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	02/22/2024

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
S 0000 Bldg. 00	This visit was for an investigation of a State Licensure Hospital Complaint. Complaint Number: IN00427205 - Deficiency unrelated to the allegations is cited at S0930. Survey Date: 02/22/2024 Facility Number: 005051 QA: 2/29/2024 & 3/1/2024	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 document intake assessments as ordered in 3 out of 5 (patients 1, 3, and 5) medical records reviewed. Findings include: 1. Review of policy titled, "Scope of Assessment", PolicyStat ID 10132831, last approved 07/27/2021, indicated measurement and recording of intake occurs by the practitioner's order. 2. Review of Patient 1's medical record indicated	S 0930	Plan of Correction Text: 1. A thorough review of P1, P3, P5 was completed identifying gaps and opportunities to improve the overall care and outcomes of the patient regarding intake and output documentation as per provider orders during hospital stay. 2. An opportunity was identified to re-educate on the standards of care and improve communication for strict intake and output between team members to meet the individualized plan of care	04/05/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heidi Coffey	Accreditation and Regulatory Manager	03/20/2024

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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	intake was ordered to be documented every 8 hours and nutrition flowsheet lacked documentation of intake on 1/31/2024, 02/01/2024, 02/02/2024, 02/03/2024, and 02/04/2024. 3. Review of patient 3's medical record indicated intake was ordered to be documented every 8 hours and nutrition flowsheet lacked documentation of intake on 01/24/2024, 01/25/2024, 01/26/2024, 01/27/2024, 1/28/2024, 1/29/2024, 1/30/2024, 01/31/2024, and 02/01/2024. 4. Review of patient 5's medical record indicated intake was ordered to be documented every 8 hours and nutrition flowsheet lacked documentation of intake on 01/26/2024, 01/27/2024, and 1/28/2024. 5. Interview with A1 (Clinical Nurse Specialist), A2 (Clinical Nurse Specialist), and A3 (Manager of Accreditation and Regulatory) on 02/22/2024 at approximately 2:20 p.m. confirmed that patients 1, 3, and 5 MR lacked documentation of nutritional intake as ordered. A2 confirmed that every 8 hours should include all intake consumed by the patient during that time and can be documented by nurse or technician.		designed for the patient. a. The unit triad team is re-educating all team members (RN, PCA, Mobility Techs) on the documentation expectations. Education will be provided via Tier 1 huddle (Shift huddle), Unit Professional Practice Council, and during leader rounding conversations. b. For increased awareness to the unit charge nurses, the unit will add a column to the charge report sheet for patients with strict intake and output orders. Prevent Recurrence: 1. IU Health University Hospital 4N Unit Leadership team started surveillance audits regarding strict intake and output documentation per Scope of Assessment policy and provider orders completing 5 audits per week for 30 days with an expectation of 90% compliance or greater on 5 audits. Any gaps will be discussed with the staff individually using Just Culture, including initial coaching. If this threshold is achieved, the auditing process will be moved to a periodic spot audit. If the referenced threshold is not met, then consistent auditing will continue until such a time that data for a consecutive 30 days reflects achievement of the 90% threshold. Results of audits will be included in the unit's Huddle space and trended through the	

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			unit's Professional Practice Council monthly. 2. Unit leadership team will continue to reinforce the practice through unit huddles. Education is also provided to Resource Pool Team through Resource Pool Leadership via email. Responsible for Corrective Action: Clinical Operations Manager Completion Date: April 5th, 2024	