STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING 00 B. WING	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
4C HEALTH	1015 MICHIGAN AVE LOGANSPORT, IN 46947

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A 0000 Bldg. 00	This visit was for investigation of a Federal hospital complaint. Complaint Number: IN00443548 - Deficiencies related to the allegations are cited at A0115, A0144, and A0395. Date of survey: 10/23/24, 10/24/24, 10/25/24, 10/28/24 and 10/29/24. Facility Number: 005199 QA: 11/6/2024	A 0000	A0115 and A0144 Staff trained on 6/25/24 on security procedures. Security Policy 11.2.043F updated on 7.15.24 and Metal Detector 31.1.018B updated on 7.15.24. Visitation Policy 11.2.094B updated on 7.15.24. Instituted updated policies and procedures. Staff trained again on 8/7/24 and 8/8/24 on security procedures as well as reviewing the three above policies. 8/17/24 Staff provided another reminder on safety and security. 9/17/24 and 9/25/24 staff trained again on policies and procedures relative to Safety and Security. 11/26/24 Staff provided another reminder regarding safety and security. Staff were also informed on this date that if they became aware a search did not occur, they were to notify their direct supervisor, DON IPU, VP of Psychiatric Hospital and/or the Chief Compliance Officer/VP of Facilities and Safety immediately. 11/12/24 Staff provided direction from Director of Nursing IPU that nursing staff were to ensure that all searches and outcomes were documented in the nursing assessment to ensure compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hope Kerns	Chief Compliance Officer/VP of Facilities and	12/05/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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.

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			Starting on 11/24/24 all IPU admissions will be reviewed to ensure that a search was completed and anything found identified this will conclude on 12/31/24. Starting on 1/1/25 15 IPU admissions will be reviewed monthly to ensure that a search was completed and anything found identified for the next 6 months. Copies of updated policies to be uploaded. The responsible party to ensure that the searches have occurred is the DON IPU. A0395 **On 9/10/24 at the nurses meeting the incident regarding the medication was reviewed by the DON IPU and nursing staff. And the following is the outcome to ensure that this does not occur again:** **1. Check the MAR.** **2. Do the 5 rights.** **3. When the medications come in from Genoa (pharmacy), the nurse will double check to make sure the medication is the same on the MAR and then put the change on the nurse's report.** **4. Highlight the sticker on the medication if it is a change from what the order reads.** **5. Have high alert medication: Clozaril, Insulin, and Coumadin**	

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			be double verified. Start putting in the comment of the medication who has verified the medication. **6. Update High Alert Medication Policy.** **Updated policy and procedure implemented at this time 9/10/24.** **Starting on 10/1/24 IPU clients with Clozaril are audited every 5 days to ensure compliance and this will conclude on 12/31/24.** **Starting on 1/1/25 IPU clients with Clozaril (1 per month) will be audited every 5 days to ensure compliance and this will occur for the next 6 months.** **DON IPU is the responsible party to ensure compliance.** **Copy of Updated High Alert Medication policy will be uploaded.** **Medication Management Policy 29.1.005V was updated on 11/26/24 to outline when notification to an IPU client is to occur regarding a medication error.** **Instituted updated Medication Management Policy on 11/27/24.** **Starting on 11/27/24 IPU clients with an identified medication error will be audited to ensure that the Medication Management Policy updated on 11/26/24 is being followed**	

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			and this will conclude on 12/31/24. **Starting on 1/1/25 at least 3 clients with an identified medication error will be audited monthly to ensure compliance with the Medication Management Policy updated on 11/26/24.** **Audit results including any identified non-compliance will be reviewed monthly by the Chief Medical Officer, VP of Psychiatric Hospital Operations, Psychiatrist and Chief Compliance Officer/VP of Facilities and Safety with the DON IPU to ensure compliance. Any areas of non-compliance identified will be addressed immediately and rectified to ensure that it does not occur again.** **The responsible party to ensure compliance is the DON IPU.**	
A 0115 Bldg. 00	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. Based on document review and interview, the facility failed to ensure nursing staff followed facility policy related to body searches of all patients upon admission to the inpatient unit to remove potentially dangerous items for 1 of 10 patient medical records reviewed. (Patient #5) The cumulative effect of this systemic problem resulted in the facility's inability to ensure that	A 0115	Staff trained on 6/25/24 on security procedures wanding at the entrance of the facility. Security Policy 11.2.043F updated on 7.15.24 and Metal Detector 31.1.018B updated on 7.15.24. Visitation Policy 11.2.094B updated on 7.15.24. Instituted updated policies and procedures.	11/26/2024

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	Patient Rights were promoted.		Staff trained again on 8/7/24 and 8/8/24 on security procedures as well as reviewing the three above policies. 8/17/24 Staff provided another reminder on safety and security. 9/17/24 and 9/25/24 staff trained again on policies and procedures relative to Safety and Security. 11/26/24 Staff provided another reminder regarding safety and security. Staff were also informed on this date that if they became aware a search did not occur, they were to notify their direct supervisor, DON IPU, VP of Psychiatric Hospital and/or the Chief Compliance Officer/VP of Facilities and Safety immediately. 11/12/24 Staff provided direction from Director of Nursing IPU that nursing staff were to ensure that all searches and outcomes were documented in the nursing assessment to ensure compliance. Starting on 11/24/24 all IPU admissions will be reviewed to ensure that a search was completed and anything found identified this will conclude on 12/31/24. Starting on 1/1/25 15 IPU admissions will be reviewed monthly to ensure that a search was completed and anything found identified for the next 6 months. Copies of updated policies to be uploaded.	

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			The responsible party to ensure that the searches have occurred is the DON IPU.	
A 0144 Bldg. 00	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. Based on document review and interview, the facility failed to ensure nursing staff followed facility policy related to body searches of all patients upon admission to the inpatient unit to remove potentially dangerous items for 1 of 10 patient medical records (MR) reviewed. (Patient #5) Findings include: 1. Facility policy titled "Admission Assessment", policy number #11.2.005R, with a revision date of 4/5/24 indicated the following: I. ADMISSION ASSESSMENT GUIDELINES: d. BODY CHECKS: i. Upon admission to the ACU, all clients will have a body search completed to remove potentially dangerous items and establish a baseline physical assessment of distinguishing body marks. 1. The body search will be done in a private setting by a same sex staff member. If a same sex member is not available, the body search will be completed by two staff members. a. A client can request a search be completed by two staff members, regardless of sex of the staff members involved. 2. Body checks may also be completed should a question of safety arise during admission, and all above procedures will be followed. ii. All findings will be documented in the admission nursing assessment, or a progress note should the check occur after admission. e. PERSONAL	A 0144	Staff trained on 6/25/24 on security procedures-wanding at entrance of facility. Security Policy 11.2.043F updated on 7.15.24 and Metal Detector 31.1.018B updated on 7.15.24. Visitation Policy 11.2.094B updated on 7.15.24. Instituted updated policies and procedures. Staff trained again on 8/7/24 and 8/8/24 on security procedures as well as reviewing the three above policies. 8/17/24 Staff provided another reminder on safety and security. 9/17/24 and 9/25/24 staff trained again on policies and procedures relative to Safety and Security. 11/26/24 Staff provided another reminder regarding safety and security. Staff were also informed on this date that if they became aware a search did not occur, they were to notify their direct supervisor, DON IPU, VP of Psychiatric Hospital and/or the Chief Compliance Officer/VP of Facilities and Safety immediately.	11/26/2024

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	POSSESSIONS: 2. Restricted items, i.e., any item that could present a safety risk, are to be sent home with a family member/guardian. If no alternative is available items will be locked in a secure area until discharge. 2. Review of Patient #5's medical record indicated the following: The patient was admitted on EDO (Emergency Detention Order) due to SI (Suicidal Ideation)/HI (Homicidal Ideation) toward (family members) with a plan/intention and means on 6/18/24 at 7:13 p.m. and was discharged on 6/20/24. The patient had diagnoses that included, but were not limited to, major depressive disorder, recurrent, severe with psychotic symptoms and posttraumatic stress disorder. (a.) A review of a nursing assessment for Patient #5 dated 6/18/24 at 7:13 p.m. indicated the following: Searches completed, and findings indicated: (Patient #5) has not had body search yet as (he/she) refuses to have body search done and is refusing to come onto the unit. (Patient #5) states, "I will stay here until Dr. (Doctor) comes in". (Patient #5) refusing to get up off of the couch. LIP (Licensed Independent Practitioner) notified and stated to monitor (patient). (b.) A review of a psychiatric note dated 6/19/24 at 9:00 a.m. indicated the following: (Patient #5) was agreeable to voluntary admission but refused admission when (he/she) arrived to (Facility #1) (Patient #5) refused to sign paperwork, allow search, vitals. EDO was obtained from (Facility #1) psychiatrist. (Patient #5) continued to refuse admission process, attempted to leave intake room, urinated on the floor, yelled and made verbal threats to staff. When (patient) was given clear direction by this writer to enter unit on		11/12/24 Staff provided direction from Director of Nursing IPU that nursing staff were to ensure that all searches and outcomes were documented in the nursing assessment to ensure compliance. Starting on 11/24/24 all IPU admissions will be reviewed to ensure that a search was completed and anything found identified this will conclude on 12/31/24. Starting on 1/1/25 15 IPU admissions will be reviewed monthly to ensure that a search was completed and anything found identified for the next 6 months. Copies of updated policies to be uploaded. The responsible party to ensure that the searches have occurred is the DON IPU.	

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	(his/her) own or staff would need to assist (patient), (he/she) was angry, yelling, but stood and walked onto unit with no physical intervention or need for PRN (as needed) medication. (Patient #5) was allowed to enter the unit with (his/her) clothing on and phone. 3. Review of an incident report for Patient #5 dated 6/20/24 indicated the following: Incident Location and Time of Day: (Facility #1 parking lot) at 3:02 p.m. Incident Description: At admission, 6/18/24, pt was severely agitated, refused to change clothes, consent to vital or body search, and refused to relinquish (his/her) phone. Due to pt's agitated state and extent of time (he/she) had been in the intake room, (he/she) was allowed to enter unit with (his/her) belongings. On 6/20/24, pt was discharged and escorted out of the building by facility staff (N6, Client Care Specialist). Outside pt showed (N6), (his/her) gun permit and then took a small firearm out of (his/her) pocket, that (he/she) had concealed during admission. 4. During an interview with A6 (Assistant Director of Quality & Compliance) on 10/25/24 at approximately 2:00 p.m., A6 verified the medical record information for Patient #5. 5. During a phone interview with N6 on 10/28/24 at 10:43 a.m., N6 indicated that they had not worked when Patient #5 was first admitted to the facility but when (he/she) had come back to work Patient #5 was on the inpatient unit and was getting discharged. N6 indicated that (he/she) had escorted the patient downstairs at approximately 11:00 a.m. via the elevator from the inpatient unit and the patient showed (him/her) a very small handgun that (he/she) had in (his/her) pant pocket. N6 indicated that they were off the inpatient unit when Patient #5 showed the			

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	handgun to (him/her). N6 indicated that (he/she) told Patient #5 to put the handgun away, when the Mobile Crisis Team arrived to transport Patient #5 back to (City #3), (N6) had Patient #5 put the handgun on their front seat until they could call the cops and get it safe. N6 indicated that the handgun was about the size of Patient #5's palm. N6 indicated that Patient #5 also had (his/her) personal cell phone on the inpatient unit and that (he/she) had all of (his/her) belongings on (him/her), because Patient #5 would not change into scrubs.			
A 0395 Bldg. 00	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. Based on document review and interview, the facility failed to ensure nursing staff followed physician orders related to medication administration and failed to follow facility policy to ensure nursing staff notified a patient related to a medication error for 1 of 10 patient medical records (MR) reviewed. (Patient #1) Findings include: 1. Facility policy titled "CLIENT RIGHTS", policy number: 26.2.030N, last revised on 6/12/24 indicated the following: "PROCEDURE: Client have the right: 17. To be informed of unanticipated outcomes of treatment and/or medical errors." 2. Review of patient #1's medical record indicated the following: (a.) The patient was admitted on 8/5/24 and discharged on 8/23/24 at 11:27 a.m. The patient had a diagnosis that included, but was not limited to, schizoaffective disorder, bipolar type.	A 0395	On 9/10/24 at the nurses meeting the incident regarding the medication was reviewed by the DON IPU and nursing staff. And the following is the outcome to ensure that this does not occur again: 1. Check the MAR. 2. Do the 5 rights. 3. When the medications come in from Genoa (pharmacy), the nurse will double check to make sure the medication is the same on the MAR and then put the change on the nurse's report. 4. Highlight the sticker on the medication if it is a change from what the order reads. 5. Have high alert medication: Clozaril, Insulin, and Coumadin be double verified. Start putting in the comment of the medication who has verified the medication.	11/27/2024

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	(b.) A review of a psychiatric note dated 8/21/24 at 11:00 a.m. indicated the following orders: Medications: Clozapine: mood stability/psychosis: Titration schedule: Day 1 (8/9/24): 12.5 mg (milligrams) QD (every day). Day 2 (8/10/24): 25 mg QD Day 3 (8/11/24): 25 mg BID (twice a day) Day 4 (8/12/24): 25 mg QD and 50 mg HS (hour of sleep) Day 5 (8/13/24): 50 mg BID Day 6 (8/14/24): 50 mg QD and 75 mg HS Day 7 (8/15/24): 50 mg QD and 100 mg HS Day 8 (8/16/24): 175 mg HS Day 9 (8/17/24): 200 mg HS Day 10 (8/18/24): 225 mg HS Day 11 (8/19/24): 250 mg HS Day 12 (8/20/24): 275 mg HS Day 13 (8/21/24): 300 mg HS Day 14 (8/22/24): 300 mg HS (c.) A review of a psychiatric note dated 8/22/24 at 12:00 p.m. indicated the following: Behavior/PRNs: None: Nursing staff reported (Patient #1) did not have clozapine in (his/her) medication tray for last night's dose. (Patient #1) will resume at current dose today. (d.) The medical record for Patient #1 did indicate that the patient was not administered Clozapine medication on 8/21/24 at HS as ordered due to the medication not being available/out of stock/not filled by pharmacy. The medical record for Patient #1 also lacked documentation that the patient was notified of the medication error related to Clozapine/Clozaril and/or the reason why the patient was not notified of the medication error.		6. Update High Alert Medication Policy. Updated policy and procedure implemented at this time 9/10/24. Starting on 10/1/24 IPU clients with Clozaril are audited every 5 days to ensure compliance and this will conclude on 12/31/24. Starting on 1/1/25 IPU clients with Clozaril (1 per month) will be audited every 5 days to ensure compliance and this will occur for the next 6 months. DON IPU is the responsible party to ensure compliance. Copy of Updated High Alert Medication policy will be uploaded. Medication Management Policy 29.1.005V was updated on 11/26/24 to outline when notification to an IPU client is to occur regarding a medication error. Instituted updated Medication Management Policy on 11/27/24. Starting on 11/27/24 IPU clients with an identified medication error will be audited to ensure that the Medication Management Policy updated on 11/26/24 is being followed and this will conclude on 12/31/24. Starting on 1/1/25 at least 3 clients with an identified medication error will be audited monthly to ensure compliance with the Medication Management Policy updated on 11/26/24. Audit results including any	

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	3. An incident report for Patient #1 dated 8/22/24 related to an incident on 8/20/24, the report indicated pharmacy sent Clozaril 50 mg tablets with a set amount for each date in the medication card to give at night. Sometime during 8/16/24 through 8/19/24, (Patient #1) received double the dose (he/she) should have due to the label not matching the order. The incident report also indicated that on 8/20/24, it was noted in the patient's EMAR that 10 pills were given versus 11 tablets and per the 50 mg label 5.5 tablets should have been given. It was also noted that on 8/21/24 there were not any tablets left to give or for 8/22/24. Clozaril 300 mg was picked up on 8/22/24 to give the HS dose. 4. During an interview with A3 (Director of Nursing) on 10/24/24 at 1:00 p.m., A3 indicated that the pharmacy had changed the dose of the Clozaril tablets that they provided for Patient #1 without letting the staff know, we should have still completed the 5 rights with each medication pass. A3 indicated the 5 rights of medication administration are 1.) Right drug. 2.) Right patient. 3.) Right dose. 4.) Right route. 5.) Right time. A3 indicated that the facility was still investigating the medication error when Patient #1 was discharged, and that Patient #1 was not notified of the medication error. A3 indicated that an incident report was completed. 5. During an interview with A6 (Assistant Director of Quality & Compliance) on 10/25/24 at approximately 2:00 p.m., A6 verified the medical record information for Patient #1.		identified non-compliance will be reviewed monthly by the Chief Medical Officer, VP of Psychiatric Hospital Operations, Psychiatrist and Chief Compliance Officer/VP of Facilities and Safety with the DON IPU to ensure compliance. Any areas of non-compliance identified will be addressed immediately and rectified to ensure that it does not occur again. The responsible party to ensure compliance is the DON IPU.	