STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	154011	A. BUILDING 00 B. WING	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INCOMPASS HEALTHCARE	285 BIELBY RD LAWRENCEBURG, IN 47025

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A 0000 Bldg. 00	This visit was for a Federal Psychiatric Hospital Recertification survey. Facility Number: 005176 Survey Dates: 05/20/2025 and 5/21/2025 QA: 5/27/2025	A 0000		
A 0085 Bldg. 00	482.12(e)(2) CONTRACTED SERVICES Based on document review and interview, the facility failed to maintain a list of all contracted services. Findings include: 1. The facility lacked or failed to produce documentation of a list of contracted services. 2. On 05-20-2025 at 1350 hours, staff A7 (Director of Quality) confirmed that they did not have a list of contracted services and no documentation was provided by the end of survey.	A 0085	**Immediate Action Taken:** ·As of 07/01/2025, the facility initiated the development of a comprehensive list of all currently contracted services. ·Staff have been directed to conducted a review of all vendor agreements and contracts on file to compile an accurate and complete inventory. **Responsible Party:** ·The Director of Quality, in coordination with the IPU Administrative Assistant, is responsible for the development and ongoing maintenance of the contracted services list for the inpatient unit. **Systemic Change:** ·A standardized template (excel) was created to document all contracted services, including vendor name, scope of service, contract start/end dates, and responsible department.	07/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heather Scott	Director of Quality	07/06/2025

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			·Annual review or specified review dates will be conducted on contracted services (based on end dates).	
A 0206 Bldg. 00	482.13(f)(2)(vii) PATIENT RIGHTS: RESTRAINT OR SECLUSION Based on document review and interview, the facility failed to ensure personnel completed CPR (Cardiopulmonary Resuscitation) recertification for 3 of 7 [N3 (Mental Heath Technician), N5 (Mental Heath Technician), and N7 (Registered Nurse)] personnel files reviewed. Findings include: 1. Policy titled, First Aid & CPR Policy # 912, Last Reviewed: 07/26/2021, indicated the following: Select staff members are required to be trained in CPR in accordance with his or her Learner Profile on Relias (staff documented training) and then on a bi-annual basis thereafter. These select staff are all inpatient unit staff members. 2. Review of N3, N5, and N7 personnel files and Relias indicated CPR training was dated greater than bi-annual. 3. Interview on 05/21/2025, with A2 (Inpatient Supervisor) confirmed N3, N5, and N7 lacked having an updated CPR certificate.	A 0206	**Immediate Action Taken:** **·As of 06/01/2025, the IPU Clinical Manager reviewed all inpatient staff CPR certification statuses.** **·Staff members N3, N5, and N7 were immediately scheduled for CPR recertification. All staff members were scheduled and completed training by 06/30/2025.** **Root Cause Analysis:** **·The lapse was due to a breakdown in the internal tracking system for certification expiration dates, compounded by a lack of automated reminders within the Relias learning management system.** **Systemic Change:** **·The HR department and IPU Clinical Manager will monitor the on-going certifications, trainings, and licensure required of the IPU staff.** **·The facility has configured Relias to generate automated alerts 60 days prior to certification expiration for both the employee and supervisor.**	06/30/2025

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A 0395 Bldg. 00	482.23(b)(3) RN SUPERVISION OF NURSING CARE Based on document review, observation, and interview, facility nursing staff failed to label an opened multidose insulin vial with an opened date and expiration date, and failed to ensure the narcotics key was in the possession of a licensed nurse at all times. Findings include: 1 Facility procedure titled: NovoLog Manufacturers Guideline, last revised 3/2023 indicated after a vial has been opened it is be thrown away after 28 days, even if the vial contains insulin. 2. Facility policy titled, "Medication Storage, Loss, Theft", no policy number, last revised 11/3/2023, indicated under Steps: 1. Medication will be stored in the locked medication cart or emergency drug kit (EDK) in a locked medication room with the medication nurse holding the key. Personnel licensed to administer medications will be allowed in the medication room, and others are permitted to enter under the direct supervision of licensed personnel, when necessary. 3. During observation tour on 5/20/25 at approximately 11:30 pm this writer observed in the medication room the controlled substance/narcotic key located in the lock of the controlled medication drawer. This writer observed in the medication refrigerator an opened	A 0395	**Staff Responsible:** IPU Clinical Manager, HR Dpt **Immediate Corrective Actions:** ·On 05/21/2025, the unlabeled insulin vial was immediately removed and discarded while CMS was on site. ·The narcotics key was secured and returned to the possession of the licensed medication nurse immediately upon discovery. ·A facility-wide audit of all multidose medications and narcotic key procedures was initiated and reviewed by IPU Clinical Manger. **Policy and Procedure Development:** ·As of 06/01/2025, "medication storage, loss, and theft" procedure was updated to add the following language: ·All multidose vials must be labeled with the date opened and the calculated expiration date (28 days unless otherwise specified by the manufacturer). ·Multidose vials not properly labeled will be discarded immediately. ·The narcotics key must remain in the possession of a licensed nurse at all times during the shift.	06/30/2025

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	vial of insulin without an indicated opened date on the vial. Without an opened date this writer was unable to determine the discard date of the opened vial. 4. In interview on 5/20/2025 at approximately 11:30 am with N2 (Registered Nurse) confirmed the narcotic/medication key should be with the medication nurse at all times but was not. N2 confirmed the multidose insulin vial found in the medication fridge was not marked with an opened date, cannot confirm when the insulin was last used, nor if there is a policy for labeling or discarding multidose medication vials. 5. In interview on 5/20/25 at approximately 4:30 pm with A2 (Inpatient Supervisor) confirmed the facility does not currently have policies for multidose patient medication at this time.		**Monitoring and Quality Assurance:** ·Regular audits of medication refrigerators and narcotic key control logs are now conducted by the Charge Nurse or Nurse Manager. **Staff Training:** ·On 06/25/2025, mandatory in-service training was conducted for all nursing staff on: ·Proper labeling, storage, and disposal of multidose vials. ·Secure handling and accountability for narcotic keys. ·New hires will receive training on these protocols during orientation and annually thereafter.	
A 0511 Bldg. 00	482.25(b)(9) FORMULARY SYSTEM Based on document review and interview, the facility failed to provide an approved formulary. Findings include: 1. Policy titled, Formulary Policy #: 703, Last Reviewed: 07/10/2023. Indicated to determine the nature and scope of pharmaceuticals prescribed, ordered, or dispensed by the facility and to ensure safe and appropriate procedures for the use of pharmaceuticals in treating the facilities patients. The inpatient unit shall use the same formulary utilizing a contract pharmacy. 2. The facility lacked documentation of a formulary or failed to produce documentation of an approved formulary.	A 0511	**Immediate Corrective Actions:** ·On 05/22/2025, the facility initiated a full review of pharmaceutical prescribing practices and contracted pharmacy services. ·The contract pharmacy was contacted to obtain the most current and complete copy of the approved formulary in use for the inpatient unit. **Root Cause Analysis:** ·The absence of an on-site copy of the approved formulary was due to a failure in communication and documentation between the facility and its contracted pharmacy	07/31/2025

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	3. On 05-21-2025 at 1500 hours, staff A7 (Director of Quality) confirmed that they did not have an approved medication formulary.		provider. **Policy Development:** ·The facility will obtain and file a current, approved formulary from the contract pharmacy. ·A policy addendum to **Formulary Policy** was developed and will be approved on 07/07/2025 through ad-hoc voting: ·Annual review and approval of the formulary by the Medical Director and Pharmacy & Therapeutics (P&T) Committee (or equivalent oversight group). ·On-site and electronic access to the formulary for all prescribing and nursing staff. ·Documentation of receipt and review of the formulary during pharmacy contract renewals and annual clinical reviews. **·Staff Training:** ·The IPU Clinical Manager and Director of Nursing will conduct an in-service for clinical staff on: ·The location and use of the approved formulary. ·The process for requesting non-formulary medications or reporting discrepancies. **·Ongoing Monitoring and Compliance:** ·The IPU Clinical Manager and DON (or directed staff) will conduct quarterly audits to verify: ·The availability of the most current formulary on-site.	

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			·Staff knowledge of formulary access and procedures. ·Audit findings will be reported to the facility's QAPI Committee and reviewed for ongoing compliance. **Responsible Parties:** **DQI, IPU Clinical Manager, Charge Nurse, Nurse Supervisor, DON**	
A 0700 Bldg. 00	482.41 PHYSICAL ENVIRONMENT Based on record review, observation and interview, the facility failed to ensure the means of egress through the double door set in the crisis stabilization unit was readily accessible for clients without a clinical diagnosis requiring specialized security measures; failed to ensure 1 of over 3 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices; and failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 3 of 4 quarters. The cumulative effect of these systemic problems resulted in the facility's inability to ensure the provision of quality health care in a safe environment.	A 0700	**Finding 1: Inaccessible Means of Egress from Crisis Stabilization Unit** **·Immediate Corrective Action:** **·On 05/22/2025, the facility assessed the double door set in the crisis stabilization unit. It was determined that the doors were improperly secured in a way that could limit egress for clients without a clinical indication for restricted movement.** **·Adjustment:** **·The door locking mechanism was adjusted on 07/02/2025 to allow for a 15 second delay to occur before release and providing a free egress for all clients not under security or clinical restriction, in accordance with NFPA 101 and CMS Conditions of Participation.** **·Signage was ordered on**	07/11/2025

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			07/02/2025 to be placed on door. **Finding 2: Self-Closing Door** **·Malfunctioning self-closing door:** **·The malfunctioning self-closing device on the identified storage room door was adjusted and tested on 06/07/2025 to ensure it closes and latches properly as required by NFPA 101 (Section 19.3.2.1.3).** **·Life Safety conducted a follow-up visit on 7/2/2025 and verified compliance.** **·Systematic:** **·A full inspection of all hazardous area doors was completed on IPU to ensure all self-closing devices were operating as expected.** **·The Facilities team received refresher training on door safety standards and documentation requirements on 06/03/2025.** **Finding 3: Missing Sprinkler Inspection Documentation** **·Immediate Corrective Action:** **·The facility contacted the St Elizabeth Hospital Facilities team who provides maintenance on the IPU and obtained confirmation that the hospital only completes them quarterly.** **·A new quarterly service procedure was developed on**	

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			07/01/2025 to ensure timely inspections of the sprinkler system in compliance with NFPA 25. These inspections will be completed by INcompass Facilities staff who have been trained and provided the checklist. **·Systemic Changes:** **·The Life Safety & Maintenance Log was revised to include a calendar-based tracking system for quarterly fire protection system inspections, with automatic alerts to Facilities Management.** **·As of 06/05/2025, the Facilities Maintenance Manager is required to maintain and file all reports with the Safety and Security Officer for quarterly Safety and Security Committee review.** **·Monitoring:** **·Quarterly fire system documentation will be reviewed by the Safety Committee to ensure inspection frequency and documentation compliance.** **Responsible Parties:** **Facilities Maintenance Manager, Facilities Team, Safety and Security Officer**	
A 0701 Bldg. 00	482.41(a) MAINTENANCE OF PHYSICAL PLANT	A 0701	p="" paraid="1114167087"	06/13/2025

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	Based on observation and interview, the facility failed to ensure the means of egress through the double door set in the crisis stabilization unit was readily accessible for clients without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. Based on observation and interview, the facility failed to ensure 1 of over 3 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 residents, as well as staff and visitors in the near the nurse's office area. Findings include: Based on observations and interviews during a tour of the facility with the Safety and Security Coordinator (SSC) and Director of Quality Improvement (DOQ) on 05/19/25 at 3:30 p.m. the double doors separating the Full Crisis Unit from the Mobil Crisis Unit, marked from each side as a facility exit, was magnetically locked and could be opened with panic hardware from the Mobil Crisis side. However, the doors could only be opened from the Full Crisis side without the use of a badge or special key. The aforementioned doors were not connected to the hospital's fire alarm system and this part of the facility did not have a fire alarm system. The DOQ stated the arrangement with the doors was added during a recent remodel/refresh of this part of the facility.		paraeid="{22c509cf-0ac1-44db-b501-c88421cea0f5}{13}" finding="" 1:="" inaccessible="" means="" of="" egress="" from="" crisis="" stabilization="" unit<="" span="">Finding 1: Inaccessible Means of Egress from Crisis Stabilization Unit The door locking mechanism was adjusted on 07/02/2025 to allow for a 15 second delay to occur before release and providing a free egress for all clients not under security or clinical restriction, in accordance with NFPA 101 and CMS Conditions of Participation. Signage was ordered on 07/02/2025 placed on door ="" span="">Life Safety completed a resurvey on 7/02/2025 and confirmed the 15-second delayed release on the egress doors for the crisis care center, confirming compliance. ="" span="">Finding 2: Non-Compliant Hazardous Area Door (Nurse’s Station Area) All combustible materials in the room were inventoried and removed; all excess storage (including cardboard boxes) was removed by 06/13/2025. Staff were provided with education on what can and cannot be stored in the Nurse’s area and where items can properly be stored both on and off the unit. A functioning self-closing	

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	This finding was acknowledged by the SSC and DOQ at the time of observation and again at the exit conference with the SSC and DOQ each present. Based on the facility tour and interview with the Safety and Security Coordinator (SSC) and Facilities Maintenance Manager (FMM) on 05/19/25 at 3:45 p.m., an office/room the facility was using as the nurse's station was greater than 50 square feet and contained a number of combustible items, such as, paper, and over 8 large cardboard boxes. The corridor door to this office/room/nurse's station was not equipped with a self-closing device and did not self-close and latch into the door frame. This finding was acknowledged by the SSC and FMM at the time of observation and again at the exit conference with the SSC and Director of Quality present.		device was no longer needed for this area as the hazardous materials were removed. Staff Responsible: IPU Clinical Manager, Nurse Supervisor, Facilities Manager	
A 0710 Bldg. 00	482.41(b)(1)(2)(3) LIFE SAFETY FROM FIRE 1. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 3 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the	A 0710	**Finding 1: Incomplete Documentation of Quarterly Sprinkler System Inspections** **Corrective Actions Taken:** ·The Facilities Maintenance Manager (FMM) contacted the contracted fire protection vendor and scheduled quarterly sprinkler inspections in accordance with **NFPA 25** and **LSC 4.6.12.1**. ·The next quarterly inspection was scheduled to be completed by **06/30/2025**, and all required documentation (inspection results, procedure performed, date, and	06/30/2025

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	authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. Findings include: Based on review of the quarterly sprinkler system inspection records with the Safety and Security Coordinator (SSC) and Facilities Maintenance Manager (FMM) on 05/19/25 at 3:15 p.m., only 1 (dated 06/13/24) of the required 4 quarterly sprinkler inspections was available for review. During an interview at the time of record review, the FMM acknowledged there was no written documentation available to show the sprinkler system had been inspected three of the four quarters stating that they had only had one inspection per year since he began working at the facility a few years ago. During a tour of the Riser Room on 05/20/25 at 10:05 a.m., hang tags from the sprinkler company indicated that only the aforementioned inspection was conducted. Previous hangtags from several years earlier revealed that once upon a time four quarterly inspections were conducted on the sprinkler system. The FMM stated he would contact the facility's sprinkler provider and begin 4 quarterly inspections immediately. 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were		vendor name). Once completed, it will be logged and reviewed by the Director of Quality. ·A retrospective audit confirmed that only one inspection was performed in the previous 12-month period. While this was a legacy scheduling oversight, the facility acknowledges the importance of compliance with NFPA 25. **Systematic Change: Quarterly Sprinkler Checks** **Person Responsible: Facilities Maintenance Manager** **·Re-establish quarterly sprinkler system inspections per NFPA 25, Sections 5.2.5 and 5.3.3.** **Person Responsible: Safety & Security Coordinator** ·Re-establish a compliance tracking system (e.g., calendar reminders, logbook, or digital maintenance software) to ensure timely inspections and proper recordkeeping. Corrective Action: Improper Storage of Spare Sprinklers and Missing Proper Cabinet Organization Person Responsible: Facility Maintenance Manager ·An Extra sprinkler head cabinet was installed on 6/12 to store extra sprinkler heads found during inspection. ·Staff educated on the proper storage standards for sprinkler	

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	provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. Findings include: Based on the facility tour and interview with the Safety and Security Coordinator (SSC) and Facilities Maintenance Manager (FMM) on 05/20/25 at 10:10 a.m., there was one spare sprinkler cabinet in the riser room that included in excess of 15 spare sprinklers; 7 or more of which were not in their own protected slot. They were stored loose in and on the cabinet and not secured in holders. Based on interview at the time of the observation, the FMM agreed the spare sprinkler cabinet had spare sprinklers not in protected slots. This finding was acknowledged by the SSC and FMM at the time of observation and again at the exit conference with the SSC and Director of Quality present.		components. ·Safety & Security Coordinator will be responsible for these records and maintain them in a designated location readily available for compliance reviews. Life Safety completed a follow-up review on 7/02/2025 and found the facility to be in compliance.	