STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	150074	A. BUILDING 00 B. WING	08/26/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) COMPLETION DATE
S 0000 Bldg. 00	This visit was for the investigation of a state licensure hospital complaint. Complaint Number: IN00252180 Substantiated: Deficiency related to the allegation is cited. Date of Survey: 08/26/21 Facility Number: 005068 QA: 8/27/2021 & 8/30/2021	S 0000		
S 0930 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based on document review and interview, nursing service failed to ensure that care was documented related to Activities of Daily Living (ADLs), in 5 of 5 (Patients 1, 2, 3, 4 and 5) medical records (MRs) reviewed. Findings include: 1. Policy and Procedure Review: Policy titled: Activities of Daily Living (ADLs), PolicyStat ID: 3377055, approved 01/2017 (policy in effect during time of complaint), indicated that the patient is encouraged to perform as much self-care as	S 0930	**Plan of Correction** In order to reinforce compliance with the existing policy on activities of daily living (ADLs), a Standard Operating Procedure (SOP) was created. The SOP clarifies expectations for daily assessment and documentation related to ADLs. The SOP will be included in current and ongoing staff education and orientation, beginning 9/17/21.	09/17/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150074	A. BUILDING 00 B. WING	08/26/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) COMPLETION DATE
	appropriate to encourage independence; any refusal of an ADL is to be reported to the RN (Registered Nurse) and the reason documented. Documentation required in the electronic medical record are as follows: a. Offers for ADLs. b. Amount of assistance required/self-care. c. Patient refusal of an ADL. d. Reason why an ADL was withheld. e. Actual care given by care team. f. Actual care given by family or significant other 2. Review of Patient's 1, 2, 3, 4 and 5's MRs lacked documentation of a. through e. mentioned in above policy. 3. Interview: On 08/26/21 at 4:00 pm, P54 (Risk Manager) confirmed that the MR lacked documentation of a. through e. as defined in the policy for Patient's 1, 2, 3, 4 and 5.		**Monitoring Plan to Prevent Recurrence:** The unit managers or their designees will audit at least 10 inpatient charts per week (at least one chart from each unit) to ensuredocumentation of a. Assessment of level of independence with ADLs b. If not independent, type of assistance required c. Patient refusal of an ADL d. Reason why an ADL was withheld e. Actual care given by care team The audit will be conducted for 3 months and monthly thereafter until 100% compliance is reached and sustained. **Responsible Person:** Director of Acute Behavioral Health Nursing	