the authentication and protects the security of the IU Health and GLES electronic medical records, at no time will I share my access code to the electronic medical record." I have read and understand the IU Health and GLES 'Information Security and Confidentiality' Policy, as well as other related policies. I have read the above information and have had the opportunity to have my questgions addressed to my satisfaction. I agree to the terms above and have indicated that by signing my name below: User's Name (Printed) User SignatureIU Health Employee Number IU/IUSOM ID NumberPhysician Number Non-IU Health Last 5 SS	

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S0630	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(d)</p> <p>(d) The medical record must contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of the patient's stay in the center and the results.</p> <p>Based on document review and interview, the facility failed to ensure that the medical record contained sufficient information to document accurately the course of the patient's stay in the center and the results for 9 of 15 medical records (MR) reviewed (Patient #2, 7, 8, 9, 11, 12, 13, 14 and 15).</p> <p>Findings include:</p> <p>1. Review of the Medical Staff Rules and Regulations indicated the following on page 2; "5.3 Discharge of Patients Physicians/dentists must write an order to discharge the patient to go home when discharge criteria is met."</p> <p>2. Review of patient #2, 7, 8, 9, 11, 12, 13, 14 and 15's MR lacked documentation of Discharge Orders written by a</p>	S0630	<p>In response to Findings 1., 2., and 3. The medical records for patient #2, 7, 8, 9, 11, 12, 13, 14, and 15 lacked documentation of Discharge Orders written by a physician. After a thorough search, it was found that the medical records had been misfiled in a "file " box that was taken to the Indiana University GI Endoscopy office at 96th and Meridian Streets. The patient medical records noted above have been discovered and retrieved. Action: Records found, retrieved and returned to GLES on March 15, 2012. A new record filing process has been initiated at GLES for patient medical record holding and collection for scanning, effective on March 2, 2012. A medical record audit form was developed to ensure all patient records for each day are complete, accurate and available for collection by Health Information Management Department. Form developed on</p>	03/15/2012			

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	<p>physician.</p> <p>3. On 02-29-12 at 1445 hours, staff #42 confirmed there were no discharge orders on patient #2, 7, 8, 9, 11, 12, 13, 14 and 15's MR.</p>		<p>March 2, 2012. Responsibility: Linda DiPalmo, Clinical Manager GLES.</p>	

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S0658	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(6)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(6) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on document review and interview, the facility failed to ensure that all patient records were documented and contained evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff for 10 of 15 medical records (MR) reviewed (Patient #6, 7, 8, 9, 10, 11, 12, 13, 14 and 15).</p> <p>Findings include:</p> <p>1. Review of the Medical Staff Rules and Regulations indicated the following on page 3; "Article VI. Consent 6.1 Informed Consent Process A separate Consent for Procedure form must be completed by the patient and his/her attending physician/dentist within</p>	S0658	In response to Findings 1., 2., and 3.The medical records for patient #6, 7, 8, 9, 10, 11, 12, 13, 14, and 15 lacked documentation of an Informed Consent. After a thorough search, it was found that the medical records had been misfiled in a "file " box that was taken to the Indiana University GI Endoscopy office at 96th and Meridian Streets. The patient medical records noted above have been discovered and retrieved. Action: Records found, retrieved and returned to GLES on March 15, 2012. A new record filing process has been initiated at GLES for patient medical record holding and collection for scanning, effective on March 2, 2012.A medical record audit form was developed to ensure all patient records for each day are complete, accurate and available for collection by Health Information Management	03/15/2012			

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	<p>sixty (60) days prior to procedure. Appropriate informed consent forms must be completed and in the patient record before a procedure is initiated."</p> <p>2. Review of patient #6, 7, 8, 9, 10, 11, 12, 13, 14 and 15's MR indicated each had a procedure and lacked documentation of an Informed Consent.</p> <p>3. On 02-29-12 at 1445 hours, staff #42 confirmed that the Informed Consent forms were not present in patient #6, 7, 8, 9, 10, 11, 12, 13, 14 and 15's MR.</p>		<p>Department. Form developed on March 2, 2012. Responsibility: Linda DiPalmo, Clinical Manager GLES.</p>				

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S0670	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAc 15-2.5-3(f)(12)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(12) Final progress note, including instructions to the patient and family, with dismissal diagnosis.</p> <p>Based on document review and interview, the facility failed to ensure that all medical records (MR) were documented and contained instructions to the patient and family, with dismissal diagnosis for 14 of 15 MRs reviewed (Patient #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 and 15).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of policy/procedure DT 10.02, Release to Home, indicated the following: "4. All postoperative instructions are complete and documented." Review of patient #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 and 15's MR lacked documentation of discharge instructions. On 02-29-12 at 1445 hours, staff #42 confirmed the discharge instructions were not in the MR. 	S0670	<p>In response to Findings 1., 2., and 3. The medical records for patient #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 15 lacked documentation of a Discharge Summary. After a thorough search, it was found that the medical records had been misfiled in a "file and scan" box that was taken to the Indiana University GI Endoscopy office at 96th and Meridian Streets. The patient medical records noted above have been discovered and retrieved. Action: Records found, retrieved and returned to GLES on March 15, 2012. A new record filing process has been initiated at GLES for patient medical record holding and collection for scanning, effective on March 2, 2012. A medical record audit form was developed to ensure all patient records for each day are complete, accurate and available for collection by Health Information Management Department. Form developed on March 2, 2012. Responsibility: Linda DiPalmo, Clinical Manager</p>	03/15/2012			

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S0732	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2)</p> <p>These bylaws and rules must be as follows:</p> <p>(2) Be reviewed at least triennially.</p> <p>Based on review of documents and interview, the medical staff did not review the medical staff rules at least once every three (3) years.</p> <p>Findings:</p> <p>1. On 2-27-12 at 10:45 am, employee #A1 was requested to provide the most recent documentation of the medical staff reviewing its rules.</p> <p>2. On 2-29-12 at 1:15 pm, upon interview, employee #A2 indicated the medical staff had never reviewed the medical staff rules.</p>	S0732	<p>GLES.</p> <p>In response to S 732, Findings 1. and 2. regarding approval of the Medical Staff Bylaws and Rules by the GLES Medical Staff. Action: A GLES Medical Staff meeting has been scheduled for Friday, March 16, 2012 at 1:00 p.m. in the GLES conference room. The Medical Staff Rules are noted on the agenda for review, discussion and approval. Responsibility: Vi Farrell, MBA, BSN, RN, Administrative Director for GLES.</p>	03/16/2012			

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S0772	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p> <p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.</p> <p>Based on document review, the facility failed to ensure that history and physical examinations were performed in accordance with medical staff requirements on history and physical examinations for 10 of 15 medical records (MR) reviewed (Patient #3, 4, 5, 6, 7, 8,</p>	S0772	<p>Actions: In response to S772, Finding 1. Patient #3, the History and Physical Note was signed by the Inpatient General Fellow. As noted in Finding 1, a resident, medical student, or allied health practitioner can assume responsibility for documenting in the patient's medical</p>	03/14/2012			

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	<p>9, 11, 12 and 14).</p> <p>Findings include:</p> <p>1. Review of the Medical Staff Rules and Regulations indicated the following on page 3; "7.3 History and Physical The admitting physician is responsible for documentation of the patient's medical history and report of physical examination. The responsibility for documentation may be delegated to a resident, medical student, or allied health practitioner. If documented by a designee, it must be reviewed and authenticated by the attending physician."</p> <p>2. Review of patient #3, 4, 5, 6, 7, 8, 9, 11, 12 and 14's MR the physician's History and Physical examinations lacked documentation of a medical history.</p>		<p>record. Policy 7.3 "History and Physical" is not a valid policy, it is under MS 2.03. Policy MS 2.03 History and Physician was changed to reflect the Fellow's responsibility to sign patient documentation. In Finding 2, regarding review of patient #3, 4, 5, 6, 7, 8, 9, 11, 12, and 14, all patient medical records were found and retrieved. Actions: The medical director for GLES reviewed documentation for patient's noted above and retrieved all of the physician's History and Physical examinations. Retrieved the documentation on Wednesday, March 14, 2012. The medical director noted that all patient records, except #3, were signed by the attending physician. #3 was signed by the IP General Fellow. It is noted that the Physician's History and Physical exam results resides within the Provation System Report under "indications" and/or under the Cerner pre-procedure note. Re-education of the pathways within these systems will be completed for staff and manager to ensure future findings of this documentation can be completed. Responsibility: Vi Farrell, Administrative Director Linda DiPalmo, Clinical Manager Debra Helper, MD, Medical Director for GLES</p>				

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NAME OF PROVIDER OR SUPPLIER GLEN LEHMAN ENDOSCOPY SUITE				STREET ADDRESS, CITY, STATE, ZIP CODE 550 N UNIVERSITY BLVE, SUITE 4100 INDIANAPOLIS, IN 46202			
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S0780	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based on interview, the medical staff failed to have a requirement that all orders are to be authenticated by a responsible practitioner within a time frame specified by the medical staff not to exceed 30 days.</p> <p>Findings:</p> <p>1. On 2-27-12 at 10:45 am, employee #A1 was requested to provide documentation of a medical staff requirement that all orders are to be authenticated by a responsible practitioner within a time frame specified by the medical staff not to exceed 30 days.</p> <p>2. On 2-29-12 at 11:30 am, employee</p>	S0780	<p>The policy MS # 2.03 was revisited and the following was added:V I. The medical record will be authenticated by a responsible practitioner within a time frame of 48 hours, but not to exceed 30 days, as specified by the medical staff.New Revision will be approved by the GLES Medical Staff on 3/16/2012. Responsible party Linda DiPalmo RN, Clinical Manager</p>	03/16/2012			

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	#A2, upon interview, indicated there was no documentation of a medical staff requirement that all orders are to be authenticated by a responsible practitioner within a time frame specified by the medical staff not to exceed 30 days. No documentation was provided prior to exit.			

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S0784	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(P)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(P) A requirement that the final diagnosis be documented along with completion of the medical record within thirty (30) days following discharge.</p> <p>Based on interview, the facility failed to have a medical staff approved policy that the final diagnosis is to be completed in the medical record within 30 days.</p> <p>Findings:</p> <p>1. On 2-27-12 at 10:45 am, employee #A1 was requested to provide documentation of a medical staff approved policy that the final diagnosis is to be completed in the medical record within 30 days.</p> <p>2. On 2-29-12 at 11:30 am, employee #A2, upon interview, indicated there was no documentation of a policy that the final diagnosis is to be completed in the medical record within 30 days. No documentation was provided prior to exit.</p>	S0784	<p>The policy MS # 2.03 was revisited and the following was revised:V D. The medical record will be considered delinquent if reports, final diagnosis and signatures are not completed within 15 days, but not to exceed 30 days, following the allocation date.New revision will be approved by the GLES Medical Staff on 3/16/2012.Responsible party Linda DiPalmo RN, Clinical Manager.</p>	03/16/2012			

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S0830	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(F)(i)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p> <p>(F) The delineation of preanesthesia, intra-operative, and post-anesthesia responsibilities as follows:</p> <p>(i) The completion, within forty-eight (48) hours before surgery, of a preanesthesia evaluation for each patient by an individual qualified to administer anesthesia for all types of anesthetics other than local and updated according to center policy (when more than forty-eight (48) hours) before surgery.</p> <p>Based on document review and interview, the facility failed to ensure that a preanesthesia evaluation for each patient by an individual qualified to administer anesthesia was documented in the medical record (MR) for 8 of 15 MRs reviewed (Patient #7, 8, 10, 11, 12, 13, 14 and 15).</p> <p>Findings include:</p> <p>1. Review of policy/procedure AS 9.19, Anesthesia Record Completion, indicated the following; "V. Policy Statements</p>	S0830	<p>Patient # 7, 8, 10, 11, 12, 13, 14, and 15. Policy # AS 9.19 Preanesthesia Evaluation documentation of what was missing. After a thorough search, it was found that the medical records had been misfiled in a "file " box that was taken to the Indiana University GI Endoscopy office at 96th and Meridian Streets. The patient medical records noted above have been discovered and retrieved. Action: Records found, retrieved and returned to GLES on March 15, 2012. A new record filing process has been initiated at GLES for patient medical record</p>	03/15/2012

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	<p>A. The anesthesia record will be completed by the anesthesiologist in attendance for any type of anesthesia including general, regional or monitored anesthesia care."</p> <p>2. Review of patient #7, 8, 10, 11, 12, 13, 14 and 15's MR indicated each had monitored anesthesia care and the MR lacked documentation of a preanesthesia evaluation.</p> <p>3. On 02-29-12 at 1445 hours, staff #42 confirmed the preanesthesia documentation was not present in patient #7, 8, 10, 11, 12, 13, 14 and 15's MR.</p>		<p>holding and collection for scanning, effective on March 2, 2012. A medical record audit form was developed to ensure all patient records for each day are complete, accurate and available for collection by Health Information Management Department. Form developed on March 2, 2012. Responsibility: Linda DiPalmo, Clinical Manager GLES.</p>				

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S0832	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(F)(ii)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p> <p>(F) The delineation of preanesthesia, intra-operative, and postanesthesia as follows:</p> <p>(ii) The completion by the practitioner administering anesthesia of intra-operative anesthesia monitoring and notations, to include vital signs, on each patient in accordance with the center policy.</p> <p>Based on document review and interview, the facility failed to ensure that the intra anesthesia documentation for each patient by an individual qualified to administer anesthesia was documented in the medical record (MR) for 8 of 15 MRs reviewed (Patient #7, 8, 10, 11, 12, 13, 14 and 15).</p> <p>Findings include:</p> <p>1. Review of policy/procedure AS 9.19, Anesthesia Record Completion, indicated the following; "V. Policy Statements A. The anesthesia record will be completed by the anesthesiologist in attendance for any type of anesthesia</p>	S0832	<p>Patient # 7, 8, 10, 11, 12, 13, 14, and 15. Policy # AS 9.19 Monitored Anesthesia Care documentation was missing. After a thorough search, it was found that the medical records had been misfiled in a "file " box that was taken to the Indiana University GI Endoscopy office at 96th and Meridian Streets. The patient medical records noted above have been discovered and retrieved. Action: Records found, retrieved and returned to GLES on March 15, 2012. A new record filing process has been initiated at GLES for patient medical record holding and collection for scanning, effective on March 2, 2012. A medical record audit form was developed to ensure all</p>	03/15/2012			

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	<p>including general, regional or monitored anesthesia care."</p> <p>2. Review of patient #7, 8, 10, 11, 12, 13, 14 and 15's MR indicated each had monitored anesthesia care and the MR lacked documentation of the intra anesthesia documentation.</p> <p>3. On 02-29-12 at 1445 hours, staff #42 confirmed the intra anesthesia documentation was not present in patient #7, 8, 10, 11, 12, 13, 14 and 15's MR.</p>		<p>patient records for each day are complete, accurate and available for collection by Health Information Management Department. Form developed on March 2, 2012. Responsibility: Linda DiPalmo, Clinical Manager GLES.</p>	

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S0834	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(F)(iii)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p> <p>(F) The delineation of preanesthesia, intra-operative, and postanesthesia as follows:</p> <p>(iii) The completion of a postanesthetic evaluation for proper anesthesia recovery of each patient prior to discharge in accordance with written policies and procedures approved by the medical staff.</p> <p>Based on document review and interview, the facility failed to ensure that the post anesthetic evaluation for each patient by an individual qualified to administer anesthesia was documented in the medical record (MR) for 8 of 15 MRs reviewed (Patient #7, 8, 10, 11, 12, 13, 14 and 15).</p> <p>Findings include:</p> <p>1. Review of policy/procedure AS 9.19, Anesthesia Record Completion, indicated the following; "V. Policy Statements A. The anesthesia record will be completed by the anesthesiologist in attendance for any type of anesthesia</p>	S0834	<p>Patient # 7, 8, 10, 11, 12, 13, 14, and 15. Policy # AS 9.19 Anesthesia Record and Documentation of Anesthesia was missing. After a thorough search, it was found that the medical records had been misfiled in a "file " box that was taken to the Indiana University GI Endoscopy office at 96th and Meridian Streets. The patient medical records noted above have been discovered and retrieved. Action: Records found, retrieved and returned to GLES on March 15, 2012. A new record filing process has been initiated at GLES for patient medical record holding and collection for scanning, effective on March 2, 2012. A medical record audit form</p>	03/15/2012			

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	<p>including general, regional or monitored anesthesia care."</p> <p>2. Review of patient #7, 8, 10, 11, 12, 13, 14 and 15's MR indicated each had monitored anesthesia care and the MR lacked documentation of the post anesthetic evaluation .</p> <p>3. On 02-29-12 at 1445 hours, staff #42 confirmed the post anesthetic evaluation was not present in patient #7, 8, 10, 11, 12, 13, 14 and 15's MR.</p>		<p>was developed to ensure all patient records for each day are complete, accurate and available for collection by Health Information Management Department. Form developed on March 2, 2012. Responsibility: Linda DiPalmo, Clinical Manager GLES.</p>	

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S0888	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on document review the facility failed to ensure that the Operative Report be written or dictated immediately following surgery for 6 of 15 medical records (MR) reviewed (Patient #9, 11, 12, 13, 14 and 15).</p> <p>Findings include:</p> <p>1. Review of the Medical Staff Rules and Regulations indicated the following on page 4; "7.4 Operative?Procedure Notes The attending physician/dentist must dictate the operative notes immediately</p>	S0888	<p>Here are the responses to the ISDH 2/29/12 statement of deficiencies ID prefix S888: General response is that the Provation note is the operative note, is initiated and finalized in Provation while in the procedure room, and is then uploaded into Cerner so the tag in Cerner of entered, modified and verified appears to be timed with the initiation of the note, but does not correctly indicate the time of finalization. The endoscopists "initiate" the operative report in Provation often before the start of the procedure to add the Provider/Doctor (MD performing the procedure), the name of the</p>	03/15/2012			

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	<p>following any procedure performed."</p> <p>2. Review of patient #9's MR indicated the patient had a procedure on 02-17-12 that started at 0926 hours and the Operative Report was signed on 02-17-12 at 0854 hours.</p> <p>3. Review of patient #11's MR indicated the patient had a procedure on 02-17-12 that started at 0908 hours and the Operative Report was completed on 02-17-12 at 0833 hours.</p> <p>4. Review of patient #12's MR indicated the patient had a procedure on 02-17-12 that started at 1326 hours and the Operative Report was started on 02-17-12 at 1258 hours.</p> <p>5. Review of patient #13's MR indicated the patient had a procedure on 02-20-12 that started at 1208 hours and the Operative Report was completed on 02-20-12 at 1152 hours.</p> <p>6. Review of patient #14's MR indicated the patient had a procedure on 02-20-12 that started at 1129 hours and the Operative Report was completed on 02-20-12 at 1121 hours.</p> <p>7. Review of patient #15's MR indicated the patient had a procedure on 02-20-12</p>		<p>procedure, the referring MDs, the indication for the procedure, the instrument used, and the pre-anesthesia assessment. After the procedure is finished the Provation report is completed with the findings, impressions, recommendations and images are attached. Then the report is "finalized and signed." Both intiation and signature (finalization) times are indicated at the end of each report. 2. Review of patient #9 – on 2/17/12 report was initiated at 08:54, procedure started at 09:26 and operative report signed 10:31:29. 3. Review of patient #11 – on 2/17/12 – no finalized report found; MD requested to finalize the report. 4. Review of patient #12 – on 2/17/12 report initiated at 12:58:29, procedure started at 13:26 and operative report signed 14:29:03. 5. Review of patient #13 – on 2/20/12 report initiated at 11:52, procedure started at 12:08 and operative report signed 12:19:42. 6. Review of patient #14 – on 2/20/12 report initiated at 11:21, procedure started at 11:29, operative report signed 12:19:31. 7. Review of patient #15 – on 2/20/12 report initiated at 09:39, procedure started at 09:51 and operative report signed 10:17:25. I have emailed Dr. Mo Al-Haddad to ask him to finalize the report on patient #11 or respond as to why the report was not completed. This will be completed by March 16, or</p>				

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	that started at 0951 hours and the Operative Report was completed on 02-20-12 at 0939 hours.		before. DH Responsible person Debra Helper MD Medical Director	