PRINTED: 06/12/2023 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 150088		A. BUILDING <u>00</u> B. WING			COMPLETED 04/06/2023	
		100000	D. WI		DDDEGG CHTM OTHER TWO CON	0-1/00/	2020	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
ASCENS	ION ST VINCENT A	ANDERSON			SON, IN 46016			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG S 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	Birtonivery		DATE	
Bldg. 00	This visit was for investigation of a state licensure hospital complaint.		S 00	000				
	_	: IN00404247 - State deficiency tions is cited at S1510.						
	Date of Survey: 4/6	5/23						
	Facility Number: 005078							
	QA: 4/24/23 & 6/2	/23						
S 1510	410 IAC 15-1.6-2							
Bldg. 00	EMERGENCY SE 410 IAC 15-1.6-2(							
	(b) The emergenc the following:	y service shall have						
	emergency service	I care provided in the e are established by ng responsibility of The policies shall e limited to, the						
	of all patients pres emergency and ob (C) Provision for tr	ostetrical care.						
	provided.							
	Based on document	review and interview, the	S 15	510	All emergency department nur	rsing	05/01/2023	
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURI		TITLE		(X6) DATE	

(X6) DATE

Jennifer Lefler Regional Director of Regulatory 06/09/2023

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.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 150088		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/06/2023			
NAME OF PROVIDER OR SUPPLIER  ASCENSION ST VINCENT ANDERSON			STREET ADDRESS, CITY, STATE, ZIP COD 2015 JACKSON ST ANDERSON, IN 46016				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY 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)	ΓE	(X5) COMPLETION DATE
PREFIX TAG	resultation of acility failed to ensure policy related to parameter policy related to parameter policy related to parameter patients for 3 of 5 m (Patients #1, 2 and ensure nursing staff to vital assessments reviewed (Patients #1). Facility policy the Vital Signs Documer reviewed/revised of following: "DEFIN Temperature, blood respiratory rate, pulticomprehensive pair Emergency Severity tool used to determ wait when seeking standard of care in Department patient the ongoing assessment emergency services following criteria: A signs recorded in the Emergency Department patient's a condition deteriorate Vital signs will be patient's dispossity documented in the patient's disp	R LSC IDENTIFYING INFORMATION sure nursing staff followed their in assessment/reassessment of nedical records reviewed 3). The facility also failed to 6 followed their policy related 8 for 2 of 5 medical records #1 and 3).  Ittled "Ongoing Assessment and entation Standards" last 10 6/2020 indicated the ITIONS: Vital signs - 10 pressure, heart rate, 11 see oximetry, and 12 scale. ESI - Triage Level - 13 y Index (ESI) is a 5 level acuity 13 ine how safely patients can 15 emergency care. It is the 16 triaging Emergency 16 sGUIDELINES: Document 17 nent and vital signs of 18 patients utilizing the 19 A. All patients shall have vital 10 te triage portion of the 10 ment medical record. B. Vital 11 sessed and documented based 12 cuity and/or as his or her 13 feet per clinical judgement. C. 14 overformed within one (1) hour of 15 tion tohomeand 16 patient's medical record. 17 iven an ESI level of 4 or 5 will 18 vital signs every 8 hours 18 ving cases: 3. Procedures are 18 saary treatment of the patient. 18 clow5. Discharged home or 19 pital. F. Adult patients given		PREFIX TAG	staff were educated by 4/20/20 on the documentation requirements for vital signs (temperature, blood pressure, heart rate, respiratory rate, pull oximetry and comprehensive pscale) and pain assessments/reassessment. They were educated that all emergency department patient will have vital signs completed triage and within one hour of discharge. The cycling of vital signs will occur on a cycle dependent on their acuity lever the Emergency Severity Index (ESI) level assigned. All emergency department nursing staff were given/emailed a copthe policies titled "Ongoing Assessment and Vital Sign Documentation Standards" and "Pain Management: Adult and Pediatric" by 4/20/2023.  To reinforce the above educativital sign and pain documentativital signs and huddle notes on 3 separate occasions in April 2023.  Compliance monitoring: The Emergency Department will rea random sample of 20 charts month to verify that vital signs pain documentation is complete these audit until compliance is achieved for	D23, see pain ts in I by g y of d fon, cion ed in view per and ded. ss or a	COMPLETION DATE
	an ESI level of 1, 2	, or 3 will require vital signs			quarter. Then random audits w	/ill	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 150088			JILDING	instruction 00	(X3) DATE : COMPL <b>04/06</b> /	ETED		
NAME OF PROVIDER OR SUPPLIER  ASCENSION ST VINCENT ANDERSON			STREET ADDRESS, CITY, STATE, ZIP COD 2015 JACKSON ST ANDERSON, IN 46016					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY 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)	ΓE	(X5) COMPLETION DATE	
	condition, and med more frequent vital	e to acuity, the patient's clinical ical treatments that warrant signs. The standard minimum			be completed quarterly to ensu ongoing compliance.			
	Ongoing reassessm score within (1) hor sedation medication management in the follow the compreh parameters as outlin Adult and Pediatric	•			Responsible Person: Regional Director of Emergency Service			
	and Pediatric" last indicated the follow RECOGNIZE ANI Pain Assessment - 2 patient history upon	ttled "Pain Management: Adult reviewed/revised on 12/2021 ving: "STANDARD I. D TREAT PAIN PROMPTLY: I. 24 Hour Care Settings. Initial andmission is to include a						
	based on patient sel specified by orderin classification will b 0-10 point scale. M scale. Severe = 7-10	n assessment when appropriate f-report. Unless otherwise ng physician, pain e as follows: Mild = 1-3 on a oderate = 4-6 on a 0-10 point 0 on a 0-10 point scale. Pain will fter a known pain producing						
	event or patient cor management interv period has elapsed effect. IV (intraven reassessed within 6 (intramuscular)Po	nplaint. After each pain ention, once a sufficient time for treatment to reach peak ous) medicationsmust be						
	the following: (a.) The patient arr 2:35 a.m. via EMS	ived to the ED on 3/14/23 at (Emergency Medical Services) oft leg pain and discharged to 5:10 a.m.						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150088	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	СОМ	E SURVEY PLETED 06/2023
	PROVIDER OR SUPPLIER		2015 J	ADDRESS, CITY, STATE, ZIP CO ACKSON ST RSON, IN 46016	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	(b.) Patient #1 was with an acuity level	triaged on 3/14/23 at 2:38 a.m. of 4.				
	completed on 3/14/a pain level of 10 o assessment indicate pressure: 145/84 m heart rate: 45 beats minute, and a temp Fahrenheit. The modocumentation of a hour and/or prior to home from the ED.  (d.) A review of Pa Administration Recadministered that in the following:  On 3/14/23 at 2:56 by mouth. The med documentation of a minutes after the pattern being di	atient #1's Medication were included but were not limited to a.m., Ibuprofen 600 milligrams lical record lacked pain level reassessment 90 min intervention and/or prior to scharged to home.				
	Release 7.5 milligra record lacked document reassessment 90 mi	a.m., Morphine Immediate ams by mouth. The medical mentation of a pain level nutes after pain intervention patient being discharged to				
	the following:  (a.) The patient arr  9:57 a.m. for composition discharged to home	nt #2's medical record indicated ived to the ED on 3/14/23 at laints of abdominal pain and on 3/14/23 at 12:25 p.m.				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150088	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 04/06/	ETED
	PROVIDER OR SUPPLIER		2015 J	ADDRESS, CITY, STATE, ZIP COD ACKSON ST RSON, IN 46016		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	pancreatitis.  (b.) Patient #2 was with an acuity level  (c.) The medical re assessment was con a.m., the patient had  (d.) The medical re assessment was con a.m., the patient had  (e.) A review of Pa Administration Recadministered that in the following:  On 3/14/23 at 10:34 intravenous. The medicumentation of pminutes after pain in On 3/14/23 at 12:17 intravenous. The medicumentation of ppain medication adr p.m. and/or prior to to home.  5. Review of patient the following:  (a.) The patient arr. 10:57 a.m. for computing discharged to home #3 had a discharge function and chest purpose the following:  (b.) Patient #3 was	triaged on 3/14/23 at 10:11 a.m. of 3.  cord indicated a pain level inpleted on 3/14/23 at 10:11 id a pain level of 8 out of 10.  cord indicated a pain level inpleted on 3/14/23 at 10:21 id a pain level of 8 out of 10.  tient 2's Medication in ord indicated medications were included but were not limited to included but were not limited to intervention.  7 p.m., Dilaudid 1 milligrams edical record lacked ain level reassessment 60 intervention.  7 p.m., Dilaudid 1 milligrams edical record lacked ain level assessment prior to innistration on 3/14/23 at 12:17 in the patient being discharged int #3's medical record indicated int #3's medical record indicated intervention of 3/14/23 at 1:24 p.m. Patient diagnosis of decreased renal pain.  triaged on 3/14/23 at 11:06 a.m.				
	(b.) Patient #3 was with an acuity level					

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AND PLAN OF COR		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150088	(X2) MULTIPI A. BUILDIN B. WING		RUCTION 00	(X3) DATE : COMPL 04/06/	ETED	
NAME OF PROVIDER OR SUPPLIER  ASCENSION ST VINCENT ANDERSON			STREET ADDRESS, CITY, STATE, ZIP COD 2015 JACKSON ST ANDERSON, IN 46016					
	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAC	CI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE	
com a pai asse: press mint temp med asse: #3's  (d.) asse: a.m.  (e.) Adm adm the f  (f.) by n docu mint Patic  (g.) micr lack mint Patic  6. E Coor the r and 7. E	pleted on 3/14/2 in level of 8 out segment indicated sure: 174/91 mm ate, 16 respiration perature of 97.9 ical record lacked segment within an discharge to hor The medical recessment was compared to the patient had A review of Pataninistration Recomment and the patient had a review of Pataninistration Recomment at the patient had a review of Pataninistration of a patent and the patient had a review of Pataninistration of a patent had a patent had a review of Pataninistration of a patent had a patent had a review of a patent had a record in the patient had a review of a patent had a record in the patient had a review of a patent had a revi	a pain level/vitals assessment 23 at 11:06 a.m., the patient had of 10. Patient #3's vitals d the following: blood nHg, heart rate: 73 beats per ons per minute, and a degrees Fahrenheit. The ed documentation of a vitals in hour and/or prior to Patient me from the ED.  cord indicated a pain level inpleted on 3/14/23 at 11:21 It a pain level of 8 out of 10.  tient #3's Medication ord indicated medications were cluded but were not limited to  1:55 a.m., Aspirin 324 milligrams ical record lacked pain level reassessment 90 intervention and/or prior to to home from the ED.  1:55 a.m., Fentanyl 50 inous. The medical record on of pain level assessment 60 intervention and/or prior to to home from the ED.  iew with A5 (Regulatory //23 at 3:15 p.m., he/she verified information for Patients #1, 2  iew with A6 (Regional Director 23 at 4:55 p.m., he/she verified						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150088	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  04/06/2023		
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	that per policy patient vitals assessments were to be completed based on the patient's ESI (Emergency Severity Index) level and within one hour of the patient's discharge from the facility.  A6 verified that the patient's vitals assessments were also to be completed upon triage/admit to the Emergency Department. A6 verified that per policy pain level assessments should be completed prior to pain medication administration, within one hour after intravenous pain medication administration and/or within 90 minutes after by mouth/intramuscular administration of pain medication. A6 also verified that a pain level assessment should be completed within one hour of discharge and at triage/admit to the Emergency Department.							

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