PRINTED: 01/13/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
150056		B. WI	B. WING 12/09/20			2024		
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH			STREET ADDRESS, CITY, STATE, ZIP COD 1701 N SENATE BLVD INDIANAPOLIS, IN 46202					
(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		COMPLETION	
TAG	•	LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		IE	DATE	
A 0000								
	This visit was for an Hospital Complaint. Complaint Number unrelated to the allegent survey Date: 12/02/2 Facility Number: 00 QA: 12/17/2024 482.23(b)(3) RN SUPERVISION A registered nurse evaluate the nursing Based on document services failed to do per provider in 1 our medical records revision for the survey of patient provider order on 10 to be taken every 4 light the 4:00 a.m. vital signal of the 4:00 a.m. vital signal consultant) on 12/0.	IN00446760 - Deficiency gations are cited at A0395. 2024 and 12/09/2024 OS051 N OF NURSING CARE must supervise and ng care for each patient. review and interview, nursing cument vital signs as ordered to f10 patient (Patient 5) iewed. at 5 medical record indicated 0/29/2024 indicated vital signs hours; medical record lacked igns on 11/01/2024. 4 (Registered Nurse, egulatory Compliance 2/2024 at approximately 2:25 I signs were not completed as	A 0	000	Plan of Correction Text: All RNs and support stafthe department were re-educated of the facility policy and their obligation to comply with physician orders regarding the timely documentation of vital subased on the individual patient orders. Prevent Recurrence: 4 N/S leadership will dochart audits per week to validate that vital signs are being completed correctly and in	igns t ten tte	01/24/2025	
					compliance with physician order. The audits will yield a 90% or greater compliance prior to the			

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

TITLE

(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: 9WKC11 Facility ID: 005051 If continuation sheet Page 1 of 5

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

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
150056		B. WING 12/09/202			2024		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD SENATE BLVD		
INDIANA	UNIVERSITY HEA	LTH			APOLIS, IN 46202		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
					completion date of 1/24/25.		
					Any documentation deficiencies found during the above audit process will be reviewed 1:1 with RN/Support by unit leadership. After 1/24/25, if 90% or greater compliance is achieve maintain periodic "spot" audits documentation to assess deficiencies in vital sign documentation.	d,	
					Responsible for Corrective Action: Manager – Clinical Operations		
					Completion Date: To show improvement to 1/24/25.	ру	
S 0000							
Bldg. 00	Licensure Hospital Complaint Number	n investigation of a State Complaint. IN00446760 - Deficiencies egations are cited at S0308 and	S 00	000			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X:		X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> C		COMPL	COMPLETED	
150056		150056	B. WING			12/09/2024	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH			STREET ADDRESS, CITY, STATE, ZIP COD 1701 N SENATE BLVD INDIANAPOLIS, IN 46202				
(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 APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG DEFICIENCY)		IE.	DATE
	S0930.						
	Survey Date: 12/02/	/2024 and 12/09/2024					
	Facility Number: 00	05051					
	QA: 12/17/2024						
S 0308	410 IAC 15-1.4-1						
	GOVERNING BOA	ARD					
Bldg. 00	15-1.4-2 (c)(6)(B)						
	for managing the h governing board si following: (6) Require that th officer develops po for the following: (B) Orientation of a including contract	hall do the e chief executive blicies and programs all new employees, and agency					
	personnel, to applicable hospital, department, service, and personnel						
	policies.	e, and personnel					
	Based on document facility failed to doc	review and interview, the nument orientation in 1 of 2 (S1, ersonnel files reviewed.	S 03	308	Plan of Correction Text: All RN files will be audite to ensure current employees h both a hard copy and are uplo	ave	01/24/2025
	Resources, last publ indicated under VI.	led, Orientation - Human ication date 04/17/2023, Procedures, E. Department mpleted department			into oracle.		
	orientation documer	nt for each team member is			Prevent Recurrence:		
	maintained in the team members document of record within the Oracle Human Resource System				Any new employees bot	h	
		ndiana State Department of			full time and contracted labor		
	Health and Joint Co	_			submit their completed orienta		
					tool to leadership prior to		
	2. Review of S1's personnel file lacked				performing independently.		

State Form Event ID: 9WKC11 Facility ID: 005051 If continuation sheet Page 3 of 5

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 150056		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/09/2024		
	PROVIDER OR SUPPLIEI		1701 N	ADDRESS, CITY, STATE, ZIP COD N SENATE BLVD NAPOLIS, IN 46202		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
	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 of the original copy to be uple oracle The original copy with placed in employee hard find the ensure there is another open available.	will sign paded to II be ile to	
				Responsible for Correcti Action: Manager – Clinical Operations	ive	
				Completion Date: All employee files w updated and orientation to uploaded to Oracle by Jan 2025.	ols	
S 0930 Bldg. 00	following: (3) A registered n					

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

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			00	COMPLETED	
150056			B. WING 12/09/2024				
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP COD		
					SENATE BLVD		
IINDIANA	UNIVERSITY HEA	ALI II	I IIN		APOLIS, IN 46202		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREI		CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
	provided to each	patient. t review and interview, nursing	S 0930		Plan of Correction Text:		01/24/2025
		ocument vital signs as ordered	3 0930		All RNs and support staff in the department were re-educated		01/24/2025
		nt (Patient 5) medical records					
	reviewed.	,			of the facility policy and their		
					obligation to comply with		
	Findings include:				physician orders regarding the		
					timely documentation of vital s	•	
	1. Review of patient 5 medical record indicated				based on the individual patient	t	
	provider order on 10/29/2024 indicated vital signs			orders. Prevent			
	to be taken every 4 hours; medical record lacked			Recurrence: 4 N/S			
	the 4:00 a.m. vital signs on 11/01/2024.				leadership will do ten chart aud	aits	
	2. Interview with A4 (Registered Nurse,				per week to validate that vital		
	Accreditation and Regulatory Compliance				signs are being completed correctly and in compliance wi	th	
	Consultant) on 12/02/2024 at approximately 2:25				physician orders. The audits v		
	p.m. confirmed vital signs were not completed as				yield a 90% or greater complia		
	ordered on 11/01/2024 at 4:00 a.m.				prior to the completion date of		
					1/24/25. Any documentat		
					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, maint	ain	
					periodic "spot" audits of		
					documentation to assess		
					deficiencies in vital sign	c	
					documentation. Responsible		
					Clinical Operations Complete	-	
					Clinical Operations CompletDate: To show improvem		
					by 1/24/25.	CIIL	
			1		Dy 1/24/23.		I

State Form Event ID: 9WKC11 Facility ID: 005051 If continuation sheet Page 5 of 5