STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152025	A. BUILDING 00 B. WING	03/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CENTRAL INDIANA AMG SPECIALTY HOSPITAL LLC	2401 W UNIVERSITY AVE 5TH FLOOR EAST TOWER MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
S 0000 Bldg. 00	The visit was for investigation of a State licensure hospital complaint. Complaint Number: IN00283872 Substantiated: No deficiency related to the allegations is cited. Unrelated deficiencies cited. Survey Date: 03/17-19/2021 Facility Number: 004811 QA: 03/26/2021	S 0000	N/A	
S 0732 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d)(1)(2)(3)(4) (d) The medical record shall contain sufficient information to: (1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of treatment and results. Based upon document review and interview, the facility failed to follow its policy/procedures and ensure that the medical record (MR) accurately documented the course of treatment and results for 1 of 5 MRs reviewed (Patient #2). Findings include: 1. Review of the policy/procedure O.15.10	S 0732	S732 AMG has changed our physician model to a full-time physician to provide care to patients. We also added a full-time NP to round and monitor patients daily while ensuring care continuum. We will audit 10 charts a month for three months to ensure all elements of	04/29/2021

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
	152025	A. BUILDING 00 B. WING	03/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CENTRAL INDIANA AMG SPECIALTY HOSPITAL LLC	2401 W UNIVERSITY AVE 5TH FLOOR EAST TOWER MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Medical Record Contents (reviewed 12-20) indicated the following: "Each medical record contains at least the following... discharge summaries. A concise clinical resume included in the medical record at discharge... shall include the reason for hospitalizations, significant findings... and care, treatment and services provided... and conclusions at the termination of hospitalization..." 2. Review of the Discharge Summary for Patient #2 indicated the following: "[Patient #2] presented to our facility with a need for PT/OT for chronic debility... He will need continued PT/OT." (Physical Therapy/Occupational Therapy) 3. Review of the MR for Patient #2 indicated admission orders on 10-23-18 for physical therapy and occupational therapy to evaluate the patient and documentation dated 10-24-18 indicated the patient was evaluated by the Physical Therapist N11 and the Occupational Therapists N20, and determined to be ineligible for skilled PT and/or skilled OT services due to the baseline need for total assistance with repositioning and transfer activity, nutritional intake, elimination, and all other personal care activity. 4. On 3-19-21 at 0950 hours, the Chief Clinical Officer A2 confirmed the above.		the policy are a part of the discharge summary. Upon completion of above, we will audit every 6 months to ensure compliance. Policy O.15.10 - Medical Records Content S732 All therapies need an order to discontinue treatment. The director of therapy will ensure therapy staff are receiving discontinuation orders for therapy and audit 10 charts for 3 months monitoring written discontinue orders. Upon completion of the above, we will audit every 6 months to ensure compliance. Responsible Party: HIM Manager *Deficiency was corrected on 4/29/2021. We will continue to monitor the above and report findings to QAPI for recommendations.*	
S 0926 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(1) (b) The nursing service shall have the following: (1) Adequate numbers of licensed registered nurses, licensed practical			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152025	A. BUILDING 00 B. WING	03/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CENTRAL INDIANA AMG SPECIALTY HOSPITAL LLC	2401 W UNIVERSITY AVE 5TH FLOOR EAST TOWER MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	nurses, and other ancillary personnel necessary for the provision of appropriate care to all patients, as needed, to include the immediate availability of a registered nurse. Based upon document review and interview, the facility failed to follow its staffing plan and ensure adequate numbers of Registered Nurses were available for all patients admitted to the facility for 1 occurrence. Findings include: 1. Review of the policy/procedure D.4.01 Staffing Plan (reviewed 9-19) indicated the following: "The appropriate number of qualified staff should be on duty at all times according to staffing guidelines based on census and acuity." 2. Review of the administrative staffing document titled Muncie-High Acuity Staffing Grid under the column titled Census on the row corresponding to 10 patients indicated a shift need for 1 charge Nurse, 2 Registered Nurses and one (1) CNA or Certified Nursing Assistant. 3. Review of the Daily Staffing Worksheet prepared by Chief Clinical Officer A2 indicated the census on Friday 12-28-18 was 10 patients and the worksheet indicated one (1) Registered Nurse and one (1) CNA were scheduled from 7 a.m. until 7 p.m. on Saturday, 12-29-18. 4. On 3-19-21 at 1410 hours, staff A2 confirmed the Daily Staffing Worksheet failed to indicate the nursing unit was adequately staffed to meet the needs of its patients for the indicated date and shift associated with the allegations and no other documentation was available.	S 0926	S926 Currently AMG has increased employment of all clinical areas to ensure the needs of our patients are met. AMG is following policy D. 4. 01 Staffing Plan while maintaining records of all staffing sheets. We will monitor the staffing grid daily to ensure we are compliant. When staffing is critical, the CCO and ACCO will ensure that staff are monitored for fatigue and their ability to perform care for all patients is not at risk. Administration will ensure that AOC is always aware and available for assistance. Responsible Party: CCO/ACCO *Deficiency was corrected on 4/29/2021. We will continue to monitor the above and report findings to QAPI for recommendations.*	04/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152025	A. BUILDING 00 B. WING	03/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CENTRAL INDIANA AMG SPECIALTY HOSPITAL LLC	2401 W UNIVERSITY AVE 5TH FLOOR EAST TOWER MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
S 0932 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4) (b) The nursing service shall have the following: (4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient. Based upon document review and interview, the facility failed to ensure an individualized plan of care was maintained for 1 of 5 medical records (MR) reviewed (Patient #2). Findings include: 1. Review of the policy/procedure I.9.02 Plan of Care (reviewed 1-21) indicated the following: "Each patient's nursing care plan is based on identified nursing diagnoses and are consistent with the therapies of other disciplines. The care plans are also based on patient care needs... Patient care planning will include interventions, therapy... and any potential referrals/consultations... The care plan will be... revised as necessary and as indicated by the changing needs of the patient." 2. Review of the nursing care plan heading titled Self Care Deficit Goal for Patient #2 indicated on 10-23-18 to (a) consult OT for bathing / grooming / dressing / toileting / hygiene and (b) to consult PT for transfers and ambulation and the care plan documentation failed to indicate the plan was updated during the hospital stay after the patient was evaluated and determined to be ineligible for skilled PT or OT services based on the baseline need for total assistance with all mobility and	S 0932	S932 AMG staff will be educated on the care plan updating the care plan appropriately and timely. Ensuring it reflects the care needs of the patient as they change. AMG is auditing the 10 charts weekly for 3 months to ensure the plan of care is following the above guidelines. Upon completion of the above, AMG will continue to audit care plans every 6 months to ensure compliance. Responsible Party: CCO/ACCO *Deficiency was corrected on 4/29/2021. We will continue to monitor the above and report findings to QAPI for recommendations.*	04/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152025	A. BUILDING 00 B. WING	03/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CENTRAL INDIANA AMG SPECIALTY HOSPITAL LLC	2401 W UNIVERSITY AVE 5TH FLOOR EAST TOWER MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	personal care activity. 3. On 3-18-21 at 1410 hours, the Chief Clinical Officer A2 confirmed the above.			