STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150088	A. BUILDING 00 B. WING	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION ST VINCENT ANDERSON	2015 JACKSON ST ANDERSON, IN 46016

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S 0000 Bldg. 00	This visit was for investigation of a state licensure hospital complaint. Complaint Number: IN00404247 - State deficiency related to the allegations is cited at S1510. Date of Survey: 4/6/23 Facility Number: 005078 QA: 4/24/23 & 6/2/23	S 0000		
S 1510 Bldg. 00	410 IAC 15-1.6-2 EMERGENCY SERVICES 410 IAC 15-1.6-2(b)(2)(A)(B)(C) (b) The emergency service shall have the following: (2) Written policies and procedures governing medical care provided in the emergency service are established by and are a continuing responsibility of the medical staff. The policies shall include, but not be limited to, the following: (A) Provision for the care of the disturbed patient. (B) Provision for immediate assessment of all patients presenting for emergency and obstetrical care. (C) Provision for transfer of patients when care is needed which cannot be provided. Based on document review and interview, the	S 1510	All emergency department nursing	05/01/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Lefler	Regional Director of Regulatory	06/09/2023

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	facility failed to ensure nursing staff followed their policy related to pain assessment/reassessment of patients for 3 of 5 medical records reviewed (Patients #1, 2 and 3). The facility also failed to ensure nursing staff followed their policy related to vital assessments for 2 of 5 medical records reviewed (Patients #1 and 3). Findings include: 1. Facility policy titled "Ongoing Assessment and Vital Signs Documentation Standards" last reviewed/revised on 6/2020 indicated the following: "DEFINITIONS: Vital signs - Temperature, blood pressure, heart rate, respiratory rate, pulse oximetry, and comprehensive pain scale. ESI - Triage Level - Emergency Severity Index (ESI) is a 5 level acuity tool used to determine how safely patients can wait when seeking emergency care. It is the standard of care in triaging Emergency Department patients...GUIDELINES: Document the ongoing assessment and vital signs of emergency services patients utilizing the following criteria: A. All patients shall have vital signs recorded in the triage portion of the Emergency Department medical record. B. Vital signs are to be reassessed and documented based upon the patient's acuity and/or as his or her condition deteriorates per clinical judgement. C. Vital signs will be performed within one (1) hour of the patient's disposition to...home...and documented in the patient's medical record. D. Adult patients given an ESI level of 4 or 5 will require documented vital signs every 8 hours except in the following cases: 3. Procedures are performed for necessary treatment of the patient. See Section "M" below...5. Discharged home or admitted to the hospital. F. Adult patients given an ESI level of 1, 2, or 3 will require vital signs		staff were educated by 4/20/2023, on the documentation requirements for vital signs (temperature, blood pressure, heart rate, respiratory rate, pulse oximetry and comprehensive pain scale) and pain assessments/reassessment. They were educated that all emergency department patients will have vital signs completed in triage and within one hour of discharge. The cycling of vital signs will occur on a cycle dependent on their acuity level by the Emergency Severity Index (ESI) level assigned. All emergency department nursing staff were given/emailed a copy of the policies titled “Ongoing Assessment and Vital Sign Documentation Standards” and “Pain Management: Adult and Pediatric” by 4/20/2023. To reinforce the above education, vital sign and pain documentation requirements were also included in daily huddle discussions and huddle notes on 3 separate occasions in April 2023. Compliance monitoring: The Emergency Department will review a random sample of 20 charts per month to verify that vital signs and pain documentation is completed. They will complete these audits until compliance is achieved for a quarter. Then random audits will	

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	more frequently due to acuity, the patient's clinical condition, and medical treatments that warrant more frequent vital signs. The standard minimum of documented vital signs is every 4 hours. M. Ongoing reassessment of vital signs and pain score within (1) hour of receiving pain and/or sedation medications. Patients receiving any pain management in the Emergency Department will follow the comprehensive pain assessment parameters as outlined in the "Pain Management: Adult and Pediatric Policy..." 2. Facility policy titled "Pain Management: Adult and Pediatric" last reviewed/revised on 12/2021 indicated the following: "STANDARD I. RECOGNIZE AND TREAT PAIN PROMPTLY: I. Pain Assessment - 24 Hour Care Settings. Initial patient history upon admission is to include a comprehensive pain assessment when appropriate based on patient self-report. Unless otherwise specified by ordering physician, pain classification will be as follows: Mild = 1-3 on a 0-10 point scale. Moderate = 4-6 on a 0-10 point scale. Severe = 7-10 on a 0-10 point scale. Pain will also be assessed: After a known pain producing event or patient complaint. After each pain management intervention, once a sufficient time period has elapsed for treatment to reach peak effect. IV (intravenous) medications....must be reassessed within 60 minutes. IM (intramuscular)...PO (by mouth) immediate-release medications must be reassessed within 90 minutes..." 3. Review of patient #1's medical record indicated the following: (a.) The patient arrived to the ED on 3/14/23 at 2:35 a.m. via EMS (Emergency Medical Services) for complaints of left leg pain and discharged to home on 3/14/23 at 5:10 a.m.		be completed quarterly to ensure ongoing compliance. Responsible Person: Regional Director of Emergency Services	

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	(b.) Patient #1 was triaged on 3/14/23 at 2:38 a.m. with an acuity level of 4. (c.) Patient #1 had a pain level/vitals assessment completed on 3/14/23 at 2:38 a.m., the patient had a pain level of 10 out of 10. Patient #1's vitals assessment indicated the following: blood pressure: 145/84 mmHg (millimeter of mercury), heart rate: 45 beats per minute, 20 respirations per minute, and a temperature of 97.8 degrees Fahrenheit. The medical record lacked documentation of a vitals assessment within an hour and/or prior to Patient #1's discharge to home from the ED. (d.) A review of Patient #1's Medication Administration Record indicated medications were administered that included but were not limited to the following: On 3/14/23 at 2:56 a.m., Ibuprofen 600 milligrams by mouth. The medical record lacked documentation of a pain level reassessment 90 minutes after the pain intervention and/or prior to the patient being discharged to home. On 3/14/23 at 2:56 a.m., Morphine Immediate Release 7.5 milligrams by mouth. The medical record lacked documentation of a pain level reassessment 90 minutes after pain intervention and/or prior to the patient being discharged to home. 4. Review of patient #2's medical record indicated the following: (a.) The patient arrived to the ED on 3/14/23 at 9:57 a.m. for complaints of abdominal pain and discharged to home on 3/14/23 at 12:25 p.m. Patient #2 had a discharge diagnosis of chronic			

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	pancreatitis. (b.) Patient #2 was triaged on 3/14/23 at 10:11 a.m. with an acuity level of 3. (c.) The medical record indicated a pain level assessment was completed on 3/14/23 at 10:11 a.m., the patient had a pain level of 8 out of 10. (d.) The medical record indicated a pain level assessment was completed on 3/14/23 at 10:21 a.m., the patient had a pain level of 8 out of 10. (e.) A review of Patient 2's Medication Administration Record indicated medications were administered that included but were not limited to the following: On 3/14/23 at 10:34 a.m., Dilaudid 1 milligrams intravenous. The medical record lacked documentation of pain level reassessment 60 minutes after pain intervention. On 3/14/23 at 12:17 p.m., Dilaudid 1 milligrams intravenous. The medical record lacked documentation of pain level assessment prior to pain medication administration on 3/14/23 at 12:17 p.m. and/or prior to the patient being discharged to home. 5. Review of patient #3's medical record indicated the following: (a.) The patient arrived to the ED on 3/14/23 at 10:57 a.m. for complaints of chest pain and discharged to home on 3/14/23 at 1:24 p.m. Patient #3 had a discharge diagnosis of decreased renal function and chest pain. (b.) Patient #3 was triaged on 3/14/23 at 11:06 a.m. with an acuity level of 2.			

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	(c.) Patient #3 had a pain level/vitals assessment completed on 3/14/23 at 11:06 a.m., the patient had a pain level of 8 out of 10. Patient #3's vitals assessment indicated the following: blood pressure: 174/91 mmHg, heart rate: 73 beats per minute, 16 respirations per minute, and a temperature of 97.9 degrees Fahrenheit. The medical record lacked documentation of a vitals assessment within an hour and/or prior to Patient #3's discharge to home from the ED. (d.) The medical record indicated a pain level assessment was completed on 3/14/23 at 11:21 a.m., the patient had a pain level of 8 out of 10. (e.) A review of Patient #3's Medication Administration Record indicated medications were administered that included but were not limited to the following: (f.) On 3/14/23 at 11:55 a.m., Aspirin 324 milligrams by mouth. The medical record lacked documentation of a pain level reassessment 90 minutes after pain intervention and/or prior to Patient #3 discharge to home from the ED. (g.) On 3/14/23 at 11:55 a.m., Fentanyl 50 micrograms intravenous. The medical record lacked documentation of pain level assessment 60 minutes after pain intervention and/or prior to Patient #3 discharge to home from the ED. 6. During an interview with A5 (Regulatory Coordinator) on 4/6/23 at 3:15 p.m., he/she verified the medical record information for Patients #1, 2 and 3. 7. During an interview with A6 (Regional Director Regulatory) on 4/6/23 at 4:55 p.m., he/she verified			

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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.			