PRINTED: 08/28/2024 FORM APPROVED OMB NO. 0938-039

08/28/2024

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII TIPI E C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		COMPLETED	
AND PLAN OF CORRECTION		150056	A. BUILDING 00 B. WING		07/31/2024	
			_		0170172027	
NAME OF P	ROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP COD		
INDIANA	UNIVERSITY HEA	ALTH		N SENATE BLVD NAPOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
A 0000						
Bldg. 00						
ышу. 00			A 0000			
	This visit was for a	n investigation of a Federal	A 0000			
	Hospital Complaint	_				
	Troopium compium					
	Complaint Number	· IN00436897 - Deficiency				
	unrelated to the alle	egations is cited at A0395.				
	Survey Date: 07/31	/2024				
	Facility Number: 0	005051				
	QA: 08/05/2024					
	Q11. 00/00/2021					
A 0395	482.23(b)(3)					
	RN SUPERVISIO	N OF NURSING CARE				
Bldg. 00	_	e must supervise and				
	evaluate the nursi	ing care for each patient.				
	D 1 1		A 0395	Starting 8/26/24, all RNs in th	ne 08/30/2024	
		t review and interview, nursing		unit were re-educated on the		
		omplete fall risk shift		facility policy titled "Fall	-t-ti	
	medical records rev	(10 (Patients 2, 4, 6, 7, 8, and 9)		Prevention" and the documer		
	medicai records rev	riewed.		requirements that it stipulates Education is provided via em		
	Findings include:			staff meetings and daily safet		
	- manage merade.			huddle in an ongoing manner	· I	
	1. Facility policy ti	tled, Fall Prevention, published				
		ted under VI. Procedures,		Prevent Recurrence:		
	Assessment, A. Fal	l Risk assessment should be		During the 30 days post-educ	cation	
	completed: b. Once	per shift.		the following will take place:		
				B5C5 leaders will complete		
		nt 2's medical record lacked		audits on 10 patients per wee	l l	
		all risk shift assessments on		documentation of completion	of fall	
	02/03/2024 night sl	hift and 02/04/2024 day shift.		risk assessment on the two		
				previous shifts to achieve 90°	% or	
		nt 4's medical record lacked		greater compliance.		
		all risk shift assessments on		Any identified gaps will	a a	
	03/23/2024 night sl	hift, 03/24/2024 day shift, and		immediately be discussed wit	tn tne	
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE	

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 disclodays 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.

Jason

Owen

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		IDENTIFICATION NUMBER 150056	A. BUILDING B. WING	00	COMPLETED 07/31/2024		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD				
INDIANA UNIVERSITY HEALTH		1701 N SENATE BLVD INDIANAPOLIS, IN 46202					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		1	
TAG	03/24/2024 night shift.		TAG	staff on an individual basis util	DATE		
	03/24/2024 Hight Sh	iii.		Just Culture including initial	121119		
	4. Review of Patient	t 6's medical record lacked		coaching with escalation to			
	documentation of a	fall risk shift assessment on		performance improvement pla	n, if		
	03/27/2024 night shift.			applicable for continuous			
				improvement.			
		t 7's medical record lacked		This audit will be completed to			
		ill risk shift assessments on		three months, with expectation			
	_	ift, 04/19/2024 day shift,		for 90% compliance or greater			
	04/21/2024 day shif	t, and 04/22/2024 night shift.		this threshold is achieved, the	n		
	6 Davious of Dation	t 8's madical record leaked		the auditing process will be			
	6. Review of Patient 8's medical record lacked			transitioned to a periodic spot audit. If the referenced threshold is			
	documentation of fall risk shift assessments on 04/10/2024 night shift, 04/11/2024 night shift,			not met, then consistent auditing			
	_	t, 04/26/2024 night shift,		will continue until such time that			
	04/27/2024 day shift, 04/27/2024 night shift, 04/27/2024 day shift, 04/27/2024 night shift,			data for a consecutive three-month			
	04/28/2024 day shift, 04/28/2024 night shift,			period reflects achievement of the			
	05/10/2024 day shift	t, 05/11/2024 day shift,		90% threshold.			
	05/14/2024 day shif	t, and 05/16/2024 night shift.					
				Responsible for Corrective Ac			
		t 9's medical record lacked		Manager – Clinical Operation	ns		
		all risk shift assessments on		Completion Date:			
	05/07/2024 day shift, 05/11/2024 day shift, and			Completion Date: 8/30/24			
	05/12/2024 night shift.			0/30/24			
	8. Interview with A.	3, (Clinical Nurse Specialist),					
		proximately 4:55 p.m. confirmed					
	Patients 2, 4, 6, 7, 8	, and 9's medical record lacked					
	documentation of fa	ll risk assessments as					
	indicated above.						
0.000							
S 0000							
Bldg. 00							
Diag. 00			S 0000				
	This visit was for ar	n investigation of a State	5 0000				
	Licensure Hospital	_					
	-						
	-	IN00436897 - Deficiency					
	unrelated to the alle	gations is cited at S0930.					

State Form Event ID: 1|Y|11 Facility ID: 005051 If continuation sheet Page 2 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150056	(X2) MULTIPLE C A. BUILDING B. WING	OO OO	(X3) DATE SURVEY COMPLETED 07/31/2024
	PROVIDER OR SUPPLIER		1701 1	ADDRESS, CITY, STATE, ZIP COD N SENATE BLVD NAPOLIS, IN 46202	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
S 0930 Bldg. 00	Survey Date: 07/31. Facility Number: 0 QA: 08/05/2024 410 IAC 15-1.5-6 NURSING SERVI 410 IAC 15-1.5-6 (b) The nursing set following: (3) A registered not and evaluate the correct provided to each provided to e	CE (b)(3) ervice shall have the urse shall supervise care planned for and patient. review and interview, nursing emplete fall risk shift 10 (Patients 2, 4, 6, 7, 8, and 9) iewed. led, Fall Prevention, published ed under VI. Procedures, I Risk assessment should be	S 0930	Starting 8/26/24, all RNs in the unit were re-educated on the facility policy titled "Fall Prevention" and the docume requirements that it stipulate Education is provided via emstaff meetings and daily safe huddle in an ongoing manner Prevent Recurrence: During the 30 days post-eduthe following will take place: B5C5 leaders will complete audits on 10 patients per we documentation of completion risk assessment on the two previous shifts to achieve 90 greater compliance. Any identified gaps will	he 08/30/2024 entation s. nail, ety er. cation e ek for n of fall
	03/24/2024 night sh			immediately be discussed wi staff on an individual basis u Just Culture including initial coaching with escalation to	l l

State Form Event ID: 1|Y|11 Facility ID: 005051 If continuation sheet Page 3 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150056	(X2) MULTIPLE CO A. BUILDING B. WING	BUILDING <u>00</u>		X3) DATE SURVEY COMPLETED 07/31/2024	
NAME OF PROVIDER OR SUPPLIER		1701 N	ADDRESS, CITY, STATE, ZIP COD SENATE BLVD				
INDIANA	UNIVERSITY HEA	LTH	INDIANAPOLIS, IN 46202				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG			DATE	
		fall risk shift assessment on		performance improvement pla	an, if		
	03/27/2024 night sł	nift.		applicable for continuous			
				improvement.			
	_	t 7's medical record lacked		This audit will be completed for			
		all risk shift assessments on		three months, with expectations			
	04/15/2024 night shift, 04/19/2024 day shift,			for 90% compliance or greater. If			
	04/21/2024 day shift, and 04/22/2024 night shift.			this threshold is achieved, then			
				the auditing process will be			
	6. Review of Patient 8's medical record lacked			transitioned to a periodic spot audit. If the referenced thresh			
	documentation of fall risk shift assessments on						
	04/10/2024 night shift, 04/11/2024 night shift, 04/26/2024 day shift, 04/26/2024 night shift,			not met, then consistent audit will continue until such time the			
	04/26/2024 day shift, 04/26/2024 night shift, 04/27/2024 day shift, 04/27/2024 night shift,			data for a consecutive three-r			
	04/2//2024 day shift, 04/2//2024 night shift, 04/28/2024 day shift, 04/28/2024 night shift,			period reflects achievement of the			
	05/10/2024 day shift, 05/11/2024 day shift,			90% threshold.			
	05/16/2024 day shift, 05/11/2024 day shift, 05/14/2024 day shift, and 05/16/2024 night shift.						
	05/11/2021 day shift, and 05/10/2024 hight shift.			Responsible for Corrective Ad	ction:		
	7. Review of Patient 9's medical record lacked			Manager – Clinical Operations			
	documentation of fa	all risk shift assessments on					
	05/07/2024 day shi	ft, 05/11/2024 day shift, and		Completion Date:			
	05/12/2024 night sl	nift.		8/30/24			
		3, (Clinical Nurse Specialist),					
	_	pproximately 4:55 p.m. confirmed					
		, and 9's medical record lacked					
		all risk assessments as					
	indicated above.						

State Form Event ID: 1|Y|11 Facility ID: 005051 If continuation sheet Page 4 of 4