Shawn McCoy

PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-039

05/10/2024

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	<u> </u>	LTIPLE CO	nstruction <u>00</u>	(X3) DATE SURVEY COMPLETED	
		150082	B. WIN	NG		04/03/	2024
	ROVIDER OR SUPPLIER			600 MA	DDRESS, CITY, STATE, ZIP COD RY ST VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
A 0000 Bldg. 00 A 0395 Bldg. 00	hospital complaint. Complaint Number: deficiency unrelated A0395. Date of survey: 4/3 Facility Number: 0 QA: 04/19/2024 482.23(b)(3) RN SUPERVISION A registered nurse evaluate the nursi Based on document services failed to do (MR) the discontinu access on 3 of 10 pa (P2, P4, and P5). Findings include: 1. Facility procedur Therapy: Discontinu April 2023, indicate procedure in the pate 2. Review of P2's M2/4/24 at 1:32 am to (discharged) from face	N OF NURSING CARE must supervise and ng care for each patient. review and interview, nursing cument in the medical record lation of intravenous (IV) tient medical records reviewed re titled, Skills: Intravenous lation-CE/NCPD, published d on page 2, 26. Document the	A 00		CORRECTIVE ACTION PLAN CMS Substantiated Complain #IN 00430099 Date: 04.03.2024 Deficiency: Corrective Action to be Take If already corrected, give steps taken and date of correct Describe how the facility reviews all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facili identified as being affected. Prevention of Future	n; e: ettion	05/14/2024
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE		Deficiencies:		(X6) DATE

Any defiency statement 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: 6l4R11 Facility ID: 005074 If continuation sheet Page 1 of 12

CEO

PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		150082	B. W	ING		04/03/2	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			ARY ST		
DEACON	NESS HOSPITAL IN	NC			SVILLE, IN 47710		
	1				,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		MR indicated IV placed on			If prevention includes education		
		o the right brachial. P4 DC'd			provide educational material a		
		7/24. MR lacked documentation			class records or attestations; i	fit	
	of IV site discontin	uation.			includes monitoring, provide		
					monitoring tool; if it involves a		
		MR indicated port a cath to			policy, include the policy; if rep	pairs	
	_	d on 2/25/24 at 7:00 am and			or PMs are part of the plan,		
	I	on 2/29/25 at 1:00 am. MR			provide appropriate		
	_	h re-accessed on 2/29/24 at			documentation.		
		from facility on 3/2/24. MR			Monitoring:		
	lacked documentat	ion of port a cath de-access.			Describe how the corrective		
	F Tu int	4/2/24 -4			actions will be monitored to	.:11	
		4/3/24 at approximately 3:00 nformatics) verified P2, P4, and			ensure the deficient practice w	/111	
		continuation of IV access			not reoccur, i.e., what quality		
		o DC (discharge) from facility.			assurance program will be put	. IIIIO	
	_	and P5 did not require IV			place)		
		l medical care after discharge			Responsible Parties for columns 2 and 3 (Give Titles,	not	
	from facility.	i medical care after discharge			personal names):	not	
	nom racinty.				Target Date: Give specific		
	6 In interview on	4/3/24 at approximately 6:10			dates (Maximum correction tir	ne l	
		tion and Regulatory Office)			is 30 days from date of survey		
		ent provided, titled Skills:			the nature of the deficiency	. "	
		by: Discontinuation-CE/NCPD,			precludes completion within 3	0	
	was a facility polic	•			days, the POC must be written		
					30-day phases.)		
					Status effective Date of		
					Submission of POC (Comple	ted	
					or in-progress):		
					A395		
					410 IAC 15-1.5-6 NURSING		
					SERVICE 410 IAC 15-1.5-6 (b)(3)	
					(b)		
					The nursing service shall have	e the	
					following: (3) A registered nurs		
					shall supervise and evaluate t	he	
					care planned for and provided		
					each patient. This RULE is no	t	
					met as evidenced by: S 930		
					Based on document review ar	nd	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6I4R11

Facility ID: 005074

If continuation sheet Page 2 of 12

PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		150082	B. WI	ING		04/03/	/2024
	PROVIDER OR SUPPLIER		-	600 MA	ADDRESS, CITY, STATE, ZIP COD IRY ST VILLE, IN 47710		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE.	DATE
140	REGULATORY OR	A LOC IDENTIFITING ENFORMATION		IAU	interview, nursing services fail document in the medical record (MR) the discontinuation of intravenous (IV) access on 3 c patient medical records review (P2, P4, and P5). Findings include: 1. Facility procedure titled, Ski Intravenous Therapy: Discontinuation-CE/NCPD, published April 2023, indicated page 2, 26. Document the procedure in the patient's recorded and the procedure and	of 10 yed ills: d on ord. d IV) ked 24 I. I. V y of to 24 by sed 'd ked	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6I4R11

Facility ID: 005074

If continuation sheet Page 3 of 12

PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-039

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		150082	B. WI	NG		04/03/	2024
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
				600 MA			
DEACO	NESS HOSPITAL IN	NC .		EVANS	SVILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE NAVOE CONDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE.	DATE
					(discharge) from facility. A5		
					verified P2, P4, and P5 did no	t I	
					require IV access for arranged		
					medical care after discharge f		
					facility. 6. In interview, on 4/3/3		
					approximately 6:10 pm, A1		
					(Accreditation and Regulatory		
					Officer) pm, A1 (Accreditation		
					Regulatory Officer) verified the		
					document provided, titled Skill		
					Intravenous Therapy:		
					Discontinuation-CE/NCPD, wa	as a	
					facility policy.		
					Registered Nurses demonstra	te	
					accountability for policy and		
					procedures regarding the		
					discontinuation of intravenous	(IV)	
					access upon discharge as	()	
					outlined in Mosbys Policy- Ski	lls:	
					Intravenous Therapy:		
					Discontinuation		
					1 Reviewed Mosbys Policy-		
					Skills: Intravenous Therapy:		
					Discontinuation and no chang	es to	
					content necessary		
					2 Education dissemination	to I	
					all RNs, LPNs and PCTs on D		
					Ortho-Surgical Unit at Deacon		
					Gateway campus via Red Ale		
					starting 4/29/2024 with goal of		
					100% for all scheduled		
					employees. (Exhibit A)		
					3 Discussed Red Alert and		
					deficiency during D500 Patien	t l	
					Care Tech unit-based council		
					meeting on 5/2/2024 (Exhibit I	₃₎	
					4 Will discuss Red Alert and		
I	1				deficiency during D500 RN/LF		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6I4R11

Facility ID: 005074

If continuation sheet

unit-based meeting scheduled to

Page 4 of 12

PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		150082	B. W	NG		04/03/	/2024
		<u> </u>		CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	8		600 MA			
DEACON	IESS HOSPITAL IN	IC			VILLE, IN 47710		
DEACON	NESS TUSPITAL IN			EVANS	VILLE, IN 4// IU		
(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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	•	DATE
					occur 5/14/2024		
					5 Red alert, deficiency, and		
					documentation requirements		
					discussed at daily AM and PM		
					shift change huddles		
					4/29/2024-5/5/2024		
					2. Monitor compliance of		
					discontinuation of intravenous	(1\/)	
					access of D500 patients at	(10)	
					discharge via random audit of	30	
					per month, with goal complian		
					of 97% or greater for three	CE	
					_	noo	
					consecutive months. Complia		
					will be reported monthly to Nu	rsing	
					Leadership and Regulatory		
					Perpetual Readiness Committ		
					(Exhibit C) Follow up will occu	r	
					with appropriate employee if		
					noncompliance is found during	9	
					audit process.		
					2. D500 Department Manager		
					1 Review complete 4/26/20	24	
					2 Education complete (100	0%)	
					5/7/2024 (Exhibit C and D)	,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6I4R11

Facility ID: 005074

If continuation sheet

Page 5 of 12

PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. B		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/03/2024	
	PROVIDER OR SUPPLIER		600 MA	ADDRESS, CITY, STATE, ZIP COD ARY ST SVILLE, IN 47710	
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				3 Audit to start 5/8/2024 (Exhibit E – audit tool) 1 Complete	
				2 Complete	
				3 In progress until 97% or greater compliance for 3 consecutive months	
S 0000					
Bldg. 00	This visit was for in hospital complaint.	vestigation of a state licensure	S 0000		
		IN00430099 - State deficiency tion is cited at S0930.			
	Date of Survey: 4/3	/24			
	Facility Number: 00	05074			

State Form Event ID: 6I4R11 Facility ID: 005074 If continuation sheet Page 6 of 12

PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	LETED
		150082	B. W	ING		04/03/	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8		600 MA			
DEACON	IESS HOSPITAL IN	IC		EVANSVILLE, IN 47710			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	QA: 04/19/2024						
S 0930	410 IAC 15-1.5-6						
3 0930	NURSING SERVI	CE					
Bldg. 00	410 IAC 15-1.5-6						
g.	110 11 10 11 11 11 11	(2)(0)					
	(b) The nursing se	ervice shall have the					
	following:						
	(3) A registered p	urse shall supervise					
	. ,	care planned for and					
	provided to each p						
	provided to each p	sauciii.	S 09	930	CORRECTIVE ACTION PLAN	1	05/14/2024
	Based on document	review and interview, nursing	50,	750	ISDH Substantiated Complai		03/14/2024
		ocument in the medical record			#IN 00430099		
		uation of intravenous (IV)			Date: 04.03.2024		
		atient medical records reviewed					
	(P2, P4, and P5).				Deficiency:		
					Corrective Action to be Take	n;	
	Findings include:				If already corrected, give	•	
					steps taken and date of correct	ction	
		re titled, Skills: Intravenous			Describe how the facility	′	
	Therapy: Disconting	uation-CE/NCPD, published			reviews all clients in the facility	y	
	-	ed on page 2, 26. Document the			that could be affected by the		
	procedure in the pat	tient's record.			same deficient practice, and		
					state, what actions the facility		
		MR indicated IV placed on			took to correct the deficient		
		the right forearm. P2 DC'd			practice for any client the facil	ity	
		acility on 2/8/24. MR lacked			identified as being affected.		
	documentation of I	V site discontinuation.			Prevention of Future		
	2 Daview of DAL- N	MR indicated IV placed on			Deficiencies:		
		o the right brachial. P4 DC'd			If prevention includes education		
	-	/24. MR lacked documentation			provide educational material a class records or attestations; i		
	of IV site discontinu				includes monitoring, provide	i IL	
	of 1 v site discontilli	uutivii.			monitoring tool; if it involves a	new	
	4 Review of D5's N	MR indicated port a cath to			policy, include the policy; if re		
		on 2/25/24 at 7:00 am and			or PMs are part of the plan,	Jans	
	-	on 2/29/25 at 1:00 am. MR			provide appropriate		
	ac accessed by 13 (211 2/2/20 at 1.00 alli. 1911	1		I provide appropriate		1

State Form Event ID: 6I4R11 Facility ID: 005074 If continuation sheet Page 7 of 12

PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 150082			(X2) MUL A. BUIL B. WING	DING	nstruction 00	(X3) DATE S COMPLI 04/03/2	ETED
	VIDER OR SUPPLIER	c		600 MAF	DDRESS, CITY, STATE, ZIP COD RY ST /ILLE, IN 47710		
DEACONES (X4) ID PREFIX TAG in 2: la 5. pr dc A ac fr fr	SUMMARY S (EACH DEFICIENCE REGULATORY OR dicated port a cath 200 am. P5 DC'd fi cked documentation. In interview, on 4 m, A5 (Clinical Inf 5 did not have disconumented prior to 5 verified P2, P4, a cess for arranged and facility. In interview, on 4 m, A1 (Accreditation, A1 (Accreditation, A1 (Accreditation))	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION re-accessed on 2/29/24 at rom facility on 3/2/24. MR on of port a cath de-access. 4/3/24 at approximately 3:00 formatics) verified P2, P4, and ontinuation of IV access DC (discharge) from facility. and P5 did not require IV medical care after discharge 4/3/24 at approximately 6:10 on and Regulatory Office) int provided, titled Skills: v: Discontinuation-CE/NCPD,	PF	600 MAF	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) documentation. Monitoring: Describe how the corrective actions will be monitored to ensure the deficient practice wo not reoccur, i.e., what quality assurance program will be put place) Responsible Parties for columns 2 and 3 (Give Titles, personal names): Target Date: Give specific dates (Maximum correction times 30 days from date of survey the nature of the deficiency precludes completion within 30 days, the POC must be written 30-day phases.) Status effective Date of Submission of POC (Complete or in-progress): \$\frac{930}{2}\$ 410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b) The nursing service shall have following: (3) A registered nurs shall supervise and evaluate the care planned for and provided each patient. This RULE is not	rill into not ne . If on in ded (3)	(X5) COMPLETION DATE
					met as evidenced by: S 930 Based on document review an interview, nursing services failed document in the medical record (MR) the discontinuation of intravenous (IV) access on 3 or patient medical records review (P2, P4, and P5). Findings include: 1. Facility procedure titled, Ski	ed to d of 10 red	

State Form Event ID: 6I4R11 Facility ID: 005074 If continuation sheet Page 8 of 12

PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 150082	A. BUILDING B. WING	00	COMPLETED 04/03/2024
	ROVIDER OR SUPPLIEF		600 MA	ADDRESS, CITY, STATE, ZIP COD ARY ST SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Intravenous Therapy: Discontinuation-CE/NCPD, published April 2023, indicate page 2, 26. Document the procedure in the patient's reco 2. Review of P2's MR indicate placed on 2/4/24 at 1:32 am to the right forearm. P2 DC'd (discharged from facility on 2/8/24. MR lac documentation of IV site discontinuation. 3. Review of MR indicated IV placed on 3/3 at 2:33 pm to the right brachia P4 DC'd from facility on 3/7/2 MR lacked documentation of site discontinuation. 4. Review P5's MR indicated port a cath right chest accessed on 2/25/ at 7:00 am and de-accessed IP5 on 2/29/25 at 1:00 am. MF indicated port a cath re-acces on 2/29/24 at 2:00 am. P5 DC from facility on 3/2/24. MR lac documentation of port a cath de-access. 5. In interview, on 4/3/24 at approximately 3:00 pm, A5 (Clinical Informatics) verified IP4, and P5 did not have discontinuation of IV access documented prior to DC (discharge) from facility. A5 verified P2, P4, and P5 did not require IV access for arrange medical care after discharge if facility. 6. In interview, on 4/3/ approximately 6:10 pm, A1 (Accreditation and Regulatory Officer) pm, A1 (Accreditation	ord. ed IV I) cked P4's 3/24 al. 4. IV v of to 24 bby R csed C'd cked

State Form Event ID: 6I4R11 Facility ID: 005074 If continuation sheet Page 9 of 12

PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150082	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/03/2024
	ROVIDER OR SUPPLIE		600 MA	ADDRESS, CITY, STATE, ZIP COD ARY ST SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
IAU	REGULATORY U	K LSC IDENTIF TING INFORMATION	IAG	Regulatory Officer) verified the document provided, titled Skillntravenous Therapy: Discontinuation-CE/NCPD, we facility policy. Registered Nurses demonstre accountability for policy and procedures regarding the discontinuation of intravenous access upon discharge as outlined in Mosbys Policy-Skilntravenous Therapy: Discontinuation Reviewed Mosbys Policy-Skills: Intravenous Therapy: Discontinuation and no change content necessary Education dissemination all RNs, LPNs and PCTs on Ortho-Surgical Unit at Deaco Gateway campus via Red Alestarting 4/29/2024 with goal of 100% for all scheduled employees. (Exhibit A) Discussed Red Alert and deficiency during D500 Patie Care Tech unit-based councimeeting on 5/2/2024 (Exhibit 4 Will discuss Red Alert and deficiency during D500 RN/L unit-based meeting schedule occur 5/14/2024 Red alert, deficiency, and documentation requirements discussed at daily AM and Pl shift change huddles 4/29/2024-5/5/2024 Monitor compliance of discontinuation of intravenou	ne ills: /as a ate s (IV) kills: /- ges to n to D500- ness ert of I nt I B) nd PN d to d M

State Form Event ID: 614R11 Facility ID: 005074 If continuation sheet Page 10 of 12

PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 150082	A. BUILDING B. WING	00 00	COMPLETED 04/03/2024
	ROVIDER OR SUPPLIEF		600 MA	ADDRESS, CITY, STATE, ZIP COD ARY ST SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	access of D500 patients at discharge via random audit of per month, with goal compliant of 97% or greater for three consecutive months. Complia will be reported monthly to Nu Leadership and Regulatory Perpetual Readiness Committ (Exhibit C) Follow up will occu with appropriate employee if noncompliance is found during audit process. 2 D500 Department Manag 1 Policy review complete 4/26/2024 2 Education complete (100 5/7/2024 (Exhibit C and D) 3 Audit to start 5/8/2024 (Exhibit E - audit tool) 1 Complete	30 ance ance arsing tee.

State Form Event ID: 6I4R11 Facility ID: 005074 If continuation sheet Page 11 of 12

PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPI	LETED
		150082	B. WING		04/03	/2024
	PROVIDER OR SUPPLIER		600 M	ADDRESS, CITY, STATE, ZIP COD ARY ST SVILLE, IN 47710	1	
(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	TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				3 In progress until 97% or greater compliance for 3 consecutive months		

State Form Event ID: 6I4R11 Facility ID: 005074 If continuation sheet Page 12 of 12