STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	150034		12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY MEDICAL CENTER INC	1500 S LAKE PARK AVE HOBART, IN 46342

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 0000 Bldg. 00	This visit was for investigation of a State hospital complaint. Complaint Number: IN00170428 Substantiated: deficiency cited related to allegations. Date: 12/3/15 Facility Number: 005786 QA: cjl 01/08/16	S 0000	tag deficiency noted during inspection Responses submitted 1/26/16	
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 staff interview, nursing staff failed to supervise and evaluate the nursing care for each patient related to reassessment of pain after an intervention for 1 of 5 (#1) closed patient medical records reviewed.	S 0930	1Re-education of nursing via email on the policy and standards visual cues will be implemented on screen savers and flyers in all nursing units Pain reassessment will be included on the agenda of nursing committees and meetings 2 An ongoing audit for	02/10/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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: 150034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER ST MARY MEDICAL CENTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 S LAKE PARK AVE HOBART, IN 46342	

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	Findings: 1. Policy ADPC 16.1, Pain Assessment and Management, revised/reapproved 4/2015, indicated on pg. 2, point 1.5., "Reassessment is required after any intervention." 2. Review of closed patient medical records confirmed: A. patient #1 was admitted 3/20/15 at 1901 hours and part of treatment was for pain control of cellulitis of left lower extremity. Dilaudid and Norco were prescribed for pain relief. According to the Medication Administration Record on 3/22/15, one tablet of Norco 10-325 mg per tablet was administered to patient at 0313 and 0702 hours, with a pain level of 8 of 10 both times. B. pain level reassessment was lacking after each intervention. 3. Staff 3 (System and Regulatory Manager) was interviewed on 12/3/15 at approximately 1350 hours and confirmed administration of pain medication is an intervention that is to be reassessed related to pain level as required by facility policy and procedure.		compliance of this standard will be implemented and reported to Nursing Quality Council 3 Debbie Krejci System and Regulatory Manager 4 Education will be completed by 2/10/16 and audit implemented	