STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150030	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HENRY COUNTY MEMORIAL HOSPITAL	1000 N 16TH ST NEW CASTLE, IN 47362

(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 an investigation of a State Licensure Hospital Complaint. Complaint Number: IN00427332 - Deficiency related to the allegations is cited at S0930. Survey Date: 02/26/2024 Facility Number: 005028 QA: 2/29/2024 & 3/1/2024	S 0000	Not Applicable	
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, the facility failed to ensure that patient's pain was assessed upon admission or reassessed following pharmacologic intervention in 3 out of 5 (patients 2, 3, and 4) medical records reviewed. Findings include: 1. Review of policy titled, "4.4 Patient Assessment", last updated 04/2022, indicated all patients will have their pain assessed in the initial assessment in triage, patients will be reassessed for their response to medication and comfort mearsures performed to allevate pain or	S 0930	Corrective action plan for State Board of Health citation We will start using the acronym A.I.R.- Assess Intervene Reassess We plan to have reminder cards made to place on the work stations. All staff to be educated on this acronym and policy 4.4 by March 31, 2024.	04/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shelley Wilson	Chief Nursing Officer	03/12/2024

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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	discomfort for their effectiveness, and the nurse must document in the medical record. 2. Review of Patients 2 and 3's medical records lacked documentation of a pain assessment upon arrival to the emergency department in triage and patient 4's medical record lacked documentation of a pain reassessment after pharmacologic intervention. 3. Interview with A1 (Chief Nursing Officer) on 02/26/2024 at 1:20 p.m. confirmed Patient 2 and 3's medical record lacked documentation of a pain assessment in triage and patient 4's medical record lacked documentation of pain reassessment after pharmacological intervention.		We will include pain policy compliance in our chart reviews The Director and Charge Nurses currently review all ED charts to ensure charging accuracy, we will add reviews of the triage note, pain assessments and reassessments, specifically looking for numeric values, reassessment after interventions, and acceptable pain levels. The ED Director and Charge Nurses will review the weekly report from the pharmacy listing all pain medications administered in the ED. This report will assist with identifying patients who required reassessment after pharmacologic invention. Staff will use the Medication Reassessment button on the wall panel as a reminder to reassess after interventions. Activating this button will send a reminder to the RN"s communication device for pain reassessment. If we discover issues with compliance, staff will have reinforcement training with the Department Educator on A.I.R and policy 4.4 Patient Assessment. A second failure will result in written counseling. Continued failures will result in disciplinary actions, including termination if the behavior is not corrected.	

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			The goal is to achieve three consecutive months of 100% compliance. Once this is achieved, then 20% of charts will be reviewed for 100% compliance for 3 consecutive months. Following this random chart audits will be completed to monitor continued compliance.	