DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

SURVEYOR NOTES WORKSHEET

Facility Name: Peterson **Surveyor Name:** _____
CCN: 28[illegible]AS **Surveyor Number:** 5380 **Discipline:** RN
Observation Dates: From 3-21-12 **To** _____

AMBULATORY SURGICAL CENTERS
MEDICAL RECORD REVIEW

PATIENT NAME	#1	#2	#3
HISTORY PHYSICAL *pre-op diagnosis *procedure to be done	DOP - 7-6-11 2nd trim abort 18.2 wks.	DOB - -81 abortion DOP - 12-17-11	DOB - -85 1st trimester abortion
ADMISSION DATA *name, address, date of birth, sex marital status, race *date, time of admission *pre-op diagnosis -previous medical history allergies current medications past adverse reactions family history physical exam	Admit 1:59p RC 2:25p offer to see ultra sound 6-29-11 5:30p MD met c pt. 7-05-11 - 1:13p	5'9" 180# LMP - 9-6-11 H+P - 12-13-11 Gest age = 14.6 12-13-11 Lab - Hgb 10.1 Rh +	DOP - 12-13-11 H+P 12-10-11 LMP - 11-2-11 V.S. taken 5'3" 180# 12-10-11 Lab 12.7 HGB.
TREATMENT DATA *MD, podiatrist, dentist orders special exams (lab, x-ray, pathology) *signed informed consent *evidence advance directive -MD note -nurses notes -meds -TPR -OR record -anesthesia record -consult record surgery site verification	5'7 # 263# Gest age = 19.0 wks. Lab - Hgb 11.4 Rh +	Femur Length 15 to recover rm 1:45p - trisect report 188gm Consent signed 12/13/11 1:54 MD - 12.13.11 1:54 verified 24hr. 12-17-11 11:17A	8 wks. fetal tissue 26 gm. refused copy of U.S. given verbally procedure 10:10A - to recover 10:20A
PRIOR DISCHARGE -exam by MD eval risk procedure -exam by anesthesiologist proper anesthesia recovery, risk anesthesia -discharge in 24 hour or transfer _discharge to hospital with record -verbal/written instruction post-op care and procedure for obtaining emergency care -written acknowledgement of written discharge instructions	complication S/P surgery heavy bleeding Review - postop arrival location EBL - 50 cc Sent to Hospital	Up prior to procedure No compln	No compln.

HCFA 807

Revised 02/26/08

F/U 7/13.
Seen by MD
OK -

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AMBULATORY SURGICAL CENTERS MEDICAL RECORD REVIEW

Notification of malpractice	NA		
advance directives			
Complications or adverse events	cervical laceration sent to ED	NA	NA
written information for obtaining appointment /services after hours	y	y	y
legible and documented in accordance with acceptable standards of practice	y	y	y
informed consent prior surgery	y	signed by pt.	signed by pt. 12-10-11 11:30A
Discharge with responsible adult.		D/C 12-17-11 2:15pm friend	MD- 12-10-11 11:30
	medical record had no documentation of transfer		verified 24 hr 12.13.11 9:43A D/C c̄ boyfriend 12-13.11 11:05A

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0288AS

Preterm

Complication Clinical Synopsis

Pt #1

Name: Camelia Girigan

AB Date: 7/6/11

Chart #: 115796

MD: Perriera

Complaint:
Heavy bleeding

Treatment:
Transferred to UH

Resolved:

not comp.

43 year old, G3P0, termination of19.1 week pregnancy. 3 dilapan inserted on 7/5/11; operator noted "LEEP procedure 2009, minimal cervix visible, + bleeding with dilator placement. Pt. needs misoprostol 400mcg PV 4 hours prior to procedure tomorrow." Bleeding in Recovery after dilapan insertion was "small, light". Patient returned to clinic 7/6/11, administered 400mcg misoprostol at 8:15a.m., procedure begun at 12:30p.m. Operator noted: "at end of procedure circumferential area noted in endometrial cavity. Posterior cervical laceration noted. Procedure complete. Rectum intact on rectal exam. No bowel or other parts noted in tissue. Laceration not bleeding. No communication between post laceration and bowel." EBL 50cc. Patient transferred via EMS to UH. HGB on 6/29 (day one) was 11.4; HGB at UH on 7/6 was 10.3. CT scan of abdomen and uterus revealed no free fluid; vaginal exam noted small cervical laceration, not actively bleeding, which required no repair. Patient was discharged from ED with IB, Percocet and Colace. Patient returned to clinic 7/13 for FUP, small healing laceration noted, not bleeding. Patient d/c'd with no further complaints.