

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 154064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2025
NAME OF PROVIDER OR SUPPLIER  ASSURANCE HEALTH PSYCHIATRIC HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP COD 900 NORTH HIGH SCHOOL ROAD INDIANAPOLIS, IN 46214		
(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 0000  Bldg. 00	<p>This visit was for an investigation of a Federal Hospital Complaint.</p> <p>Complaint Number IN00453879 - Deficiency cited related to allegations at A0395.</p> <p>Survey Date: 03/03/2025</p> <p>Facility Number 013899</p> <p>QA: 03/07/2025</p>	A 0000		
A 0395  Bldg. 00	<p>482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient.</p> <p>Based on document review and interview, nursing services failed to obtain provider ordered labs in 1 of 10 (Patient 2) medical records reviewed.</p> <p>Findings include:</p> <p>1. Review of Patient 2's medical record indicated the following:</p> <p>a. The patient was admitted on 12/27/2024</p> <p>b. On Saturday, 01/04/2025, at 6:09 p.m. the provider ordered a Basic Metabolic Panel (BMP) and a Lithium level to be drawn on Mondays and Thursdays. MR indicated the order was noted on Sunday, 01/05/2025, at 7:39 a.m. MR lacked documentation that lab was drawn and completed as ordered on Monday, 01/06/2025.</p> <p>c. Patient 2 was discharged on Tuesday, 01/07/2025, in stable condition.</p>	A 0395	<p>To correct standard A 395, education on completing lab work was posted to all staff on 2/28/25. Starting on 3/24/25, Director of Nursing will review every patient chart to ensure all lab work is completed once a week for four weeks. Lab work will also be reviewed during treatment team once a week for each patient from now on to ensure it has all been completed prior to discharge.</p>	04/21/2025

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

TITLE

(X6) DATE

Mikah Duncan

Regional Quality Manager

03/21/2025

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

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

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	2. Interview with A1 (Quality Manager) on 03/03/2025 at approximately 10:45 a.m. confirmed nursing staff failed to obtain Basic Metabolic Panel and Lithium level as ordered by the provider during patient 2's hospitalization.			