Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER		(X3) DATE SURVEY COMPLETED						
			A. BUILDING:		С						
		011506	B. WING		03/17/2021						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
INDIANA UNIVERSITY HEALTH ARNETT HOSPITAL 5165 MCCARTY LN LAFAYETTE, IN 47905											
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE						
S 000	INITIAL COMMENTS		S 000								
	This visit was for the investigation of two state licensure hospital complaints.										
	Complaint Number: IN00266631										
	Unsubstantiated: State deficiency unrelated to the allegation is cited.										
	Complaint Number: IN00291963										
	Substantiated: State allegation cited.	deficiency related to the									
	Facility Number: 011506										
	Date of Survey: 03/17/21										
	QA: 3/22/21										
S 930	410 IAC 15-1.5-6 NURSING SERVICE		S 930		4/19/21						
	410 IAC 15-1.5-6 (b)((3)									
	(b) The nursing service following:	ce shall have the									
	(3) A registered nurse and evaluate the care provided to each patie	e planned for and									
	failed to provide pain reassessments in 9 o	review and interview, nursing assessments and/or									
	Findings Include:										

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

TITLE (X6) DATE

PRINTED: 04/22/2021 FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED				
		011506	B. WING		I	C 17/2021				
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH ARNETT HOSPITAL LAFAYETTE, IN 47905										
(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 (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLE' CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) (X5)		COMPLETE				
S 930	1. Review of policy ti Management Guidelin 07/2017 (policy curre indicated that "Pain a interventionspain redocumented in the path 2. Review of Patient' 12's medical records presentation to the Ellacked documentation 3. Interview on 03/17 (Manager Emergency confirmed that it is the	tled: Pain Assessment and thes - Adults, approved int at time of complaint) issessmentpain eassessmentare atient's medical record". Is 1, 3, 4, 5, 8, 9, 10, 11 and indicated a pain level upon mergency Department, but in of further reassessments. If 21 at 11:30 am with P53 or Department {ED}) is expectation of nursing to document a patient's pain	S 930							

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