STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150056	A. BUILDING 00 B. WING	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 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
A 0000 Bldg. 00	This visit was for an investigation of a Federal Hospital Complaint. Complaint Number IN00436897 - Deficiency unrelated to the allegations is cited at A0395. Survey Date: 07/31/2024 Facility Number: 005051 QA: 08/05/2024	A 0000		
A 0395 Bldg. 00	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. Based on document review and interview, nursing services failed to complete fall risk shift assessments in 6 of 10 (Patients 2, 4, 6, 7, 8, and 9) medical records reviewed. Findings include: 1. Facility policy titled, Fall Prevention, published 10/17/2023, indicated under VI. Procedures, Assessment, A. Fall Risk assessment should be completed: b. Once per shift. 2. Review of Patient 2's medical record lacked documentation of fall risk shift assessments on 02/03/2024 night shift and 02/04/2024 day shift. 3. Review of Patient 4's medical record lacked documentation of fall risk shift assessments on 03/23/2024 night shift, 03/24/2024 day shift, and	A 0395	Starting 8/26/24, all RNs in the unit were re-educated on the facility policy titled “Fall Prevention” and the documentation requirements that it stipulates. Education is provided via email, staff meetings and daily safety huddle in an ongoing manner. Prevent Recurrence: During the 30 days post-education the following will take place: • B5C5 leaders will complete audits on 10 patients per week for documentation of completion of fall risk assessment on the two previous shifts to achieve 90% or greater compliance. • Any identified gaps will immediately be discussed with the	08/30/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason	Owen	08/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150056	A. BUILDING 00 B. WING	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDIANA UNIVERSITY HEALTH	1701 N SENATE BLVD INDIANAPOLIS, IN 46202

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	03/24/2024 night shift. 4. Review of Patient 6's medical record lacked documentation of a fall risk shift assessment on 03/27/2024 night shift. 5. Review of Patient 7's medical record lacked documentation of fall risk shift assessments on 04/15/2024 night shift, 04/19/2024 day shift, 04/21/2024 day shift, and 04/22/2024 night shift. 6. Review of Patient 8's medical record lacked 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, 04/27/2024 day shift, 04/27/2024 night shift, 04/28/2024 day shift, 04/28/2024 night shift, 05/10/2024 day shift, 05/11/2024 day shift, 05/14/2024 day shift, and 05/16/2024 night shift. 7. Review of Patient 9's medical record lacked documentation of fall risk shift assessments on 05/07/2024 day shift, 05/11/2024 day shift, and 05/12/2024 night shift. 8. Interview with A3, (Clinical Nurse Specialist), on 07/31/2024 at approximately 4:55 p.m. confirmed Patients 2, 4, 6, 7, 8, and 9's medical record lacked documentation of fall risk assessments as indicated above.		staff on an individual basis utilizing Just Culture including initial coaching with escalation to performance improvement plan, if applicable for continuous improvement. • This audit will be completed for three months, with expectations for 90% compliance or greater. If this threshold is achieved, then the auditing process will be transitioned to a periodic spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive three-month period reflects achievement of the 90% threshold. Responsible for Corrective Action: • Manager – Clinical Operations Completion Date: 8/30/24	
S 0000 Bldg. 00	This visit was for an investigation of a State Licensure Hospital Complaint. Complaint Number IN00436897 - Deficiency unrelated to the allegations is cited at S0930.	S 0000		

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	150056	A. BUILDING 00 B. WING	07/31/2024

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INDIANA UNIVERSITY HEALTH	1701 N SENATE BLVD INDIANAPOLIS, IN 46202

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	Survey Date: 07/31/2024 Facility Number: 005051 QA: 08/05/2024			
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, nursing services failed to complete fall risk shift assessments in 6 of 10 (Patients 2, 4, 6, 7, 8, and 9) medical records reviewed. Findings include: 1. Facility policy titled, Fall Prevention, published 10/17/2023, indicated under VI. Procedures, Assessment, A. Fall Risk assessment should be completed: b. Once per shift. 2. Review of Patient 2's medical record lacked documentation of fall risk shift assessments on 02/03/2024 night shift and 02/04/2024 day shift. 3. Review of Patient 4's medical record lacked documentation of fall risk shift assessments on 03/23/2024 night shift, 03/24/2024 day shift, and 03/24/2024 night shift. 4. Review of Patient 6's medical record lacked	S 0930	Starting 8/26/24, all RNs in the unit were re-educated on the facility policy titled “Fall Prevention” and the documentation requirements that it stipulates. Education is provided via email, staff meetings and daily safety huddle in an ongoing manner. Prevent Recurrence: During the 30 days post-education the following will take place: • B5C5 leaders will complete audits on 10 patients per week for documentation of completion of fall risk assessment on the two previous shifts to achieve 90% or greater compliance. • Any identified gaps will immediately be discussed with the staff on an individual basis utilizing Just Culture including initial coaching with escalation to	08/30/2024

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	documentation of a fall risk shift assessment on 03/27/2024 night shift. 5. Review of Patient 7's medical record lacked documentation of fall risk shift assessments on 04/15/2024 night shift, 04/19/2024 day shift, 04/21/2024 day shift, and 04/22/2024 night shift. 6. Review of Patient 8's medical record lacked 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, 04/27/2024 day shift, 04/27/2024 night shift, 04/28/2024 day shift, 04/28/2024 night shift, 05/10/2024 day shift, 05/11/2024 day shift, 05/14/2024 day shift, and 05/16/2024 night shift. 7. Review of Patient 9's medical record lacked documentation of fall risk shift assessments on 05/07/2024 day shift, 05/11/2024 day shift, and 05/12/2024 night shift. 8. Interview with A3, (Clinical Nurse Specialist), on 07/31/2024 at approximately 4:55 p.m. confirmed Patients 2, 4, 6, 7, 8, and 9's medical record lacked documentation of fall risk assessments as indicated above.		performance improvement plan, if applicable for continuous improvement. • This audit will be completed for three months, with expectations for 90% compliance or greater. If this threshold is achieved, then the auditing process will be transitioned to a periodic spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive three-month period reflects achievement of the 90% threshold. Responsible for Corrective Action: • Manager – Clinical Operations Completion Date: 8/30/24	