STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	150051	A. BUILDING 00 B. WING	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
IU HEALTH BLOOMINGTON HOSPITAL	2651 EAST DISCOVERY PARKWAY BLOOMINGTON, IN 47408

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S 0000 Bldg. 00	This visit was for investigation of a state licensure hospital complaint. Complaint Number: IN00425929 - State deficiencies related to the allegations are cited at S0732 and S1318. Dates of Survey: 6/20/2024, 6/28/2024 and 7/1/2024 Facility Number: 005047 QA: 6/28/2024, 7/2/2024 and 7/3/2024	S 0000		
S 0732 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d)(1)(2)(3)(4) (d) The medical record shall contain sufficient information to: (1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of treatment and results. Based on document review and interview, the facility failed to maintain an accurate medical record (MR) for 1 of 5 MR reviewed. (Patient P2) Findings include: 1. Facility policy titled, Moderate sedation, no policy number, last revised 8/21/23, indicated on page 5, under Implementation; Clinical alert; Assess the patient for conditions that might make	S 0732	***How will you correct the deficiency?*** *A review of the event was completed by a multidisciplinary group including physician leadership to identify the root cause for noncompliance and potential opportunities for improvement. It was identified that the paper M24 GI Pre-Screening*	07/15/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Grace, BSN, RN, CPHQ	SCR Accreditation & Regulatory, Senior Cons	07/18/2024

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	ventilation difficult, such as age older than 55, significant obesity, history of smoking or sleep apnea, facial hair, missing teeth, limited neck extension, short neck, cervical spine disease, neck mass, small mouth, high arched palate, macroglossia, dysmorphic facial features, decreased hyoid-mental distance, nonvisible uvula, Mallampati classification of III or IV, jaw abnormalities, history of problems with anesthesia or sedation, advanced rheumatoid arthritis, chromosomal abnormality, tonsillar hypertrophy, and stridor. The policy indicated on page 10, under Documentation; Documentation associated with moderate sedation includes: preprocedure assessment findings. 2. Review of MR document Screening Indications Requiring Anesthesia for GI Endoscopic Procedure, completed by MD1 (facility provider) for P2 on 9/19/24 at 10:55 am, indicated under Clinical Indication, the following boxes were check marked: 3. history of previous problems with anesthesia or sedation, and 4. history of intolerance to sedatives (i.e. chronic benzodiazepines or narcotic). 3. Review of P2's MR lacked documentation of patient stating they had a history of previous problems with sedation and/or a history of intolerance to sedatives. 4. In interview, on 6/20/24 at approximately 12:00 pm, A6 (Clinical Nurse Quality Coordinator) verified the MRs were as reviewed and there was no documentation of history of problems with sedation. The boxes mentioned above were incorrectly check marked.		*for MAC was not a required document and created risk for conflicting documentation within the health record. The form will no longer be utilized, has been deactivated, and archived. The pre-anesthesia screening and risk assessment will be completed and documented in the electronic health record by the Anesthetist administering sedation/anesthetics during the procedure. The process changes and documentation expectations have been communicated to applicable providers, including Gastroenterology & Anesthesiology practitioners.* ***How will you prevent the deficiency from recurring the future (sustainment plan & monitoring)?*** *A minimum of five (5) random audits will be completed weekly to ensure the pre-anesthesia risk assessment has been completed and documented in the electronic health record as required and no discrepancies identified. Auditing will continue for 60 days or until 90% compliance is achieved for 30 consecutive procedural days.* ***Who (by title) is responsible for #1 & #2 above?*** *Director of Surgical Services*	

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S 1318 Bldg. 00	410 IAC 15-1.5-10 UTILIZATION REVIEW & DISCHARGE PLANNING 410 IAC 15-1.5-10 (e)(3)(A)(B)(C)(D)(E)(F) (e) To facilitate discharge as soon as an acute level of care is no longer required, the hospital shall have effective, ongoing discharge planning that: (3) transfers or refers patients, along with the necessary medical information and records, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. The information shall include, but not be limited to, the following: (A) medical history; (B) current medications; (C) activities status; (D) nutritional needs; (E) outpatient service needs; (F) follow-up care needs; and Based on document review and interview, the facility failed to ensure the follow-up care needs were met per policy for 1 of 3 discharged patients medical record (MR) reviewed. (Patient P2) Findings include: 1. Facility policy titled, Post Discharge Follow-Up Phone Call, no policy number, last approved 9/29/22, indicated on page 1, under V. Policy Statements, Post-Discharge Follow-Up Phone Calls will be made within 24-48 business hours after discharge from the hospital to patients as defined below. Under VI. Procedures, A. 1.	S 1318	***How will you correct the deficiency?*** *Statement of Deficiency and Accreditation & Regulatory requirements were reviewed to determine root cause of noncompliance & identify opportunities for improvement. The Post-Discharge Policy was reviewed for applicability based on best practice recommendations and it was determined the Minor Procedure Unit was not included within the scope of the current*	07/15/2024

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	Outpatient surgery patients will be called by Outpatient Surgery Nurses; E. The Follow-up phone call will be documented and become a part of the electronic health record for the hospital encounter. 2. Review of P2's MR indicated discharged to home on 9/19/23 at 1:05 pm. MR lacked documented follow up phone call. 3. In interview, on 6/20/24 at approximately 9:46 am, A1 (Manager Infection Control) verified in relation to policy and procedure the facility Endoscopy Unit would be considered same day surgery or outpatient surgery. 4. In interview, on 6/20/24 at approximately 12:00 pm, A6 (Clinical Nurse Quality Coordinator) verified the MRs were as reviewed and there was no documentation of a post discharge phone call made to P2 in the MR.		*policy. Revisions were made to the policy scope and discharge call process to reflect departmental & organizational expectation. The revised process includes the recommendation to complete post-discharge calls on patients discharged from the Minor Procedure Unit; however, is not required to be completed on all Minor Procedure Discharges. The Minor Procedure team members were educated on policy revisions, the discharge process, and documentation requirements.* ***How will you prevent the deficiency from recurring the future (sustainment plan & monitoring)?*** *A minimum of five (5) random audits/week will be completed to ensure written discharge instructions are provided and include but not limited to the following: what to do when concerns, issues, or problems arise, including who to call, and when to seek emergency assistance, medications, pain management, post-sedation limitations, post-discharge follow-up appointments, referrals for specialized services and/or resources, as applicable. Audits will be conducted for 60 days or until 90% compliance is achieved for 30 consecutive discharges.* ***Who (by title) is responsible for***	

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			#1 & #2 above? *Director of Surgical Services*	