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	06/12/2024

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 the investigation of a state licensure hospital complaint. Complaint Number: IN00412947 - Deficiency related to the allegations is cited at tag S2104. Survey Date: 06/12/2024 Facility Number: 005051 QA: 6/20/2024, 7/2/2024, 7/3/2024 & 7/9/2024	S 0000		
S 2104 Bldg. 00	410 IAC 15-1.6-8 SURGICAL SERVICES 410 IAC 15-1.6-8(a) (a) If the hospital provides inpatient or ambulatory surgical services, the services shall meet the needs of the patients served, within the scope of the service offered, and in accordance with acceptable standards of practice and safety. Based on document review and interview, the facility failed to follow hospital policy and file an incident report related to an unexpected outcome resulting in a patient safety incident of bodily harm. Additionally, facility policy was not followed when P1's provider did not inform and/or discuss with the patient or a family member that an unexpected outcome occurred for 1 of 5 patients (P1) medical records reviewed. Findings include: 1. Medical record (MR) review indicated P1 presented to F1's outpatient surgery on	S 2104	How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. The clinical manager will re-educate staff the week of 7/22/24 – 7/26/24 during morning huddle of the importance of tracking patient injury through our incident reporting structure. The Director of Anesthesia Services will educate our anesthesia team on the IU Health Policy "Patient Incident and	07/26/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason Owen		07/25/2024

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	07/12/2023. Upon completion of the procedure, MD2 (Medical Doctor, Anesthesiology) explained to nursing that skin tears occurred when the provider removed the endo tracheal tape off P1's cheeks and nose. The MR lacked documentation of communication between MD1 (Medical Doctor, Surgeon) and/or MD2 post procedure with either P1 or FM1, Family Member. 2. Review of policy titled, "Patient Incident and Significant Event Management", published 09/11/2022, indicated: A. On page 1, under section IV. DEFINITIONS, Patient Safety Incident: Any unintended or unexpected incident which could have or did lead to harm for one or more patients including near misses/good catches. Significant Event: An unexpected clinical or nonclinical occurrence that threatens the organization's assets or reputation, disrupts operations, or results in bodily harm or loss of life. A significant event may or may not be the result of an error. B. On page 2, under section VI. PROCEDURES, A. Immediate Response to Significant Events, 2. c. An incident report should be completed in the web-based incident reporting system in as timely manner as possible. C. Patient Disclosure of Significant Events, When a significant event results in an unanticipated patient outcome, the patient and/or the patient's family should be informed as soon as reasonably possible. The unanticipated patient outcome should be discussed with the family by the attending physician or his or her designee. 3. Review of policy titled, "Patient/Parent Rights and Responsibilities, Complaints and Grievances", published 06/22/2023, attachment of "Your rights as a patient" indicated [patient] has the right to be informed of outcomes of care, treatments and		Significant Event Management". The education will include proper medical record documentation of patient incidents as well as proper follow up with the patient/patient family regarding incidents that happen during care. This will be done via email (the week of 7/22) as well as in person at our next anesthesia team meeting in late August 2024. How are you going to prevent the deficiency from recurring in the future? During daily huddle going forward, a review of significant events will take place to ensure that incident reports have been entered. All incident reports will be reviewed by the perioperative clinical nurse specialist team. Any incident related to patient injury will be escalated up to perioperative leadership triad (clinical director, surgical medical director, & anesthesia medical director), team for full review. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? Director of Clinical Operations and Director of Anesthesia Services By what date are you going to have the deficiency corrected?	

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	services, including unexpected outcomes. 4. Interview on 6/12/2024 at 1100 hours with S4, Clinical Manager, indicated that generally the surgeon speaks with the patient/family prior to discharge. No documentation was found in P1's MR to substantiate this. 5. Interview on 6/12/2024 at 1300 hours with S2, Manager, Accreditation and Regulatory, indicated policy requires that a provider or designee speak with the patient or family member as soon as possible when a significant event and/or unexpected outcome occurs. 6. An incident report was not filed for this unexpected outcome of skin tears sustained by P1 post procedure on 07/12/2023.		Correction and personnel education will be completed by 7/26/2024.	