EPARTMENT OF H ENTERS FOR MEDI	FORM APPROVED OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150162	(X2) MULTIPLE (A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2023	
NAME OF PROVIE			8111	I ADDRESS, CITY, STATE, ZIP COD S EMERSON AVE	1
FRANCISCAN	HEALTH IN	DIANAPOLIS	INDIA	NAPOLIS, IN 46237	
	(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETIO
Lice Con the a Surv Faci	ensure Hospita nplaint IN0038 allegations is c vey Date: Sepi lity Number:	7240 - State deficiency related to ited at tag S0930. rember 11, 2023	S 0000	 How are you going to correct the deficiency? If air corrected, include the steps and the date of correction. Re-educate all clinical on linen change, catheter of and replacement of extern catheter guidelines via Huddle-Up educational document. How are you going to prevent the deficiency from recurring in the future? Nursing departments complete chart audits to ver adequate linen change, catheter care, and replacer of external catheter. Chart audits on will be document via Vocera care rounds. Nursing managers w audit 5 charts per month for consecutive months with a compliance rate of 100% ai quarterly audits thereafter. Audit results to be complied on the Quality PI Dashboard for each department and reported u through Quality Council quarterly. Who is going to be responsible for numbers 1 ai 	eady taken staff care, aal s will erify ment ted fill or 3 a nd

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURETITLE(X6) DATEJulie Marie Temperly BornsAccreditation Coordinator10/03/2023

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. PRINTED:

10/10/2023

OF DEFICIENCIES F CORRECTION	x1) provider/supplier/clia identification number 150162	A. BU	ILDING	DNSTRUCTION	X3) DATE SURVEY COMPLETED 09/11/2023	
OVIDER OR SUPPLIE	•		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			
	NAME OF PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
CAN HEALTH IND	DIANAPOLIS			IAPOLIS, IN 46237		
(EACH DEFICIEN				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	ETION
				above; i.e., director, supervisor etc.?	,	
				 Nursing Director of Operations is responsible for ongoing compliance for this action plan. Nursing manager is responsible for department chart audits. Education manager is responsible for staff re-education. 		
				 to have the deficiency corrected OCTOBER 25, 2023 5. You must provide a spect date the deficiency will be or habeen corrected (month, day, ar year) in the "Completion Date" column. The maximum correcti time allowed is thirty (30) days from the Notice of Noncomplian October 25, 2023, for education and monitoring (audits will be ongoing). 6. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written the stable of the deficiency of the notice of the deficiency for the notice of the no	d? sific as nd on nce.	
		(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		•	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG TAG above; i.e., director, supervisor etc.? above; i.e., director, supervisor etc.? • Nursing Director of Operations is responsible for ongoing compliance for this action plan. • Nursing manager is responsible for department chart audits. • Education manager is responsible for staff re-education. 4. By what date are you go to have the deficiency correcte • OCTOBER 25, 2023 5. You must provide a spec date the deficiency will be or ha been corrected (month, day, ar year) in the "Completion Date" column. The maximum correct time allowed is thirty (30) days, time education and monitoring (audits will be ongoing). 6. If the nature of the deficiency (30) days, time	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG COMPLE TAG COMPLE DEFICIENCY COMPLE DEFICIENCY COMPLE DEFICIENCY DAT above; i.e., director, supervisor, etc.? I.e., Nursing Director of Operations is responsible for ongoing compliance for this action plan. I.e., Nursing manager is responsible for department chart audits. I.e., Education manager is responsible for staff re-education. 4. By what date are you going to have the deficiency corrected? I.e., OCTOBER 25, 2023 I.e., OCTOBER 25, 2023 5. You must provide a specific date the deficiency will be or has been corrected (month, day, and year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the Notice of Noncompliance. I.e., October 25, 2023, for education and monitoring (audits will be ongoing). I.e. If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written

ation sheet Page 2 of 5

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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 150162 B. WING 09/11/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8111 S EMERSON AVE FRANCISCAN HEALTH INDIANAPOLIS INDIANAPOLIS. IN 46237 (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 S 0930 410 IAC 15-1.5-6 NURSING SERVICE Bldg. 00 410 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 provided to each patient. S 0930 How are you going to 10/25/2023 1. Based on document review, and interview, the correct the deficiency? If already facility failed to document bed linen changes in 4 corrected, include the steps taken of 5 (patients 1, 2, 3, and 4) medical records; linen and the date of correction. change after incidence of incontinence in 1 of 5 (patient 5) medical records; and perineal/catheter Re-educate all clinical staff care and replacement of external catheter in 1 of 5 on linen change, catheter care, (patient 5) medical records reviewed. and replacement of external catheter guidelines via Findings include: Huddle-Up educational document. 1. Review of policy titled, "Urinary Catheter Infection Prevention and Removal Guideline", last 2. How are you going to revised 09/29/2022, stated catheter care and prevent the deficiency from perineal care be completed each shift, with each recurring in the future? stool, and as needed, and document perineal care in the EMR (electronic medical record). Nursing departments will complete chart audits to verify 2. Review of policy titled, "Linen/Bed Makeup adequate linen change, Guideline", last revised on 07/07/2022, stated bed catheter care, and replacement linen will be changed when wet, or visibly soiled, of external catheter. Chart or contaminated with blood and body fluids; any audits on will be documented time the patient or family requests; and on via Vocera care rounds. scheduled linen days, and to document on flow Nursing managers will sheet. audit 5 charts per month for 3 consecutive months with a 3. Review of document titled, "Purewick Female compliance rate of 100% and External Catheter", stated to replace the Purewick quarterly audits thereafter. female external catheter at least every 8 to 12 Audit results to be hours or if soiled with feces or blood; and assess complied on the Quality PI State Form

YTKN11 Event ID: Facility ID: 004972 If continuation sheet Page 3 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150162	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 09/11/2023		
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP COD 8111 S EMERSON AVE INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION and nationt's skin at least every		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE PRIATE	(X5) COMPLETION DATE
	 2 hours. 4. Review of medi documentation of p each shift. 5. Review of medi bed linen change d of stay and medica documentation of p incontinence. 6. Review of medi documentation of p female catheter. 7. Interview with A Registered Nurse) 2:30 pm confirmed linen change docum replacement of ext 8. Interview with A Coordinator and R at 3:20 pm, confirm education stated to hours or if soiled y device placement a 2 hours. 9. Interview with A Education) on 09/1 pm, confirmed pol on use of external 	linen changes after incidents of cal record 5 lacked change replacement of external A2 (Clinical Informaticist and on 09/11/2022, at approximately d that the MRs reviewed lacked mentation, catheter care, and			 Dashboard for each department and reported of through Quality Council quarterly. Who is going to be responsible for numbers 1 a above; i.e., director, superv etc.? Nursing Director of Operations is responsible ongoing compliance for th action plan. Nursing manager is responsible for departmer chart audits. Education manager responsible for staff re-education. By what date are you to have the deficiency corretsions. You must provide a st date the deficiency will be of been corrected (month, day year) in the "Completion Data column. The maximum corr time allowed is thirty (30) data from the Notice of Noncomption October 25, 2023, for education and monitoring (audits will be ongoing). If the nature of the defici- precludes completion within 	and 2 isor, for his nt is going ected? pecific or has v, and hte" ection ays poliance. r	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0							
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		150162	B. WING			09/11/2023	
	NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP COD 8111 S EMERSON AVE INDIANAPOLIS, IN 46237			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
					Plan of Correction must be written in incremental thirty (30) day phases. N/A		

State Form

Event ID: YTKN11 Facility ID: 004972 If continuation sheet Page 5 of 5