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	12/09/2024

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 IN00446760 - Deficiency unrelated to the allegations are cited at A0395. Survey Date: 12/02/2024 and 12/09/2024 Facility Number: 005051 QA: 12/17/2024	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 document vital signs as ordered per provider in 1 out of 10 patient (Patient 5) medical records reviewed. Findings include: 1. Review of patient 5 medical record indicated provider order on 10/29/2024 indicated vital signs to be taken every 4 hours; medical record lacked the 4:00 a.m. vital signs on 11/01/2024. 2. Interview with A4 (Registered Nurse, Accreditation and Regulatory Compliance Consultant) on 12/02/2024 at approximately 2:25 p.m. confirmed vital signs were not completed as ordered on 11/01/2024 at 4:00 a.m.	A 0395	***Plan of Correction Text:*** All RNs and support staff in the department were re-educated of the facility policy and their obligation to comply with physician orders regarding the timely documentation of vital signs based on the individual patient orders. **Prevent Recurrence:** 4 N/S leadership will do ten chart audits per week to validate that vital signs are being completed correctly and in compliance with physician orders. The audits will yield a 90% or greater compliance prior to the	01/24/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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			completion date of 1/24/25. Any documentation deficiencies found during the above audit process will be reviewed 1:1 with RN/Support staff by unit leadership. After 1/24/25, if 90% or greater compliance is achieved, maintain periodic “spot” audits of documentation to assess deficiencies in vital sign documentation. **Responsible for Corrective Action:** Manager – Clinical Operations **Completion Date:** To show improvement by 1/24/25.	
S 0000 Bldg. 00	This visit was for an investigation of a State Licensure Hospital Complaint. Complaint Number IN00446760 - Deficiencies unrelated to the allegations are cited at S0308 and	S 0000		

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	S0930. Survey Date: 12/02/2024 and 12/09/2024 Facility Number: 005051 QA: 12/17/2024			
S 0308 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies. Based on document review and interview, the facility failed to document orientation in 1 of 2 (S1, Registered Nurse) personnel files reviewed. 1. Facility policy titled, Orientation - Human Resources, last publication date 04/17/2023, indicated under VI. Procedures, E. Department Orientation, 2. A completed department orientation document for each team member is maintained in the team members document of record within the Oracle Human Resource System as required by the Indiana State Department of Health and Joint Commission. 2. Review of S1's personnel file lacked	S 0308	***Plan of Correction Text:*** All RN files will be audited to ensure current employees have both a hard copy and are uploaded into oracle. **Prevent Recurrence:** Any new employees both full time and contracted labor will submit their completed orientation tool to leadership prior to performing independently.	01/24/2025

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	documentation of unit based orientation. 3. Interview with A5 (4 S Unit Manager) on 12/02/2024 at approximately 3:00 p.m. confirmed S1's personnel file lacked documentation of orientation to the unit.		Immediately upon completion of the orientation tool leadership, and educator will sign and scan a copy to be uploaded to oracle The original copy will be placed in employee hard file to ensure there is another option available. **Responsible for Corrective Action:** Manager – Clinical Operations **Completion Date:** All employee files will be updated and orientation tools uploaded to Oracle by January 24, 2025.	
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			

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	provided to each patient. Based on document review and interview, nursing services failed to document vital signs as ordered in 1 out of 10 patient (Patient 5) medical records reviewed. Findings include: 1. Review of patient 5 medical record indicated provider order on 10/29/2024 indicated vital signs to be taken every 4 hours; medical record lacked the 4:00 a.m. vital signs on 11/01/2024. 2. Interview with A4 (Registered Nurse, Accreditation and Regulatory Compliance Consultant) on 12/02/2024 at approximately 2:25 p.m. confirmed vital signs were not completed as ordered on 11/01/2024 at 4:00 a.m.	S 0930	***Plan of Correction Text:*** All RNs and support staff in the department were re-educated of the facility policy and their obligation to comply with physician orders regarding the timely documentation of vital signs based on the individual patient orders. **Prevent Recurrence:** 4 N/S leadership will do ten chart audits per week to validate that vital signs are being completed correctly and in compliance with physician orders. The audits will yield a 90% or greater compliance prior to the completion date of 1/24/25. Any documentation deficiencies found during the above audit process will be reviewed 1:1 with RN/Support staff by unit leadership. After 1/24/25, if 90% or greater compliance is achieved, maintain periodic "spot" audits of documentation to assess deficiencies in vital sign documentation. **Responsible for Corrective Action:** Manager – Clinical Operations **Completion Date:** To show improvement by 1/24/25.	01/24/2025