	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		154064	B. WING		C 09/12/2023
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
ASSURAN	ICE HEALTH PSYCHIATI	RIC HOSPITAL		900 NORTH HIGH SCHOOL ROAD INDIANAPOLIS, IN 46214	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
A 000	INITIAL COMMENTS		A 00	00	
	This visit was for the hospital complaint.	investigation of a Federal			
	-	N00416664 - Federal o the allegation are cited at 2 and A0395.			
	Survey Date: 9/12/23	3 - 9/13/23			
	Facility Number: 013	899			
A 144	QA: 9/22/2023 PATIENT RIGHTS: C CFR(s): 482.13(c)(2)	ARE IN SAFE SETTING	A 14	14	11/4/23
	setting. This STANDARD is r Based on document facility failed to ensur	ght to receive care in a safe not met as evidenced by: review and interview, the e care in a safe setting in 8 P 3, P 4, P 5, P 6, P 7 & P			
	Findings include:				
	Responsibilities", Pol 06/2021, indicated pa treated in a safe envi	titled, "Patient Rights And icy No RE 09, last reviewed atients have the right to be ronment with reasonable cal or emotional abuse or			
	admitted on 3/24/23 a	was a 81 y/o (year/old)			
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
154064		154064	B. WING				C 12/2023
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	. <u> </u>	
				9	900 NORTH HIGH SCHOOL ROAD		
ASSURAN	ICE HEALTH PSYCHIATE	RIC HOSPITAL		I	INDIANAPOLIS, IN 46214		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
A 144	Admission Review Do at 2:07 pm indicated I 3 (Acute Care Hospita (Rehabilitation Facility staff member with a w face/head/neck unpro- to return to H 2 follow P 1 was aggressive w refusing a lab drawl a had a recent arrest in spraying bleach on cu upon assessment P 1 person/place, suspicie aggressive and hostili- ordered inpatient at H 3. Incident Reports (II aggression and/or vio a. IR dated 3/28/23 at pushed P 7 causing h close to P 1's food. Incident Report (IR) d indicated P 1 pushed walking near him/her. No new orders for P 1 b. IR dated 4/4/23 at in the face because P sustained a cut on the new orders for P 1. c. IR dated 5/3/23 at 8 punched P 4 in the her near P 1 in the Milieu P 4. No new orders for d. IR dated 5/5/23 at 4 pushed P 4 down to t	ted to, schizoaffective hizophrenia, hysema and hypertension. boumentation dated 3/24/23 P 1 was transferred from H al) after an incident at H 2 y) where he/she stabbed a vriting instrument in the woked. P 1 was not allowed ing the discharge from H 3. vith staff at H 3 while ttempt, refuses medication, 09/23 for swallowing and ustomers at a retail store, was oriented to bus/paranoid, guarded, e. P 1 is currently a court 11. R) reviewed related to P 1's lence are as follows: t 5:00 pm indicated P 1 sim/her to fall for getting too fated 8/15/23 at 5:00 pm P 2 to the ground for No injuries noted for P 2. I. 7:00 am indicated P 1 hit P 7 P 7 grabbed P 1. P 7 e nose and a nose bleed. No B:20 am indicated P 1 ead for grabbing a spoon . No injuries were noted for or P 1	A	144			

Facility ID: 013899

If continuation sheet Page 2 of 9

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/08/2023 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 154064		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		154064	B. WING				C 1 2/2023
NAME OF P	ROVIDER OR SUPPLIER	·		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ASSUDAN				90	0 NORTH HIGH SCHOOL ROAD		
ASSURAN	CE REALTH FOTCHIAN	RICHOSPITAL		IN	DIANAPOLIS, IN 46214		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
A 144	ROVIDER OR SUPPLIER CE HEALTH PSYCHIATRIC HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 new orders for P 1 e. IR dated 5/20/23 at 9:25 pm indicated P 1 pushed P 5 while the patient was ambulating in the Milieu next to P 1' room location. No injuries were noted for P 5. No new orders for P 1. f. IR dated 5/30/23 at 4:05 pm indicated P 1 poured 1 1/2 cup of water on and pushed P 5 for reaching for a cup that didn't belong to P 5. P 5 slid on the poured water and fell in the milieu. No injuries noted for P 5 g. IR dated 5/31/23 at 11:45 am indicated P 1 dumped P 6 out of his/her wheelchair for entering P 1's room. P 6 sustained two skin tears. No new orders for P 1. h. IR dated 6/6/23 at 8:00 pm indicated P 1 poured a full cup of water on and punching P 5 in the head for coming into his/her space. i. IR dated 6/18/23 at 4:00 pm indicated P 1 spilled water on, placed both hands over P 5 's eyes to gouge his/her eyes out for touching him/her by the nurse's station. P 5 sustained a red bruise below the right eye. No new orders for P 1. j. IR dated 7/30/23 at 2:45 pm indicated P 1 hit P 3 in the head with a small cup for going towards P 1 room. P 3 required an emergency send out as a result of this altercation. No new orders for P 1. k. IR dated 8/5/23 at 12:10 pm indicated P 1 splashed water in the face of and hit P 3 in the head with a fist for opening the door to P 1's room. P 3 sustained a cut to the right side of the head which required an emergency send out. No new orders for P 1. I. IR dated 8/5/23 at 8:49 pm indicated P 1 threw a cup of water on P 3 while yelling and verbally threatening him/her. P 3 fell on the floor as a result of the thrown water. No injuries were noted from the fall. No new orders for P 1.		A	144			

Facility ID: 013899

If continuation sheet Page 3 of 9

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION UMBER:		(X2) MULTIPL	(X3) DATE SURVEY COMPLETED		
	154064		A. BUILDING	C	
			B. WING		09/12/202
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
ASSURANCE HEALTH PSYCHIATRIC HOSPITAL				900 NORTH HIGH SCHOOL ROAD INDIANAPOLIS, IN 46214	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPL E APPROPRIATE DA
A 144	Continued From page	e 3	A 144	1	
		cause he/she was tired of P			
	8. The MR lacked documentation of initiation of adequate interventions related to (r/t) patient # 2's aggression to ensure other patients were not physically assaulted.				
	pm with administrativ (Licensed Practical N refuses meds, pushe pours/throws/splashe baseline aggressive t 6 is fearful that P 1 w patient based on disp	lurse), confirmed that P 1 s, hits, es water on, and is at cowards other patients and A rill potentially kill another played behaviors. Staffing is ission, the facility needs			
	pm with administrativ Mental Health Tech), more staff, P 1 is a ve sit by his/her door bu increased to accomm some admissions of v	2/23 at approximately 12:30 e staff member A 7 (Lead confirmed the facility needs ery violent patient, staff is to t staffing numbers aren't nodate and feels there are very sick patients that need an this facility can provide.			
	pm with administrativ Practitioner), confirm violence against othe observation was orde medications are orde because P 1 is clam	2/23 at approximately 2:30 e staff member A 8 (Nurse ed P 1 is very well known for ers, no increased level of ered until 6/19/23 and no prn red after acts of violence post incidents, no adequate ut in place to ensure the			

Facility ID: 013899

If continuation sheet Page 4 of 9

	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/08/202 FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154064			(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED
		B. WING		C 09/12/2023	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE	• • • • •
ASSURAN	ICE HEALTH PSYCHIATE	RIC HOSPITAL		NORTH HIGH SCHOOL ROAD ANAPOLIS, IN 46214	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
A 144	Continued From page		A 144		
4.040	Chief Executive Office understaffed, P 1's ba facility was responsib and no adequate inter to ensure the above p safe setting	e staff member A 5 (Interim er), confirmed the facility is se line is aggressive, the e for care in a safe setting ventions were put in place atients received care in a			
A 340	MEDICAL STAFF PE CFR(s): 482.22(a)(1)	RIODIC APPRAISALS	A 340		10/18/23
		ot met as evidenced by: he facility failed to provide			
A 392	 Files requested by approximately 10:30 a Interview on 9/13/2 with administrative sta Chief Executive Office files are unable to rev appropriate personne currently on berevem member has access to STAFFING AND DEL CFR(s): 482.23(b) The nursing service non numbers of licensed repractical (vocational) to provide nursing car There must be supervision 	ent leave and no other staff o credential files. VERY OF CARE	A 392		11/4/23

Facility ID: 013899

If continuation sheet Page 5 of 9

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
154064		B. WING				C 12/2023	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>,</u>	
ASSURAN	ICE HEALTH PSYCHIATI				900 NORTH HIGH SCHOOL ROAD INDIANAPOLIS, IN 46214		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
A 392	needed, the immedia nurse for care of any This STANDARD is r Based on document	te availability of a registered	A	392	2		
	1. The hospital policy Staffing Guide", Polic	/ titled, "Patient Acuity and y No. NU 96, last reviewed l the goal of staffing the ure patient safety in					
	-	icated if the census was nimum staffing requirement es.					
	17-20 patients the millis 2 nurses and 3 aide the staff to patient rat 2. Staffing Pattern Wo the dates listed on ind 12 out of 27 days wer facility's staffing matri understaffed are as fo a. 3/25/23 - 2 RN / 2 7:30 pm) and night sh a census of 18. b. 3/28/23 - 2 RN / 2 2 BHA for night shift c. 4/9/23 - 2 RN / 2 2 BHA for night shift d. 5/3/23 - 2 RN / 2 census of 17.	orksheet was reviewed for cident reports and indicated re understaffed per the x . Facility dates					

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				FO	ED: 11/08/2023 RM APPROVED NO. 0938-0391
		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
154064	B. WING			C	C 9/12/2023
•	•	STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
		900 N	ORTH HIGH SCHOOL ROAD		
RICHOSPHAL		INDIA	ANAPOLIS, IN 46214		
Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
CE HEALTH PSYCHIATRIC HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 / 2 BHA for night shift with a patient census of 18. f. 5/ 15/23 - 2 RN / 2 BHA for day shift with a census of 18. g. 5/30/23 - 2 RN / 2 BHA for day shift and 2 RN / 2 BHA for night shift with a patient census of 19. h. 6/14/23 - 2 RN / 2 BHA for day shift and 2 RN / 2 BHA for night shift with a patient census of 19. j. 6/16/23 - 2 RN / 2 BHA for day shift with a census of 17. i. 6/16/23 - 2 RN / 2 BHA for day shift with a census of 18. k. 7/3/23 - 2 RN / 2 BHA for day shift with a census of 18. k. 7/3/23 - 2 RN / 2 BHA for day shift with a census of 19. l. 9/10/23 - 2 RN / 2 BHA for night shift with a census of 19. l. 9/10/23 - 2 RN / 2 BHA for night shift with a census of 19. f. In interview on 9/12/23 at approximately 12:00 pm with administrative staff member A 6 (Licensed Practical Nurse), confirmed that P 1 refuses meds, pushes, hits, pours/throws/splashes water on, and is at baseline aggressive towards other patients and A 6 is fearful that P 1 will potentially kill another patient based on displayed behaviors. Staffing is short on days of admission, the facility needs stricter guidelines for admission. 5. In interview on 9/12/23 at approximately 12:30 pm with administrative staff member A 7 (Lead Mental Health Tech), confirmed the facility needs more staff, P 1 is a very violent patient, staff is to sit by his/her door but staffing numbers aren't increased to accommodate and feels there are some admissions of very sick patients that need a higher level care than this facility can provide. 6. In interview on 9/12/23 at approximately 2:30 pm with administrative staff member A 8 (Nurse		392			
	IDENTIFICATION NUMBER: 154064 RIC HOSPITAL ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 6 t with a patient census of 18. 2 BHA for day shift and 2 RN t with a patient census of 19. 2 BHA for day shift and 2 RN t with a patient census of 19. 2 BHA for day shift and 2 RN t with a patient census of 19. 2 BHA for day shift with a 2 BHA for day shift with a BHA for day shift with a 2 BHA for day shift with a 2 BHA for night shift with a 2/23 at approximately 12:00 e staff member A 6 lurse), confirmed that P 1 s, hits, es water on, and is at towards other patients and A ill potentially kill another olayed behaviors. Staffing is ission, the facility needs admission. 2/23 at approximately 12:30 e staff member A 7 (Lead confirmed the facility needs admission. 2/23 at approximately 12:30 e staff member A 7 (Lead confirmed the facility needs admission. 2/23 at approximately 12:30 e staff member A 7 (Lead confirmed the facility needs admission. 2/23 at approximately 12:30 e staff member A 7 (Lead confirmed the facility needs admission. 2/23 at approximately 12:30 e staff member A 7 (Lead confirmed the facility needs admission. 2/23 at approximately 12:30 e staff member A 7 (Lead confirmed the facility needs admission.	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 154064 B. WING RIC HOSPITAL ID ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ID PREFI LSC IDENTIFYING INFORMATION) ID 2 BHA for day shift and 2 RN with a patient census of 18. A: 2 BHA for day shift with a BHA for day shift with a 2 BHA for day shift with a BHA for day shift with a 2 BHA for day shift with a BHA for day shift with a 2 BHA for day shift with a BHA for day shift with a 2 BHA for night shift with a ID 2 BHA for night shift with a ID	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE COT A BUILDING 154064 B. WING STREE 900 N INDI/ ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) at 6 A 392 at 86 A 392 A 392 BHA for day shift and 2 RN with a patient census of 19. 2 BHA for day shift and 2 RN with a patient census of 19. 2 BHA for day shift with a BHA for day shift with a 2 BHA for night shift with a	MEDICAID SERVICES (x1) PROVIDERSUPPLENCLA IDENTIFICATION NUMBER: 154064 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 90 NORTH HIGH SCHOOL ROAD INDIANAPOLIS, IN 46214 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL ISC IDENTIFYING INFORMATION) 26 6 A 392 with a patient census of 18. 2 BHA for day shift and 2 RN with a patient census of 19. 2 BHA for day shift with a 2 BHA for ight shift with a 2 2/23 at approximately 12:00 e staff member A 5 (Iurse). confirmed that P 1 s, hils, is water on, and is at iowards other patients and A ill potentially kill another layed behaviors. Staffing is ission. 2/23 at approximately 12:30 <td< td=""><td>UD HUMAN SERVICES FO MEDICAID SERVICES OMB1 (x1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING (x3) MULTIPLE CONSTRUCTION A BUILDING (x4) MULTIPLE CONSTRUCTION A BUILDING (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x4) MULTIPLE CONSTRUCTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x4) MULTIPLE CONSTRUCTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x4) MULTIPLE CONSTRUCTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 BHA for day shift with a 2 BHA for day shift with a 2 BHA for day shift with a 2 BHA for day shift with a 2 BHA for day shift with a 2 BHA for day shift with a 2 BHA for day shift with a <</td></td<>	UD HUMAN SERVICES FO MEDICAID SERVICES OMB1 (x1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING (x3) MULTIPLE CONSTRUCTION A BUILDING (x4) MULTIPLE CONSTRUCTION A BUILDING (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x4) MULTIPLE CONSTRUCTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x4) MULTIPLE CONSTRUCTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x4) MULTIPLE CONSTRUCTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 BHA for day shift with a 2 BHA for day shift with a 2 BHA for day shift with a 2 BHA for day shift with a 2 BHA for day shift with a 2 BHA for day shift with a 2 BHA for day shift with a <

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
	154064 B. WING				_ 12/2023		
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ASSURANCE HEALTH PSYCHIATRIC HOSPITAL					000 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)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
A 392	 violence against othe observation was ordered in one of ten urse interventions were purabove patients receiv 7. In interview on 9/13 pm with administrative Chief Executive Office understaffed, P 1's bafacility was responsib and no adequate interto ensure the above psafe setting. RN SUPERVISION CCFR(s): 482.23(b)(3) A registered nurse muthe nursing care for e This STANDARD is r Based on document obtain an oxygen saturor ordered in one of ten Findings include: 1. The hospital failed "Oxygen Therapy", Pereviewed 06/2023, by STNA/CNA/MHT asset (SPO2) three times d needed. 2. P 10's 's medical repatient was an 81 y/ordered in the set of the	rs, no increased level of red until 6/19/23 and no prn red after acts of violence post incidents, no adequate t in place to ensure the ed care in a safe setting. 3/23 at approximately 5:30 e staff member A 9 (Interim er), confirmed the facility is ase line is aggressive, the le for care in a safe setting rventions were put in place batients received care in a OF NURSING CARE ust supervise and evaluate ach patient. not met as evidenced by: review the facility failed to uration three times a day as patients. (P 10) to follow their policy titled,		392			10/18/23

Facility ID: 013899

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 11/08/2023 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
	154064		B. WING			C 9/12/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		
ASSURAN	ICE HEALTH PSYCHIAT	RIC HOSPITAL		900 NORTH HIGH SCHOOL RO INDIANAPOLIS, IN 46214	OAD	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	-	AN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTI) CROSS-REFERENCE	VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	COMPLETION DATE
A 395	Continued From page	28	A 39	5		
		lementia with behavioral	A00			
	disturbances, hyperte	ension, chronic obstructive				
	pulmonary disease, h polyosteoarthritis.	yperlipidemia and				
		/23 indicated O2 (oxygen) at				
		cannula) PRN (as needed)				
		f breath) or SPO2 (oxygen 90%, Oxygen for saturations				
	less than 90% - 2LNC	C , Vital signs TID (three				
	times a day) and PRN					
	b. SPO2 readings are i. 8/21/23 - 98% at 5	:50 pm, 96 % at 8:19 pm				
	ii. 8/22/23 - 96 % at	3:10 pm, 97 % at 9:15 pm				
		9:55 am, 94% at 2:48 pm rd lacked documentation of				
		ling three times a day with				
	vital signs on 8/21/23	, 8/22/23 and 8/25/23.				

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