PRINTED: 03/03/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFI		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150128	· /	ILDING	nstruction <u>00</u>	(X3) DATE ( COMPL 01/13/	ETED
NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOSPITAL SOUTH			STREET ADDRESS, CITY, STATE, ZIP COD  1402 E COUNTY LINE RD S INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG S 0000	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
Bldg. 00	This visit was for an investigation of a State Licensure Hospital Complaint.  Complaint Number: IN00445574 - Deficiency related to the allegations is cited at S0930.  Survey Date: 01/13/2025  Facility Number: 005109  QA: 02/06/2025		S 0000				
S 0930 Bldg. 00	QA: 02/06/2025  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 services failed to document pain assessment/reassessment in 2 of 5 patient (Patient 3 and 5) medical records reviewed; and failed to document catheter maintenance per policy in 1 of 5 patient (Patient 3) medical records reviewed.  Findings include:  1. Facility policy titled, Pain Management: Adult Pediatric, and Infant, PolicyStat 15498476, last approved 03/2024, indicated under POLICY STATEMENTS: B. Assessment and documentation of pre- and post-intervention is		S 09	930	p="" paraid="1928493946" paraeid="{4a1a85fe-82ed-4767-c01895ba7831}{80}"> Plan of Correction Complaint #: IN-004-455-74  1 Finding 1: Pain The nursing manager will proeducation and expectations in weekly update email and hudd with all nurses reviewing Policy Pain Management: Adult Pediatric, and Infant, by 3/7/25 Specifically focusing on minimassessment parameters include	ovide Iles y: 5. al	03/07/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Desiree Huebner-Tunny

Director of Acute Quality and Safety

02/27/2025

Any defiency statement 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.

State Form Event ID: 7EML11 Facility ID: 005109 If continuation sheet Page 1 of 7

PRINTED: 03/03/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		150128	B. WING			01/13/	/2025
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					COUNTY LINE RD S		
COMMUNITY HOSPITAL SOUTH							
COMINO	NITY HUSPITAL SC	JUTH		INDIAN	IAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΤF	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	necessary to evalua	te the effectiveness of that			intensity, description, location	of	
	intervention. Reasse	essment after pharmacologic			pain and intervention provided	if	
	intervention will be	done within 60 minutes. Under			appropriate. Additionally, if		
	GENERAL INFOR	MATION: A. Minimal			pharmacologic intervention is		
	assessment paramet	ters include intensity,			provided, post pain reassessm	ent	
	description, and loc	ation of pain. Under			is completed within 60 minutes	s of	
	PROCEDURE, I. D	Occument pain assessment,			administration.		
	pharmacologic and	non-pharmacologic			2 Finding 2: Suprapubic		
	interventions, side e	effects, and other symptoms.			Catheter		
	Under DOCUMEN	TATION: Document pain			The nursing manager will pro	ovide	
	assessment/symptor	ms and interventions in the			education and expectations in		
	electronic medical r	record in the appropriate			weekly update email and hudo	lles	
	flow-sheet.				with all nurses reviewing Polic	y:	
					Suprapubic Catheter: Changin	g,	
	2. Facility policy tit	tled, Suprapubic Catheter:			Maintenance and Discontinuat	ion,	
	Changing, Maintena	ance and Discontinuation.,			by 3/7/25. Focusing on		
	PolicyStat 1094880	5, last approved 03/2022,			documentation of maintenance	e Q8	
	indicated under PRO	OCEDURE: B. Maintenance of			hours. Additionally, if ordered	for	
		er, 17. Document maintenance.,			flushing of the suprapubic		
	under DOCUMENT	ГАТІОN: b. Maintenance Q			catheter, documentation of the	<b>;</b>	
	8hrs or unit protoco	ıl.			flush will be noted in the I and	0	
					flowsheet.		
	3. Review of Patien	at 3 medical record indicated the			<b>3</b> Finding 3: Pain and		
	following:				Suprapubic Catheter		
	_	admitted on 10/15/2024.			The nursing manager will pro	ovide	
		t 4:33 p.m., provider order			education and expectations in		
		ne patient's suprapubic			weekly update email and hudo		
	catheter with 10 mi	lliliters of normal saline every 8			with all nurses reviewing Polic	y:	
		ord lacked documentation for			Pain Management: Adult		
	the patient's entire h	nospitalization for suprapubic			Pediatric, and Infant, by 3/7/25	5.	
		he suprapubic catheter			Specifically focusing on minim	al	
		ibic catheter flowsheet lacked			assessment parameters include	le	
	complete document	ation of suprapubic catheter			intensity, description, location	of	
		licy on the following dates:			pain and intervention provided	if	
	·	2024, 10/20/2024, and 10/22/2024.			appropriate. Additionally, if		
		acked documentation of pain			pharmacologic intervention is		
	_	pharmacologic intervention on			provided, post pain reassessm		
		3 a.m., 10/17/2024 at 2:47 p.m.,			is completed within 60 minutes	s of	
		p.m., and 10/21/2024 at 8:34 p.m.			administration.		
	d. On 10/16/2024 medical record lacked pain				The nursing manager will pro	ovide	

State Form Event ID: 7EML11 Facility ID: 005109 If continuation sheet Page 2 of 7

PRINTED: 03/03/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		150128	B. WING		01/13/2025		
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
OOMMUNITY HOODITAL COLUTH			1402 E COUNTY LINE RD S				
COMMO	NITY HOSPITAL SO	JUTH		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	assessment docume	entation from 1 a.m. to 11:59			education and expectations in		
	p.m.				weekly update email and hudo	lles	
	e. On 10/17/2024 at	t 2:47 p.m. patient rated pain at			with all nurses reviewing Polic		
		d lacked documentation of pain			Suprapubic Catheter: Changir		
	location.	•			Maintenance and Discontinua	-	
	f. On 10/18/2024 at	9:29 a.m. the patient rated their			by 3/7/25. Focusing on	,	
		abdomen; medical record			documentation of maintenance	e Q8	
	1 ~	on of intervention for pain.			hours. Additionally, if ordered		
		t 11:31 a.m. patient rated pain at			flushing of the suprapubic		
		nedical record lacked			catheter, documentation of the	<b>;</b>	
		ntervention for pain.			flush will be noted in the I and		
		nedical record lacked pain			flowsheet.		
		entation from 12:00 a.m. to			4 Finding 4: Pain		
	11:59 p.m.				The nursing manager will pro	ovide	
		2:08 p.m. patient rated pain at			education and expectations in		
		d laced documentation of pain			weekly update email and hudo		
	location.	F			with all nurses reviewing Polic		
		8:19 a.m. patient rated pain at			Pain Management: Adult	<b>,</b>	
	1 ·	nedical record lacked			Pediatric, and Infant, by 3/7/25	5	
		ntervention for pain.			Specifically focusing on minim		
		F			assessment parameters include		
	4. Review of Patien	at 5's medical record indicated			intensity, description, location		
	the following:				pain and intervention provided		
	a. Patient was admi	tted on 09/26/2024.			appropriate. Additionally, if		
		t 8:43 a.m. patient rated pain at			pharmacologic intervention is		
		d lacked documentation of pain			provided, post pain reassessm	nent	
	reassessment and pa	_			is completed within 60 minutes		
	_	t 10:40 p.m. patient rated pain at			administration.		
		d lacked documentation of pain			5 Finding 5: Pain		
	reassessment and pa	_			The nursing manager will pro	ovide	
	Toussessinom una po				education and expectations in		
	5 Interview with A	2 (Quality Director) and A3			weekly update email and hudo		
		on 01/13/2024 at approximately			with all nurses reviewing Polic		
	• •	patient 5's medical record			Pain Management: Adult	y ·	
		on of pain reassessment and			Pediatric, and Infant, by 3/7/25	5	
	pain location.	on or pain reassessment una			Specifically focusing on minim		
	pain location.				assessment parameters include		
	6 Interview with A	2 and A5 (Director Medical			intensity, description, location		
		on 01/13/2024 at approximately			pain and intervention provided		
	3:30 p.m. indicated				appropriate. Additionally, if	11	
	J.50 p.m. maicated	the following.	1		appropriate. Additionally, if		

State Form Event ID: 7EML11 Facility ID: 005109 If continuation sheet Page 3 of 7

PRINTED: 03/03/2025 FORM APPROVED OMB NO. 0938-039

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150128	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/13/2025
	PROVIDER OR SUPPLIEF NITY HOSPITAL SO		1402 E	ADDRESS, CITY, STATE, ZIP COD E COUNTY LINE RD S NAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
IAU	a. Nursing documer in the urinary flows b. Patient 3's medic of suprapubic flush per provider order f hospitalization.  7. Interview with A approximately 3:50 related to patient 3's a. Lacked documen after pharmacologic 12:33 a.m., 10/17/2 2:08 p.m., and 10/2 b. Lacked documen on 10/18/2024 at 9: 7/10 in abdomen; o patient rated pain of 10/21/2024 at 8:19 their head. c. Lacked documen	nts suprapubic catheter flushes heets. al record lacks documentation es in the urinary flowsheets for the duration of the patient's  2 and A3 on 01/13/2024 at p.m. indicated the following s medical record: tation of pain reassessment entervention on 10/16/2024 at 024 at 2:47 p.m., 10/20/2024 at	TAG	pharmacologic intervention is provided, post pain reassessi is completed within 60 minute administration.  6 Finding 6: Suprapubic Catheter  The nursing manager will preducation and expectations in weekly update email and hud with all nurses reviewing Polic Suprapubic Catheter: Changi Maintenance and Discontinua by 3/7/25. Focusing on documentation of maintenance flushing of the suprapubic catheter, documentation of the flush will be noted in the I and flowsheet.  7 Finding 7: Pain  The nursing manager will preducation and expectations in weekly update email and hud with all nurses reviewing Polic Pain Management: Adult Pediatric, and Infant, by 3/7/2 Specifically focusing on minin assessment parameters incluintensity, description, location pain and intervention provided appropriate. Additionally, if pharmacologic intervention is provided, post pain reassessi is completed within 60 minute administration.  Monitoring Plan to Prevent Recurrence  To prevent the deficient recurring in the future, data monitoring will be initiated in	nent s of   rovide a diles by: ng, ation, se Q8 at for se a diles by: 5. nal de a of di if   ment s of sof

State Form Event ID: 7EML11 Facility ID: 005109 If continuation sheet Page 4 of 7

PRINTED: 03/03/2025 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150128	(X2) MULTIPLE CO A. BUILDING B. WING	00	COME	E SURVEY PLETED 3/2025
	ROVIDER OR SUPPLIE		1402 E	ADDRESS, CITY, STATE, ZIP CO COUNTY LINE RD S NAPOLIS, IN 46227	OD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE
				March 2025 and will be and discussed at the si and Safety committee in 8 months. Monitoring with a quarterly report of initial 8 month reporting department manager with the policy and documer requirements with the complete the desired an will complete any indivision follow-up.  Monitoring Plan for Initial (Pre-Intervention) reaswill be to reach a minimal documentation complial Monthly, 30 chart audicompleted to ensure pareceiving a pharmacologinatervention for pain has assessment documente the intervention. The awill be reported out in the Quality and Safety Commonitoring will occur for consecutive months. Consecutive	te Quality monthly, for vill continue out after the g cycle. The vill review ntation care team. ger will udits and dual staff  or Pain: (1) ) pain nin ssessment num of 95% nnce. dits will be atients ogical s a pain ed prior to nudit results he monthly nmittee. or eight orrective ing goal: complete d coaching  assessment ion: dits will be	

State Form Event ID: 7EML11 Facility ID: 005109 If continuation sheet Page 5 of 7

PRINTED: 03/03/2025 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150128	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 01/13/2025
	ROVIDER OR SUPPLIE		1402 E	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE RD S IAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				receiving a pharmacological intervention for pain, has a documented reassessment with 60 minutes. The audit results be reported out in the monthly Quality and Safety Committee Monitoring will occur for eight consecutive months. Corrective Action Plan if not meeting goaresponsible leader will complete individual follow up and coach of staff.  Data point: Pain (Post-Intervention) reassessment and (2) ordered flush documentation will be to reach a minimum of documentation compliance.  Monthly, up to 5 chart audits be completed to ensure patien with suprapubic catheters have assessment documentation completed every 8 hours per policy. The audit results will be reported out in the monthly Quand Safety Committee.  Monitoring will occur for eight consecutive months. Corrective Action Plan if not meeting goaresponsible leader will complete individual follow up and coach of staff.  Q8H Suprapubic Catheterizal Assessment Date of corrective action: 03/07/2025	ithin will / / / / / / / / / / / / / / / / / /

State Form Event ID: 7EML11 Facility ID: 005109 If continuation sheet Page 6 of 7

PRINTED: 03/03/2025 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP COD	
COMMUNITY HOSPITAL SOUTH  1402 E COUNTY LINE RD S INDIANAPOLIS, IN 46227	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X	(X5) PLETION ATE

State Form Event ID: 7EML11 Facility ID: 005109 If continuation sheet Page 7 of 7