Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AB0007	A. BUILDING: ______ B. WING ______	05/31/2018

NAME OF PROVIDER OR SUPPLIER: **HALLMARK WOMEN'S CLINIC**

STREET ADDRESS, CITY, STATE, ZIP CODE: **1919 GILLESPIE STREET FAYETTEVILLE, NC 28306**

12/10/18 [handwritten initials]

(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
E 163	.0313(C) Post-Operative Care 10A-14E .0313 (c) The following criteria shall be documented prior to discharge: (1) the patient shall be ambulatory with a stable blood pressure and pulse; and (2) bleeding and pain shall be controlled. This Rule is not met as evidenced by: Based on medical record reviews and staff interviews, the nursing staff failed to document patients' pain level for 5 of 5 surgical abortion procedure (SAB) patients sampled prior to discharge. (Patient #1, #2, #3, #4 and #5) The findings include: 1. Closed medical record review of patient # 1 on 05/31/2018 revealed the patient had a SAB on 05/18/2018. Review revealed no documentation of pain assessment prior to patient discharge. Interview on 05/31/18 at 1130 with Clinic Administrator revealed they were using old charts. Interview revealed there is nowhere in the medical record for the nurses to document the required information on the medical record. Interview revealed the nurses are aware of the requirements the patients need to meet for discharge criteria. Interview revealed she performs chart audits and missing information is usually identified. Interview on 05/31/2018 at 1205 with RN #1 (Registered Nurse) revealed she is aware she needs to document pain and bleeding as a part of the discharge criteria. Interview revealed she usually documents it "free hand" in the blanks. Interview revealed unknown why she had not	E 163	We are now using New medical records which include location required information discharge criteria pain and bleeding all documentation to be completed by R.N. Will double Check patient Charts Making sure all Charts Complete. The physician will sign off on E[illegible] daily sheets. For quarter. Then Review quarterly with RN	6-15-18

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE (X6) DATE

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E 163	Continued From page 3 Interview on 05/31/18 at 1130 with Clinic Administrator revealed they were using old charts. Interview revealed there is nowhere in the medical record for the nurses to document the required information on the medical record. Interview revealed the nurses are aware of the requirements the patients need to meet for discharge criteria. Interview revealed she performs chart audits and missing information is usually identified. Interview on 05/31/2018 at 1205 with RN #1 revealed she is aware she needs to document pain and bleeding as a part of the discharge criteria. Interview revealed she usually documents it "free hand" in the blanks. Interview revealed unknown why she had not documented the pain assessments on all records reviewed.	E 163	WE Are now using New medical records which include location for required discharge criteria pain bleeding. This documentation to be completed by RN. The physician will Sign off OR Initial Daily SHEETS FOR Quarter. Then will Review Quarterly with RN.	6-15-18

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E 163	Continued From page 1 documented the pain assessments on all records reviewed. 2. Closed medical record review of patient # 2 on 05/31/2018 revealed the patient had a SAB on 05/17/2018. Review revealed no documentation of pain assessment prior to patient discharge. Interview on 05/31/18 at 1130 with Clinic Administrator revealed they were using old charts. Interview revealed there is nowhere in the medical record for the nurses to document the required information on the medical record. Interview revealed the nurses are aware of the requirements the patients need to meet for discharge criteria. Interview revealed she performs chart audits and missing information is usually identified. Interview on 05/31/2018 at 1205 with RN #1 revealed she is aware she needs to document pain and bleeding as a part of the discharge criteria. Interview revealed she usually documents it "free hand" in the blanks. Interview revealed unknown why she had not documented the pain assessments on all records reviewed. 3. Closed medical record review of patient # 3 on 05/31/2018 revealed the patient had a SAB on 05/15/2018. Review revealed no documentation of pain assessment prior to patient discharge. Interview on 05/31/18 at 1130 with Clinic Administrator revealed they were using old charts. Interview revealed there is nowhere in the medical record for the nurses to document the required information on the medical record. Interview revealed the nurses are aware of the requirements the patients need to meet for discharge criteria. Interview revealed she	E 163	WE are now using new medical records which include to required information, discharge criteria, pain and bleeding this documentation to be completed by RN. Will double check all charts to make sure all are completed. The physician will sign off OR Initial daily. For quarter Then will Review Chart quarterly with RN	

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FORM APPROVED

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E 163	Continued From page 2 performs chart audits and missing information is usually identified. Interview on 05/31/2018 at 1205 with RN #1 revealed she is aware she needs to document pain and bleeding as a part of the discharge criteria. Interview revealed she usually documents it "free hand" in the blanks. Interview revealed unknown why she had not documented the pain assessments on all records reviewed. 4. Closed medical record review of patient # 4 on 05/31/2018 revealed the patient had a SAB on 05/11/2018. Review revealed no documentation of pain assessment prior to patient discharge. Interview on 05/31/18 at 1130 with Clinic Administrator revealed they were using old charts. Interview revealed there is nowhere in the medical record for the nurses to document the required information on the medical record. Interview revealed the nurses are aware of the requirements the patients need to meet for discharge criteria. Interview revealed she performs chart audits and missing information is usually identified. Interview on 05/31/2018 at 1205 with RN #1 revealed she is aware she needs to document pain and bleeding as a part of the discharge criteria. Interview revealed she usually documents it "free hand" in the blanks. Interview revealed unknown why she had not documented the pain assessments on all records reviewed. 5. Closed medical record review of patient # 5 on 05/31/2018 revealed the patient had a SAB on 05/04/2018. Review revealed no documentation of pain assessment prior to patient discharge.	E 163	WE are now Using new medical records which include location for required information discharge criteria, pain & bleeding. This documentation to be completed by RN. Physician will Review daily SHEETS FOR a Quarter. Then will Review quarterly WITH RN.	