STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	150074	A. BUILDING 00 B. WING	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY HOSPITAL EAST	1500 N RITTER AVE INDIANAPOLIS, IN 46219

(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: IN00425027 - Deficiency unrelated to the allegations is cited at S0930. Survey Date: 02/20/2024 Facility Number: 005068 QA: 3/11/2024 & 3/12/2024	S 0000		
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 reassessed following pharmacologic intervention or prior to discharge for 2 of 5 (patient 3 and 5) medical records reviewed; and failed to ensure that patient's pain was assessed upon admission for 1 of 5 (patient 5) medical records reviewed. Findings include: 1. Review of policy titled, "Pain Management: Adult, Pediatric, and Infant", PolicyStat ID 12591817, approved 01/2023, indicated patients	S 0930	**Plan of Correction** 410 IAC 15-1.5-6 (b)(3) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. The Rule not met as evidenced by: Based on document review and interview, the facility failed to ensure that patient's pain was reassessed following pharmacologic	04/11/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brett Shipley	Director of Quality	04/04/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150074	A. BUILDING 00 B. WING	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY HOSPITAL EAST	1500 N RITTER AVE INDIANAPOLIS, IN 46219

(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
	will have their pain assessed at admission, assessed post-intervention to evaluate the effectiveness of that intervention, and reassessed after pharmacologic intervention within 60 minutes. 2. Review of Patient 3's medical record lacked documentation on pain assessment after pharmacologic intervention and prior to discharge and Patient 5's medical record lacked documentation of pain assessment upon admission, after pharmacologic intervention, and prior to discharge. 3. Interview with A4 (Quality and Safety Coordinator for Emergency Department) on 02/20/2024 at 11:55 a.m. confirmed Patient 3's medical record lacked documentation of pain reassessment after pharmacological intervention and prior to discharge. 4. Interview with A4 on 02/20/2024 at 12:35 p.m. confirmed Patient 5's medical record lacked documentation of a pain assessment upon admission, prior to medication administration, reassessment after pain medication administration, and prior to discharge.		intervention or prior to discharge for 2 of 5 (patient 3 and 5) medical records reviewed; and failed to ensure that patient's pain was assessed upon admission for 1 of 5 (patient 5) medical records reviewed. The “Pain Management: Adult, Pediatric, and Infant” policy was revised to defer to department specific policies for if pain assessment is required at admission, as it was not intended to guide the practice of the Emergency Department triage “admission” process. This revision of the policy was approved by the Acute Care Pain Management Committee on 3/20/2024. The Emergency Department follows the policy “Triage, Emergency Department,” which indicates that pain assessment may be included as part of the triage assessment process, as not all patients are appropriate for a nursing pain assessment during triage. Emergency Department leadership will provide education and expectations regarding clinically appropriate pain assessment during the triage process in mandatory staff meetings occurring on 4/11/2024. Emergency department leadership reviewed policy expectations in “Pain Management: Adult, Pediatric, and Infant” for pain	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150074	A. BUILDING 00 B. WING	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY HOSPITAL EAST	1500 N RITTER AVE INDIANAPOLIS, IN 46219

(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
			assessment before, and within 60 minutes after, pharmacological intervention in staff huddles beginning 3/25/2024. Additionally, supporting education outlining expected practices was sent by e-mail to caregivers on 3/25/2024. Emergency Department leadership will provide education and expectations regarding pain assessment prior to, and within 60 minutes after, pharmacological intervention during mandatory staff meetings occurring on 4/11/2024. **Monitoring Plan to Prevent Recurrence** **1** Monthly, 30 chart audits will be completed to ensure patients receiving a pharmacological intervention for pain has a pain assessment documented prior to the intervention. The audit results will be reported out in the monthly Emergency Department leadership meeting and the hospital based monthly Quality and Safety Committee. Monitoring will occur for eight consecutive months. **2** Monthly, 30 chart audits will be completed to ensure patients receiving a pharmacological intervention for pain in the emergency department have a documented reassessment within 60 minutes or before discharge, whichever is first. The audit results will be reported out in the monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	150074	A. BUILDING 00 B. WING	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY HOSPITAL EAST	1500 N RITTER AVE INDIANAPOLIS, IN 46219

(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
			Emergency Department leadership meeting and the hospital based monthly Quality and Safety Committee. Monitoring will occur for eight consecutive months. **3** Monthly, 30 chart audits will be completed to ensure compliance with the policy “Triage, Emergency Department” related to clinically appropriate pain assessment at triage. The audit results will be reported out in the monthly Emergency Department leadership meeting and the hospital based Quality and Safety Committee. Monitoring will occur for eight consecutive months. **Responsible Person** Director of Nursing, Emergency Services	