STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154054	A. BUILDING _____ B. WING _____	C 10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARSHA BEHAVIORAL CENTER INC	1980 E WOODSMALL DR TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS This visit was for the Investigation of a Federal Hospital Complaint. Complaint Number: IN00444219- Deficiencies related to the allegations are cited. (A0147, A0398) Survey date: 10/7/24 Facility Number: 012013 QA: 12/17/2024	A 000		
A 147	PATIENT RIGHTS: CONFIDENTIALITY OF RECORDS CFR(s): 482.13(d)(1) The patient has the right to the confidentiality of his or her clinical records. This STANDARD is not met as evidenced by: Based on document review and interview, facility failed to uphold patient's rights of confidentiality per facility policy for 2 of 10 MR's (Medical Records) reviewed. (P1, P2) Findings include: 1. Facility document titled Adult Unit Patient Handbook, under Patient Rights, the patient has the right to confidentiality of communications by the patient to staff and all information in the case record. 2. Review of P1 MR indicated:	A 147		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154054	A. BUILDING _____ B. WING _____	C 10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARSHA BEHAVIORAL CENTER INC	1980 E WOODSMALL DR TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 147	Continued From page 1 a. Patient admitted to facility 7/16/24 through 7/24/24 for diagnosis of Brief Psychotic Disorder. b. MR indicated P2 signature on P1's Prescription Manifest Form to take Haloperidol prescription home on 7/23/24, signature was lined out, error marked, and P1 signed form at discharge on 7/24/24. 3. In interview on 10/7/24 at approximately 1055 hours with N6, he/she indicated signing for P1's medication when pharmacy delivered them to the facility, and he/she placed them on P1's chart in medication room. N6 indicated he/she went on break and upon returning P2 had discharged to home and he/she's chart was gone. Approximately one hour later P2 phoned facility reporting he/she was sent home with another patient's medications, N6 instructed P2 to return medication to facility and P2 returned medication. N6 confirmed wrong medication was sent home with P2. N6 also confirmed P2 did sign a copy of P1's medication form with confidential information on it on 7/23/24 at 1430 hours, and the following day P2's name was crossed off Prescription Manifest form and P1 signed the same form with P2's name on it the following day on 7/24/23 with incorrect discharge date and time for P1. 5. In interview on 10/7/24 at approximately 1130 hours, A1 (Chief Nursing Officer) and A5 (Chief Operating Officer), they confirmed a breach in patient rights of confidentiality for P1 and P2.	A 147		
A 398	SUPERVISION OF CONTRACT STAFF CFR(s): 482.23(b)(6) All licensed nurses who provide services in the hospital must adhere to the policies and procedures of the hospital. The director of	A 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154054	A. BUILDING _____ B. WING _____	C 10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARSHA BEHAVIORAL CENTER INC	1980 E WOODSMALL DR TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 398	Continued From page 2	A 398		

nursing service must provide for the adequate supervision and evaluation of all nursing personnel which occur within the responsibility of the nursing service, regardless of the mechanism through which those personnel are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer).
This STANDARD is not met as evidenced by:
Based on document review and interview, Nursing Services failed to complete an incident report per facility policy for 2 of 10 patient MR's (medical records) reviewed. (P1 & P2)

Findings include:

1. Facility policy titled Medication Errors, no policy number, last reviewed 12/2022, under Policy: It is the responsibility of all clinical staff to report medication errors utilizing an Incident Report (form CS29OA). Under Procedure: 2. Clinical staff documents the description of the incident, action, and notification of physician and/or supervisor on the Incident Report (CS290A). The original form will be sent to the CNO (Chief Nursing Officer) and/or the Director of Quality to be reviewed and report on Quality and Process Improvement Committee meeting. 4. All incident report forms are reported by the clinical staff to the CNO or Director of Quality within 24 hours of identification.

2. Facility policy titled Incident and Regulatory Reporting, no policy number, last reviewed 1/2023, under Policy: The responsibility for completing an Incident report rests with any hospital staff member, volunteer, student or physician who witnesses, discovers or has direct knowledge of any incident. Incidents are defined as any happening not consistent with the routine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154054	A. BUILDING _____ B. WING _____	C 10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARSHA BEHAVIORAL CENTER INC	1980 E WOODSMALL DR TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 398	Continued From page 3	A 398		

care and/or operation of the facility at increased risk for liability. Under Procedure: 1. Any hospital staff member who witnesses, discovers or has direct knowledge of an occurrence should complete an Incident Report as soon as practical after the incident is witnessed or discovered, before the end of the shift/workday. E. An event occurs which, by standards, appears unexpected and/or unintended (i.e., medication error, medical emergency, exposure to allergen). 2. Information to be entered on the Incident Report includes (items with * MUST be completed). A. Patient label if applicable. B.*Date and time of occurrence. C.*Shift during which the incident occurred (i. e. 7 a.m.-7 p.m.). D.*Location occurrence took place. E.*Person(s) involved (patient, employee, volunteer, visitor, student, etc.). F.*Name of individual involved. G. If the individual is not a patient, the address and telephone number of the individual. H. Type of occurrence (accidental injury, elopement, fall, etc.). I. *Brief description of the incident, resulting, if any and outcome. The individual completing the Incident Report should provide a narrative description of the occurrence to include facts witnessed, discovered or of which the individual has direct knowledge. No assumption of facts or opinions should be stated. Comments made by the party involved should be documented as quotes by the individual completing the report. Print and attach documentation of the incident from the EMAR. J.*Immediate correction actions taken when the incident occurred, or was discovered. K.*How the writer became aware of the incident (witness to incident, discovered after the incident, told of incident by patient, etc.). L.*Notification of supervisor, MD, administrator on-call, and/or family to include who was contacted, when and by whom. The unit nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154054	A. BUILDING _____ B. WING _____	C 10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARSHA BEHAVIORAL CENTER INC	1980 E WOODSMALL DR TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 398	Continued From page 4	A 398		

should determine whether the incident warrants contacting the administrator on-call, risk manager and/or the family member based on the severity of the incident and the Communication Protocol (CS1055) policy which specifies notification will occur for all Acute Changes in Condition, ER Transfers, Falls, injuries, Seclusions and Restraints, Medication Errors, and Psychotropic Medication Changes in Youth. M.*Name of any witnesses to the actual occurrence. N.*The signature of the staff person completing the report.

3. Review of P1 MR indicated:
a. Patient admitted to facility 7/16/24 through 7/24/24 for diagnosis of Brief Psychotic Disorder.
b. MR indicated P2 signature on P1's Prescription Manifest Form to take Haloperidol prescription home on 7/23/24; signature was lined out, error marked, and P1 signed form at discharge on 7/24/24.

4. Review of facility Incident Reports on 10/7/24 at approximately 1005 hours, lacked documentation of an incident report on 7/23/24 regarding wrong medication sent home with P2.

5. In interview on 10/7/24 at approximately 1055 hours with N6, he/she indicated signing for P1's medication when pharmacy delivered them to the facility, and he/she placed them on P1's chart in medication room. N6 indicated he/she went on break and upon returning P2 had discharged to home and his/her chart was gone. Approximately one hour later P2 phoned facility reporting he/she was sent home with another patient's medications, N6 instructed P2 to return medication to facility and P2 returned medication. N6 confirmed wrong medication was sent home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154054	A. BUILDING _____ B. WING _____	C 10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARSHA BEHAVIORAL CENTER INC	1980 E WOODSMALL DR TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 398	Continued From page 5 with P2. N6 confirmed there was not an incident report filled out on the medication error. N6 also confirmed P2 did sign a copy of P1's medication form with confidential information on it on 7/23/24 at 1430 hours, and the following day P2's name was crossed off form and P1 signed the same form with P2's name on it the following day on 7/24/23 with incorrect discharge date and time for P1. 7. In interview on 10/7/24 at approximately 1130 hours, A1 (Chief Nursing Officer) and A5 (Chief Operating Officer), they confirmed a breach in patient rights of confidentiality for P1 and P2, no incident report was filed, and facility administration was unaware of the incident	A 398		