PRINTED: 10/01/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150056	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/22/2024	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH			STREET ADDRESS, CITY, STATE, ZIP COD 1701 N SENATE BLVD INDIANAPOLIS, IN 46202					
				ID	I		(7/5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	l ,	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
TAG		LSC IDENTIFYING INFORMATION		TAG				
A 0000								
Bldg. 00	This visit was for the investigation of a federal hospital complaint.  Complaint Number: IN00439876 - Deficiency related to the allegations is cited A 0130.  Survey Date: 8/13/24 & 8/22/24  Facility Number: 005051  QA: 8/19/24		A 00	000				
A 0130 Bldg. 00	482.13(b)(1) PATIENT RIGHTS:PARTICIPATION IN CARE PLANNING The patient has the right to participate in the development and implementation of his or her plan of care. Based on documentation review and interview the facility failed to follow their policy ensuring a surrogate decision maker was included in and/or notified of the patient's plan of care for 1 of 10 medical records reviewed. (P1)  Findings include:  1. Facility policy titled, "Patient/Parent Rights and Responsibilities, Complaints and Grievances", no policy number, publication date 06/22/2023, indicated under Your rights as a patient: To participate in decisions about care, treatment and services, which may include family and loved ones, as permitted by the patient or decision maker; this includes the development and implementation of an inpatient care plan, outpatient treatment or care plan, pain		A 01	30	How we will correct the findings: Goal: improve documentation a. Method: To improve documentation the medical director will provide communication monthly and the quarterly to the team on documentation opportunities a education. The information will also be communicated during medical director physician statementing, with the target audies of chief resident, faculty, fellow all residents that go through the ICU. i. Education components: 1. Emphasize documentation	and I the ff nce vs,	10/15/2024	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Heidi Coffey Accreditation and Regulatory Manager 09/26/2024

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: JUJ911 Facility ID: 005051 If continuation sheet

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CTATEMENT OF DEFICIENCIES (V1) PROVIDED (CUIDDLIED (CLIA			(VA) ) (I = mem = = =	ONGERVICEION	TANK DA THE CHIPATRA	
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		150056	B. WING		08/22/2024	
NAME OF BROWNING OR CARRY IS			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER			1701 N	I SENATE BLVD		
INDIANA	UNIVERSITY HEA	LTH	INDIAN	NAPOLIS, 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 APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		nes of care, treatment and		2. Emphasize plan of care and		
	services, including	unexpected outcomes.		goals of care in documentatio		
				a. Including current plan of ca	re	
		on for P1 indicated on 7/18/24		and expected outcomes		
	_	d P1 wished to remain full code		3. Documentation improveme	nt	
		ex-spouse to be the medical		strategies include:		
		im/her because was unable to		a. Utilization of template;		
	_	es. Social Work note		appropriate addendum of note	•	
		d 7/18/24 at 6:48 pm indicated		b. Suggested use of goals of	care	
		nfirmed with P1's ex-spouse		powerform		
	_	not have an advance directive		c. Use of global autotext		
		ed and intubated. The		4. Highlight best practices:		
		was provided an overview of		a. Patient or surrogate decision	on	
	the roles/responsibilities of a surrogate decision			maker		
	maker and an overview of the State's Consent			b. Advance directives, POA		
	Law. It was then determined that P1's only living			c. Code status		
	child declined the role of surrogate decision			How will we prevent reoccurre	ence:	
	maker, P1's parents and/or siblings were no longer			i. Sustain educational		
	living, and the patient had no other living			components in MICU resident		
		s, P1's ex-spouse was made		orientation		
	I	on maker for the patient.		ii. Sustain quarterly topic in		
		umentation dated 7/20/24		medical director meetings		
	•	t was extubated on 7/19/24		iii. Weekly chart audits of goa	ls of	
		lynamically unstable on		care and plan of care with		
	7/21/24 requiring reintubation, central line placement, and arterial line placement. MR (medical record) for P1 lacked documented of prior notification to his/her surrogate decision maker on 7/19/24 of the plan to extubate P1, and lacked			coaching/feedback		
				Who is responsible for plan of		
				correction: Medical Director of	f	
				Medical Intensive Care Unit		
				Date of completion: 10/15/202	24	
		otification on 7/20/24 of an				
	_	rrogate decision maker of				
	patient's care plan related to P1 being extubated on 7/19/24.  3. In telephone interview on 8/22/2024 at approximately 12:51 pm with A1 (Manager of					
	Accreditation & Re	gulatory) confirmed there was				
	no documented fam	ily/surrogate decision maker				
	notification related	to P1's extubation on				
	7/20/2024.					

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

PRINTED: 10/01/2024 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER  150056	A. BUILDING 00  B. WING			COMPLETED 08/22/2024		
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH			STREET ADDRESS, CITY, STATE, ZIP COD 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 PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE	
S 0000								
Bldg. 00	This visit was for the investigation of a State Licensure Complaint.  Complaint Number: IN00439876 - Deficiency related to the allegations is cited at S 0322.  Survey Date: 8/13/24 & 8/22/24  Facility Number: 005051  QA: 8/19/24  IDR Committee met on 09/18/2024. No Changes.		S 0000					
S 0322 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOA 410 IAC 15-1.4-1(						l	
	for managing the h governing board s following: (6) Require that th	hall do the e chief executive blicies and programs						
	(H) Requiring all s policies and proce updated as neede least triennially.	dures that are						
	Based on document facility failed to foll surrogate decision n	ation review and interview the ow their policy ensuring a maker was included in and/or nt's plan of care for 1 of 10 iewed. (P1)	S 03	22	How we will correct the findings: Goal: improve documentation a. Method: To improve documentation the medical director will provide communication monthly and the	en	10/15/2024	

State Form Event ID: JUJ911 Facility ID: 005051 If continuation sheet Page 3 of 5

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

PRINTED: 10/01/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
150056		B. WING 08/22/2024			2024		
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
					SENATE BLVD		
INDIANA	UNIVERSITY HEA	LIH		INDIAN	APOLIS, 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 APPROPRIA	<sub></sub>	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	'E	DATE
					quarterly to the team on		
	1. Facility policy tit	led, "Patient/Parent Rights and			documentation opportunities a	ind	
		omplaints and Grievances", no			education. The information wil		
	-	lication date 06/22/2023,			also be communicated during		
		ır rights as a patient: To			medical director physician stat		
		ons about care, treatment and			meeting, with the target audier		
		y include family and loved		of chief resident, faculty, fellows,			
		by the patient or decision			all residents that go through th		
	-	s the development and			ICU.		
		an inpatient care plan,			i. Education components:		
	outpatient treatment				Emphasize documentation	<sub>&amp;</sub>	
	•				communication best practices		
	management plan and discharge plan. To be informed of outcomes of care, treatment and				Emphasize plan of care and		
	services, including unexpected outcomes.				goals of care in documentation		
	services, meraanig	unexpected dateomes.			a. Including current plan of car		
	2 MR documentation	on for P1 indicated on 7/18/24			and expected outcomes		
		d P1 wished to remain full code			Documentation improvementation impr	nt	
	and wanted his/her ex-spouse to be the medical				strategies include:	"	
	decision maker of him/her because was unable to				a. Utilization of template;		
	speak for themselves. Social Work note				appropriate addendum of note		
	-				b. Suggested use of goals of o		
	documentation dated 7/18/24 at 6:48 pm indicated social work staff confirmed with P1's ex-spouse				powerform	Jaie	
	that the patient did not have an advance directive				c. Use of global autotext		
	prior to being sedated and intubated. The				4. Highlight best practices:		
					a. Patient or surrogate decisio	n	
	patient's ex-spouse was provided an overview of					"	
	the roles/responsibilities of a surrogate decision maker and an overview of the State's Consent				maker		
					b. Advance directives, POA		
	Law. It was then determined that P1's only living				c. Code status  How will we prevent reoccurre	noo:	
	child declined the role of surrogate decision						
	maker, P1's parents and/or siblings were no longer			i. Sustain educational components		enis	
	living, and the patient had no other living relatives. Due to this, P1's ex-spouse was made			in MICU resident orientation			
		-			ii. Sustain quarterly topic in		
	_	on maker for the patient.			medical director meetings		
		umentation dated 7/20/24			iii. Weekly chart audits of goal	S 01	
	_	t was extubated on 7/19/24			care and plan of care with		
		lynamically unstable on			coaching/feedback		
		eintubation, central line			Who is responsible for plan of		
	-	rial line placement. MR			correction: Medical Director of		
		r P1 lacked documented of prior			Medical Intensive Care Unit		
	notification to his/h	er surrogate decision maker on			Date of completion: 10/15/202	4	

State Form Event ID: JUJ911 Facility ID: 005051 If continuation sheet Page 4 of 5

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

PRINTED: 10/01/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150056	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/22/2024		
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH			STREET ADDRESS, CITY, STATE, ZIP COD 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
	7/19/24 of the plan to extubate P1, and lacked documentation of notification on 7/20/24 of an update to his/her surrogate decision maker of patient's care plan related to P1 being extubated on 7/19/24.  3. In telephone interview on 8/22/2024 at approximately 12:51 pm with A1 (Manager of Accreditation & Regulatory) confirmed there was no documented family/surrogate decision maker notification related to P1's extubation on 7/20/2024.						

State Form Event ID: JUJ911 Facility ID: 005051 If continuation sheet Page 5 of 5