PRINTED: 11/24/2019 FORM APPROVED OMB NO. 0938-039

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S 0000 Bldg. 00 This v hospit. Comp Substa allegat Survey Facilit QA: 1 S 0930 410 IA NURS	s visit was for in			TAG		ΤE	COMPLETION
Bldg. 00 This v hospit. Comp Substa allegat Survey Facilit QA: 1 S 0930 410 IA NURS					DEFICIENCY)		DATE
This v hospit. Comp Substa allegat Survey Facilit QA: 1 S 0930 410 IA NURS							
Survey Facilit QA: 1 S 0930 410 IA NURS	This visit was for investigation of a state licensure hospital complaint. Complaint Number: IN00221628 Substantiated: Deficiency related to the allegations is cited. Survey Date: 10/10/2019 Facility Number: 005051		S 0000				
S 0930 410 IA							
NURS	: 10/31/19						
(b) Th follow (3) A I and elements are also also also also also also also also	A registered nut evaluate the covided to each page on document ality failed to project to shampoointent medical reco	rvice shall have the urse shall supervise eare planned for and patient. review and interview, the vide documentation of care and patient's hair for 1 of 5 ands (MR) reviewed (patient 1) antities for 1 of 5 patient MRs	S 09	30	Finding #1 Review of patient 1's MR indic patient required assistance at times with daily hygiene and patient had hair shampooed or 1/08/2017, then not again until 1/26/2017 (17 days). During a review of unit operation early 2017 leadership identification opportunities with documentation around activities of a daily living a review of a daily	n ons fied ion	11/11/2019

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.

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STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
150056		B. WING 10/10/2019			2019		
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
INIDIANA UNIVERSITY HEALTH					SENATE BLVD		
INDIANA	UNIVERSITY HEA	LIH		INDIAN	IAPOLIS, IN 46202		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	1.5	DATE
	weeks (14 days) should elapse between hair				we discovered team members	;	
	shampooing.				were actually completing these	е	
					tasks but were not accurately		
	2. Review of patier	nt 1's MR indicated patient			recording them in the medical		
	-	at times with daily hygiene			record. We began developing		
	-	shampooed on 1/08/2017,		standard work in early 2017 which			
	_	1/26/2017 (17 days).			included the completion and	ļ	
	-				offering of ADLS and reinforce	ed the	
	3. Review of patier	nt 2's MR indicated an order		importance of charting ADLS. This			
	start date of 1/26/20	017 for elevated lower left			re-education and reinforcing o		
	extremity on 2 pillows. MR lacked documentation			standard work expectations was			
	of elevated lower le	eft extremity on 1/29/2017 and			completed with all team memb	oers	
	1/30/2017.			by May of 2017. We also began			
					weekly spot audits of patients		
	4. Interview on 10/10/2019, at approximately 14:55				charting to ensure improved		
	hours with N2 (Quality Improvement Consultant)				charting and compliance and i	n	
	confirmed the facility followed Lippincott				the moment coaching of team		
	Procedures.				members. We noticed an		
					improvement in compliance w	ith	
	 5. Interview on 10/10/2019, at approximately 11:44 hours with N2, confirmed patient 1 went 17 days between hair washings. 6. Interview on 10/10/2019, at approximately 14:22 hours with N2, confirmed MR lacked documentation of elevated lower left extremity on 				charting ADLS which includes	hair	
					washing so the unit moved to)	
					quarterly audits in January of		
					2018.		
					The unit will continue quarterly	,	
					audit process as we feel that t	he	
					finding related to this complain		
	1/29/2017 and 1/30/2017 per Physician order.				dates back to January 2017 h	ave	
					been corrected, but with on		
					boarding of new team membe	rs it	
					is important that we continue t	.О	
					monitor. We will continue to		
					randomly audit patient charts		
					quarterly. If we detect someth	-	
					through this monitoring or hav	е	
					other reasons to believe		
					compliance has slipped than v		
					will increase frequency of aud		
					monitoring until a satisfactory	level	
					has been achieved.		
					Auditing is completed by the s	hift	

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

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER						COMPLETED		
150056		B. WING 10/10/2019				2019		
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH			STREET ADDRESS, CITY, STATE, ZIP COD 1701 N SENATE BLVD INDIANAPOLIS, IN 46202					
IIIDIANA	·			INDIAN	AI OLIO, IIV 40202			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION	
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE	
	•				coordinators or assigned to a charge nurse who provides real-time feedback on perform to team members and then resare reviewed by the manager then reported to the director. Thursing leadership team consisting of shift coordinators educator, manager and director will discuss the results and loc for any trends or opportunities improve documentation and patient care. Finding #2 Review of patient 2's MR indicated an order start date of 1/26/201 elevated lower left extremity of pillows. MR lacked documentation of elevated low left extremity on 1/29/2017 and 1/30/2017. During a review of unit operation early 2017 leadership idention opportunities with documentation are patient care orders which inclusive tremity elevation. We investigated and performed set days of observations and discovered team members we actually completing these task but were not accurately documenting them in the mediate record in a consistent fashion. The unit began developing standard work in early 2017 wincluded the completion of patient completion of patients of the patients of the provided the completion of patients.	ance sults and The a, or ok to atted 7 for n 2 ver d ons fied ion nd ude everal ere is ical		
					care such as elevation, turn ar mobility. Leadership reinforced			

State Form Event ID: O5H411 Facility ID: 005051 If continuation sheet Page 3 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>		00	COMPLETED		
150056		150056	B. WING 10,		10/10/	10/10/2019		
		1	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF PROVIDER OR SUPPLIER					SENATE BLVD			
INDIANA	UNIVERSITY HEA	ALTH			APOLIS, IN 46202			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
					importance of charting and if r			
					completed because of refusal	that		
					was documented. This	_		
					re-education and reinforcing o			
					standard work expectations w			
					completed with all team memb			
					by May of 2017. We also beg	an		
					weekly spot audits to ensure			
					improved charting and complia			
					and in the moment coaching of			
					team members. As improvement	ent		
					was noted and charting and compliance improved through	out		
					2017 auditing was moved to	but		
					random quarterly audits in last			
					quarter of 2017.	•		
					The unit will continue quarterly	,		
					audit process as we feel that t			
					finding related to this complain			
					dates back to January 2017 ha			
					been corrected, but with on	440		
					boarding of new team membe	rs it		
					is important that we continue t			
					monitor. We will continue to	· -		
					randomly audit patient charts			
					quarterly. If we detect someth	ing		
					through this monitoring or hav			
					other reasons to believe			
					compliance has slipped than v	ve		
					will increase frequency of aud			
					monitoring until a satisfactory			
					has been achieved.			
					Auditing is completed by the s	hift		
					coordinators or assigned to a			
					charge nurse who provides			
					real-time feedback on perform	ance		
					to team members and then re-			
					are reviewed by the manager	and		
					then reported to the director. 7	「he		
			1		nursing leadership team			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
111,15 12,111	or condition.	150056	B. WING		10/10/2019		
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH			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 APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
				consisting of shift coordinators educator, manager and direct will discuss the results and loc for any trends or opportunities improve documentation and patient care.	tor ok		

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