PRINTED: 11/12/2024 VED

EPARTMENT OF HEALTH AND HUMAN SERVICES						
ENTERS FOR MEDICARE & MEDIC	AID SERVICES		OMB NO. 0938-0			
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			

		IDENTIFICATION NUMBER 150056	A. BUILDING 00 B. WING		COMPLETED 10/09/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1701 N SENATE BLVD INDIANAPOLIS, IN 46202					
(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 APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE			
A 0000 Bldg. 00	hospital complaint. Complaint IN00442 allegations are cited Survey dates: 10/08 Facility Number: 0	3/2024 - 10/09/2024	A 0000					
A 0395 Bldg. 00	A registered nurse evaluate the nursi Based on document services failed to en care by failing to pe dose, for 1 medical and failed to ensure report (IR) related to	N OF NURSING CARE a must supervise and ang care for each patient. review and interview, nursing sure supervision of nursing arform one of the 5 rights, right record (MR) reviewed (P9); completion of an incident opatient leaving against IA) in 1 out of 10 patient MRs	A 0395	A0395 Plan of Correction Text 1. Medication Administration at Management: Failing to perform one of the 5 rights, right dose: IVF laware totals not signed, patient frequently ambulating with pur paused and disconnected, missing clinical note related to fluids not running.	nd np			
	Administration and date 05/08/2023, in VI. Procedures: Administration: B. The team member must perform the 5	occedure titled, "Medication Management," publication dicates the following: er administering medications rights plus 4 checks (9 rights) orior to administering them to a		Unit leadership will reinforce nursing staff to improve the us iaware correctly and provide a reminder to sign fluid totals ea shift through tier 1 huddles and safe handoff checklist that includes (as of October 2024) iaware signing beginning 11/6/2024. Unit team leads ve safe handoff checklists complete	ch d			

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

TITLE

(X6) DATE

Heidi Coffey

Accreditation and Regulatory Manager

11/11/2024

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: HFY711 Facility ID: 005051 If continuation sheet Page 1 of 7

PRINTED: 11/12/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 150056 B. WING 10/09/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1701 N SENATE BLVD INDIANAPOLIS, IN 46202 INDIANA UNIVERSITY HEALTH (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE patient. This includes right patient, right by each nurse every shift for 30 medication, right dose, right time, right route, right days. documentation, right action, right form, and right response. If bar code scan technology is Secondary IV fluids infusions may available, scan patient identification band and disrupt primary IV total fluid patient medication. volumes as well as providers approving pump pause and 2. Facility Policy/procedure titled, "Patient disconnections for patients. Leaving Against Medical Advice (AMA)," publication date 02/01/2023 indicates under: 2. AMA Process: Policy: Nursing Leadership will reinforce VI. PROCEDURES: Patient Leaving Against Medical A. The patient requests to leave AMA. Advice (AMA) Policy in tier 1 5. Complete an incident report in the web-based huddles, rounding and monitor incident reporting system. compliance. AMAs will be reported to department leadership 3. Review of P9 MR indicated the patient was through escalation process. admitted on 08/27/24: a. On 08/27/24 at 1202 hours P9 had orders to be **Prevent Recurrence:** nothing by mouth (NPO) except sips of water and 1. Medication Administration and Lactated Ringers 110 milliliters (ml) per hour, Management: continuous infusion. Unit manager or delegated charge On 08/27/24 MR indicated 605.57 ml was infused. nurse will audit iaware signing/IVF Per order, it should have infused 1320 ml over 12 totals with Cerner chart reviews on 10 random patient charts per week On 08/28/24 at 0826 hours, P9 had an order for for 30 days or until 2 consecutive clear liquid diet, start no fluid restrictions, and weeks achieve 100% compliance. Dextrose 5% Sodium Chloride 0.45% PREMIX + 2. AMA Process: Potassium Chloride PREMIX IV (Intravenous) Manager to audit AMA and continuous 84 ml per hour. On 08/28/24 MR incident report completions for 6 indicated 1218.42 ml was infused over 24 hours. months or until there are no Per order, it should have infused 2016 ml over 24 identified deviations from standard. On 08/29/24 at 0721 hours, P9 had an order for full Role Responsible: Clinical liquid diet, no fluid restrictions, and Dextrose 5% Manager Sodium Chloride 0.45% PREMIX + Potassium Completion Date: 12/1/24 Chloride PREMIX IV continuous 42 ml per hour. On 08/29/24 MR indicated 606.49 ml was infused. Per order, it should have infused 1008 ml over 24

hours.

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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 00 COMPLETED				
		150056	B. WING			10/09/	2024
NAME OF T	PROVIDER OR SUPPLIER		STRE	ET ADDR	RESS, CITY, STATE, ZIP COD		
					NATE BLVD		
INDIANA	UNIVERSITY HEA	LTH	INDI	ANAPO	DLIS, IN 46202		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	С	(EACH CORRECTIVE ACTION SHOULD BE EROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	_	DEFICIENCY)		DATE
		8 hours, P9 had an order to be					
		ps and Dextrose 5% Sodium EMIX + Potassium Chloride					
		uous 84 ml per hour. On					
		ated 470.24 ml was infused. Per					
		e infused 2016 ml over 24					
	hours.	c infused 2010 inflover 24					
		8 hours, orders continue from					
		ept ice chips and Dextrose 5%					
		45% PREMIX + Potassium					
		IV continuous 84 ml per hour.					
		dicated 782.85 ml was infused.					
	Per order, it should	have infused 2016 ml over 24					
	hours.						
	On 09/01/24 at 173	7 hours, P9's diet was changed					
	to NPO except med	ications, Dextrose 5% Sodium					
	Chloride 0.45% PR	EMIX + Potassium Chloride					
	PREMIX IV contin	uous 125 ml per hour. On					
		ated 0 ml was infused. Per order,					
	it should have infus	ed 3000 ml over 24 hours.					
	b. P9 MR indicated	on discharge summary P9					
		F1 against medical advice					
	_	ated P9 had the capacity to					
		gned the AMA form and left.					
	-	ly ready to leave, but left					
	AMA, not tolerating	g PO and with concern for					
	anastomotic strictur	e.					
	4 Review of Incide	ent Report Logs from 03/05/24 -					
		nds related to allegations and					
	indicated there were no incidents related to						
	patients reviewed.						
		1 (Manager Accreditation &					
		08/24 at 4:15 p.m., confirmed					
	there were no IR's r	related to P9 leaving AMA.					
	6. Interview with A	2 (Clinical Nurse Specialist), on					
		n., confirmed P9's IV fluids were					

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

Event ID:

HFY711 Facility ID: 005051

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PRINTED: 11/12/2024
FORM APPROVED
OMB NO. 0938-039
ONSTRUCTION
P33 DATE SURVEY

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) D			(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	COMPLETED	
		150056	B. WING			10/09/2024		
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		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	I E	DATE	
	not given per physic	rian order.						
S 0000								
Bldg. 00								
ыад. 00	This visit was for th Licensure hospital c	e investigation of a State omplaint.	S 00	000				
	Complaint IN00442 allegations are cited	461 - Deficiencies related to the at S0930.						
	Survey dates: 10/08	3/2024 - 10/09/2024						
	Facility Number: 005051							
	QA: 10/21/24							
S 0930	410 IAC 15-1.5-6 NURSING SERVI	0 F						
Bldg. 00	410 IAC 15-1.5-6							
	(b) The nursing se following:	rvice shall have the						
	and evaluate the oprovided to each passed on document services failed to en	arse shall supervise care planned for and patient. review and interview, nursing sure supervision of nursing rform one of the 5 rights, right	S 0930		S0930 Plan of Correction Text 1. Medication Administration a Management:		12/01/2024	
	dose, for 1 medical and failed to ensure report (IR) related to medical advice (AM reviewed (P9).	record (MR) reviewed (P9); completion of an incident patient leaving against IA) in 1 out of 10 patient MRs			Failing to perform one of the 5 rights, right dose: IVF laware totals not signed, patient frequently ambulating with pun paused and disconnected, missing clinical note related to fluids not running.	mp		
	Findings include:							
	1. Facility Policy/pr	ocedure titled, "Medication			Unit leadership will reinforce nursing staff to improve the us	e of		

State Form Event ID: HFY711 Facility ID: 005051 If continuation sheet Page 4 of 7

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

PRINTED: 11/12/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 150056		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/09/2024	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH			STREET ADDRESS, CITY, STATE, ZIP COD 1701 N SENATE BLVD INDIANAPOLIS, IN 46202				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE
IAU		Management," publication		IAU	iaware correctly and provide a	1	DATE
		dicates the following:			reminder to sign fluid totals ea		
	VI. Procedures:	8			shift through tier 1 huddles an		
	Administration:				safe handoff checklist that		
	B. The team memb	er administering medications			includes (as of October 2024)		
	must perform the 5	rights plus 4 checks (9 rights)			iaware signing beginning		
	on all medications	prior to administering them to a			11/6/2024. Unit team leads ve	rify	
	_	es right patient, right			safe handoff checklists compl		
		ose, right time, right route, right			by each nurse every shift for 3	30	
		ht action, right form, and right			days.		
	response. If bar code scan technology is available, scan patient identification band and patient medication.						
					Secondary IV fluids infusions	may	
					disrupt primary IV total fluid		
	2 Eggility Doligy/n	rocedure titled, "Patient			volumes as well as providers		
		fedical Advice (AMA),"			approving pump pause and disconnections for patients.		
		/01/2023 indicates under:			disconnections for patients.		
	Policy:	70172023 marcutes under.			2. AMA Process:		
	VI. PROCEDURES	S:			Nursing Leadership will reinfo	rce	
	A. The patient requ				Patient Leaving Against Medic		
		ident report in the web-based			Advice (AMA) Policy in tier 1		
	incident reporting s	ystem.			huddles, rounding and monito	r	
					compliance. AMAs will be		
		R indicated the patient was			reported to department leader	ship	
	admitted on 08/27/2				through escalation process.		
		202 hours P9 had orders to be					
		NPO) except sips of water and			Prevent Recurrence:		
	continuous infusior	10 milliliters (ml) per hour,			Medication Administration a Management:	ırıa	
		ndicated 605.57 ml was infused.			Management: Unit manager or delegated ch	orgo	
		have infused 1320 ml over 12			nurse will audit iaware signing	_	
	hours.	nave infused 1520 ini 0vel 12			totals with Cerner chart review		
		6 hours, P9 had an order for			10 random patient charts per		
		art no fluid restrictions, and			for 30 days or until 2 consecut		
	•	m Chloride 0.45% PREMIX +			weeks achieve 100% complia		
		PREMIX IV (Intravenous)			2. AMA Process:		
	continuous 84 ml p	er hour. On 08/28/24 MR			Manager to audit AMA and		
	indicated 1218.42 r	nl was infused over 24 hours.			incident report completions for	r 6	
	Per order, it should	have infused 2016 ml over 24			months or until there are no		
	hours.				identified deviations from		

State Form Event ID: HFY711 Facility ID: 005051 If continuation sheet Page 5 of 7

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

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 150056		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/09/2024		
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH				1701 N	ADDRESS, CITY, STATE, ZIP COD I SENATE BLVD NAPOLIS, IN 46202		
PRI) ID EFIX 'AG	(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 APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
		On 08/29/24 at 072 liquid diet, no fluid Sodium Chloride 0. Chloride PREMIX On 08/29/24 MR in Per order, it should hours. On 08/30/24 at 052: NPO except ice chip Chloride 0.45% PR PREMIX IV contin 08/30/24 MR indica order, it should have hours. On 08/31/24 at 052: 08/30/24, NPO except ice chip Chloride 0.45% PR PREMIX IV contin 08/30/24 MR indica order, it should have hours. On 08/31/24 at 052: 08/30/24, NPO except ice chip Chloride PREMIX IV Chloride PREMIX IV Chloride PREMIX IV Chloride 0.45% PR PREMIX IV contin 09/01/24 MR indicated it should have infus b. P9 MR indicated requested to leave F (AMA). MR indicated requested to leave F (AMA). MR indicated leave AMA; they si P9 was not medical	I LSC IDENTIFYING INFORMATION I hours, P9 had an order for full restrictions, and Dextrose 5% 45% PREMIX + Potassium IV continuous 42 ml per hour. dicated 606.49 ml was infused. have infused 1008 ml over 24 Is hours, P9 had an order to be ps and Dextrose 5% Sodium EMIX + Potassium Chloride uous 84 ml per hour. On ated 470.24 ml was infused. Per e infused 2016 ml over 24 Is hours, orders continue from ept ice chips and Dextrose 5% 45% PREMIX + Potassium IV continuous 84 ml per hour. dicated 782.85 ml was infused. have infused 2016 ml over 24 If hours, P9's diet was changed ications, Dextrose 5% Sodium EMIX + Potassium Chloride uous 125 ml per hour. On ated 0 ml was infused. Per order, ed 3000 ml over 24 hours. On discharge summary P9 If against medical advice ated P9 had the capacity to gned the AMA form and left. By ready to leave, but left g PO and with concern for		CROSS-REFERENCED TO THE APPROPRI	ATE	
		09/05/24 lacked trea	nt Report Logs from 03/05/24 - nds related to allegations and e no incidents related to				

State Form Event ID: HFY711 Facility ID: 005051 If continuation sheet Page 6 of 7

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

PRINTED: 11/12/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A.		(X2) MULT A. BUILE B. WING	DING	nstruction <u>00</u>	(X3) DATE COMPL 10/09/	ETED	
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH				1701 N	ADDRESS, CITY, STATE, ZIP COD SENATE BLVD APOLIS, IN 46202		
(X4) ID		STATEMENT OF DEFICIENCIE	Ī	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		ATE	COMPLETION DATE
IAG			1	Au			DATE
		1 (Manager Accreditation &					
	1 0 2//	08/24 at 4:15 p.m., confirmed					
	there were no IR's r	related to P9 leaving AMA.					
	6. Interview with A	2 (Clinical Nurse Specialist), on					
	10/08/24 at 4:30 p.i not given per physic	m., confirmed P9's IV fluids were cian order.					

State Form Event ID: HFY711 Facility ID: 005051 If continuation sheet Page 7 of 7