STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005068	A. BUILDING: _____ B. WING _____	01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL EAST	1500 N RITTER AVE INDIANAPOLIS, IN 46219

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S 000	INITIAL COMMENTS The visit was for investigation of one State hospital complaint. Complaint Number: IN00217979 Substantiated: A deficiency related to the allegations is cited. Unrelated deficiencies are cited. Date: 1-12-17 Facility Number: 005068 QA: 1/26/17 jlh	S 000		
S 732	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. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to follow policy/procedure and ensure all Medical Record (MR) entries were accurate and contained sufficient information to describe the course of treatment and results for 1 of 10 MR reviewed (patient #1). Findings include: 1. The policy/procedure Documentation in the	S 732		

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S 732	Continued From page 1 Medical Record (approved 4-16) indicated the following: "The medical record shall contain sufficient information to... document accurately the course of treatment and results." 2. Review of the MR for patient #1 indicated a copy of an imaging order was printed 7-8-16 at 0850 hours for a routine abdominal and pelvis CT (computerized tomography) with oral and IV (intravenous) contrast. The Imaging Center medication administration record (MAR) indicated at 0700 hours that patient #1 consumed 50 ml (milliliters) of oral contrast and indicated at 0907 hours that 130 ml of IV contrast was administered by IV route at the start of the CT imaging study. The entries by radiologic technologist AH14 that indicated the CT exam began at 1003 hours and ended at 1058 hours and the times were not consistent with the CT image acquisition times that indicated the CT exam began at 0907 hours and ended at 0915 hours. The MAR entry on 7-8-16 at 1020 hours by radiologic tech AH14 indicated that 0.3 mg (milligrams) of Epinephrine 1mg/ml (mgs/milliliter) was administered by IM (intra-muscular) route and 50 mg Diphenhydramine (Benadryl) 50 mg/ml was administered by IV route to patient #1. The radiologic tech AH14's entry under Comments indicated: "...unable to get delay scan due to allergic reaction to contrast - Pt (patient) was sent to ER (emergency room; ED)." No MR documentation by radiologic technologist AH14 indicated the symptoms observed and/or reported by patient #1 as an allergic reaction, indicated the patient lost consciousness and experienced a fall, or indicated the patient sustained injuries associated with the fall event. 3. Review of the related ED MR on 7-8-16 indicated patient #1 arrived to the ED at 0947	S 732		

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S 732	Continued From page 2	S 732		

hours and was examined by the ED physician, staff MD15. The ED record indicated the patient reported having diffuse itching before experiencing a syncopal episode (loss of consciousness with rapid onset and short duration) and falling face forward onto the floor with injuries including a lip laceration and chipped 2 front teeth.

4. The Medcheck East outpatient services documentation entered on 8-12-16 at 1614 hours by the physician, staff MD12 for care on 7-8-16 involving patient #1 indicated the physician was requested to respond to a patient experiencing an allergic reaction to IV contrast. The Medcheck progress note entry indicated the patient was complaining of itching, nausea and shortness of breath and facial flushing was observed by the physician. The progress note indicated physician MD12 gave orders to administer Epinephrine 0.3 mg IV and Diphenhydramine 50 mg IM before leaving the Imaging Center to obtain the assistance of additional staff to administer the medications and indicated the patient experienced a fall during the physician's absence and was lying on the floor and bleeding from the mouth and chin upon the return of physician MD12. The progress note indicated 911 was called and the patient remained on the floor until the arrival of EMS for transport to the ED. The Medcheck MAR (medication administration record) entries on 8-12-16 by physician MD12 indicated orders on 7-8-16 at 1018 hours to administer Epinephrine 0.3 mg by IM route and Diphenhydramine 50 mg by IV route. The routes of administration documented by physician MD12 in the Medication Record were inconsistent with the routes of administration documented in the physician's progress note and the times associated with both entries were inconsistent

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S 732	Continued From page 3 with the patient's arrival to the ED at 0947 hours on 7-8-16. 5. The Medcheck East outpatient services documentation created on 8-9-16 at 1118 hours by the Licensed Practical Nurse (LPN), staff AH15 for care on 7-8-16 involving patient #1 indicated the nurse administered Epinephrine 0.3 mg by IM route and no time of administration was identified. No Medcheck East documentation indicated a staff member responding to a patient emergency at the Imaging Center administered Diphenhydramine 50 mg by IV or IM route to patient #1. 6. On 1-12-17 at 1240 hours and 1300 hours, the medical imaging manager, staff A6 confirmed the imaging center MR for patient #1 lacked documentation of vital signs, description of the allergic reaction to IV contrast, or a syncopal episode resulting in a fall with injuries. The manager A6 confirmed the imaging center and Medcheck MR entries failed to accurately document the timing for the CT study, fall event, medications administered, arrival of EMS, and patient departure from the outpatient facility and confirmed the MR entries by physician MD12 and nurse AH15 were entered more than 30 days after the 7-8-16 episode of care. 7. Review of email documentation received on 1-17-17 from the director of quality and risk, staff A3 confirmed the Radiant module for radiology staff documentation in the EMR is limited to comments of less than 150 characters and confirmed no other process for documenting facts of the event in the MR by radiology staff is in use at the present time. The director of quality and risk, staff A3 confirmed the facility lacked a process for monitoring the Medcheck staff	S 732		

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S 732	Continued From page 4 documentation associated with a medical response to an IV contrast reaction or other adverse patient occurrence at the outpatient Imaging Center.	S 732		
S 776	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(h)(3) (h) Outpatient records shall document and contain, but not be limited to, the following: (3) Description of treatment given, procedures performed, and documentation of patient response to intervention, if applicable. This RULE is not met as evidenced by: Based upon document review, the facility failed to follow its policy/procedures and ensure all outpatient medical records (MR) were complete for 1 of 10 MR reviewed (patient #1). Findings include: 1. The policy/procedure Documentation Standards, General, Patient Medical Records (effective 10-14) indicated the following: "To provide guidelines for documentation within the electronic medical record (EMR) during Code White and when supplemental paper documentation is required based on the limitations of the EMR... the person providing the care will document that care... all entries must... reflect accurate information related to the	S 776		

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S 776	Continued From page 5 patient's condition and treatment..." 2. Review of the outpatient Imaging Center documentation in the Radiant module of the EMR on 7-8-16 for patient #1 failed to indicate a description of an allergic response, a medical emergency alert (Code Blue) with time of activation, a description of a syncopal episode (loss of consciousness with rapid onset and short duration) resulting in a fall with injury, vital signs monitoring or patient status, names of staff responding to the patient emergency, EMS (emergency medical services) arrival and time of departure for transport to a higher level of care. 3. Review of administrative documentation dated 8-1-16 by the imaging center manager, staff A7 indicated the MR entries by radiologic technologist AH14 failed to indicate a description of the patient activity in the department as otherwise documented in an incident/event report. 4. On 1-12-17 at 1240 hours and 1300 hours, the manager of inpatient medical imaging, staff A6 confirmed the imaging center documentation for patient #1 failed to indicate a description of the allergic reaction to IV contrast, syncopal episode resulting in a fall with injuries, vital signs, or time of the patient's departure from the outpatient facility. 5. On 1-17-17 at 1648 hours, the director of quality and risk, staff A3 confirmed the Radiant module for radiology staff documentation in the EMR is limited to comments of less than 150 characters and confirmed no other process for documenting the facts of the patient events, treatment(s) provided and patient's response to the intervention(s) in the medical imaging EMR by	S 776		

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S 776	Continued From page 6 radiology staff was currently in use.	S 776		