STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154057	A. BUILDING _____ B. WING _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIONS BEHAVIORAL HEALTH SYSTEM	5602 CAITO DRIVE INDIANAPOLIS, IN 46226

(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 000	INITIAL COMMENTS This visit was for the investigation of a Federal Hospital Complaint. Complaint Number: IN00445891 - Deficiencies related to the allegations are cited A 0115, A 0164, A 0166, A 0179, A 0186, A 0188, A 0395 and A 0398. Survey Date: 11/21/24, 11/22/24, and 11/25/24 Facility Number: 012773 QA: 12/4/24	A 000		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on document review and interview, facility nursing staff failed to document of a lesser restrictive methods prior to implementing a chemical restraint; failed to update a care plan that included restraint or seclusion; failed to conduct a 1 hour face-to-face evaluation of the patient within one hour of initiation of restraint; failed to document the least restrictive methods of restraint prior to administering a chemical restraint; and failed to document the patient's reaction to a chemical restraint in 1 of 11 medical records reviewed. (P1) See Tags A0164, A0166, A0179, A0186, and A0188. The cumulative effect of this systemic problem resulted in the facility's inability to ensure that Patient Rights were promoted.	A 115		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/22/2025

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A 164	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(2) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. This STANDARD is not met as evidenced by: Based on document review and interview, facility nursing staff failed to document of a lesser restrictive methods prior to implementing a chemical restraint in 1 of 11 medical records reviewed. (P1) Findings include: 1. Facility policy titled, "Restraint", no policy number, last reviewed 01/2023, indicated under POLICY: 1. Restraint means the use of manual hold, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his arms, legs, body, or head freely; OR a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. 2. Restraint may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others after less restrictive interventions are ineffective or ruled-out. 2. Review of P1's medical records indicated on 9/11/24 at 8:00 am P1 was impulsive and oppositional defiant. 1:1 Observation monitoring was initiated, was placed in a gown, and placed on unit restriction because P1 displayed an	A 164		

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A 164	Continued From page 2 increase in suicidal thoughts. P1 had a physical altercation with another patient at approximately 5: 15 pm. At 5:20 pm N1(Registered Nurse) took a verbal order over the telephone from NP2 (Nurse Practitioner) to administer 5 mg (milligrams) IM (Intramuscular) of Diazepam (Valium) x 1 (times one) Now. The indication for this order was agitation and aggression r/t (related to) P1 was an immediate danger to the safety of another. P1's parents were notified. P1 was given 5 mg Diazepam (Valium) IM administered by N1 on 9/11/24 at approximately 5:25 pm. P1 was on 1:1 observation at the time of the altercation. The medical record for P1 lacked documentation of lesser restrictive or methods such as verbal deescalating, relaxation activity, voluntary time out, redirection and/or distraction utilized or attempted prior to the use of a chemical restraint. 3. In an interview on 11/22/24 at approximately 2:00 pm with A1 (Director of Quality) confirmed nursing staff did not complete required restraint documentation including less restrictive means used prior to the use of chemical restraint for P1 but should have.	A 164		
A 166	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(4)(i) The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by: Based on document review and interview, facility staff failed to update a care plan that included restraint or seclusion for 1 of 11 medical records	A 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 166	Continued From page 3 reviewed. (P1) Findings include: 1. Facility policy titled, "Restraint", no policy number, last reviewed 01/2023, indicated PROCEDURE: 12. The treatment plan shall be reviewed and revised following the first episode of restraint to include measures to prevent recurrence. Additional reviews of the treatment plan, with revisions as indicated, will occur if the patient is restrained on more than one occasion. 2. Review of MR (Medical Record) for P1 indicated the patient had a physical altercation with another patient on 9/11/24 at approximately 5:15 pm. At 9/11/2024 at 5:20 pm N1(Registered Nurse) took a verbal order over the telephone from NP2 (Nurse Practitioner) to administer 5 mg (milligrams) IM (Intramuscular) of Diazepam (Valium) x 1 (times one) Now. P1 was given 5 mg Diazepam (Valium) IM administered by N1. P1's medical record lacked documentation that the care plan was updated. 3. In an interview on 11/22/24 at approximately 2:00 pm with A1 (Director of Quality) confirmed there was no documentation in P1's care plan and/or treatment plan related to restraint for P1 and should have been.	A 166		
A 179	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(12) [the patient must be seen face-to-face within 1 hour after the initiation of the intervention --] §482.13(e)(12)(ii)To evaluate -	A 179		

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A 179	Continued From page 4 1. The patient's immediate situation; 2. The patient's reaction to the intervention; 3. The patient's medical and behavioral condition; and 4. The need to continue or terminate the restraint or seclusion. This STANDARD is not met as evidenced by: Based on document review and interview, facility staff failed to conduct a 1 hour face-to-face evaluation of the patient within one hour of initiation of restraint in 1 of 10 medical records reviewed. (P1) Findings include: 1. Facility policy titled, "Restraint", no policy number, last reviewed 01/2023, indicated under PROCEDURE: 8. A practitioner or trained registered nurse shall conduct an in-person evaluation of the patient within one hour of initiation of restraint to assess physical and psychological status. The in-person evaluation includes the patient's immediate situation, reaction to the intervention, medical and behavioral condition and the need to continue or terminate the intervention. The evaluation must be completed even if the physical restraint has been discontinued prior to the in-person evaluation. 2. Review of MR (Medical Record) for P1 indicated on 9/11/2024 at 5:20 pm, N1(Registered Nurse) took a verbal order over the telephone from NP2 (Nurse Practitioner) to administer 5 mg (milligrams) IM (Intramuscular) of Diazepam (Valium) x 1 (times one) Now. The indication for this order was agitation and aggression r/t	A 179		

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A 179	Continued From page 5 (related to) P1 was an immediate danger to the safety of another. P1 was given 5 mg Diazepam (Valium) IM administered by N1. P1's medical record lacked documentation of a 1 hour face to face debriefing with P1 addressing P1's response to interventions and/or medications used. 3.. In an interview on 11/22/24 at approximately 2:00 pm with A1 (Director of Quality) confirmed staff did not complete a 1 hour face-to face debriefing but should have.	A 179		
A 186	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(16)(iii) [there must be documentation in the patient's medical record of] Alternatives or other less restrictive interventions attempted (as applicable); This STANDARD is not met as evidenced by: Based on document review and interview, facility nursing staff failed to document the least restrictive methods of restraint prior to administering a chemical restraint in 1 or 11 medical records reviewed. (P1) Findings include: 1. Facility policy titled, "Restraint", no policy number, last reviewed 01/2023, indicated under POLICY: 2. Restraint may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others after less restrictive interventions are ineffective or ruled-out.	A 186		

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A 186	Continued From page 6 2. Review of P1's medical records indicated on 9/11/24 at 8:00 am P1 was impulsive and oppositional defiant. 1:1 Observation monitoring was initiated, was placed in a gown, and placed on unit restriction because P1 displayed an increase in suicidal thoughts. P1 had a physical altercation with another patient at approximately 5: 15 pm. At 5:20 pm N1(Registered Nurse) took a verbal order over the telephone from NP2 (Nurse Practitioner) to administer 5 mg (milligrams) IM (Intramuscular) of Diazepam (Valium) x 1 (times one) Now. The indication for this order was agitation and aggression r/t (related to) P1 was an immediate danger to the safety of another. P1's parents were notified. P1 was given 5 mg Diazepam (Valium) IM administered by N1 on 9/11/24 at approximately 5:25 pm. P1 was on 1:1 observation at the time of the altercation. The medical record for P1 lacked documentation of lesser restrictive or methods such as verbal deescalating, relaxation activity, voluntary time out, redirection and/or distraction utilized or attempted prior to the use of a chemical restraint. 3. In an interview on 11/22/24 at approximately 2:00 pm with A1 (Director of Quality) confirmed nursing staff failed to document in P1's medical record a less restrictive intervention prior to using a chemical restraint.	A 186		
A 188	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(16)(v) [there must be documentation in the patient's medical record of the following:]	A 188		

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A 188	Continued From page 7	A 188		

The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

This STANDARD is not met as evidenced by:
Based on documentation and interview, facility nursing staff failed to document the patient's reaction to a chemical restraint in 1 of 11 medical records reviewed. (P1)

Findings include:

1. Facility policy titled, "Restraint", no policy number, last reviewed 01/2023, indicated under PROCEDURE: 8. A practitioner or trained registered nurse shall conduct an in-person evaluation of the patient within one hour of initiation of restraint to assess physical and psychological status. The in-person evaluation includes the patient's immediate situation, reaction to the intervention, medical and behavioral condition and the need to continue or terminate the intervention. The evaluation must be completed even if the physical restraint has been discontinued prior to the in-person evaluation.

2. Review of MR (Medical Record) for P1 indicated on 9/11/2024 at 5:20 pm P1 was given 5 mg Diazepam (Valium) IM administered by N1. P1's medical record lacked documentation of a 1 hour assessment and 1 hour face to face debriefing with P1 addressing P1's response to interventions and/or medications used.

3. In an interview on 11/22/24 at approximately 2:00 pm with A1 (Director of Quality) confirmed there was no documentation in P1's MR of an in-person evaluation assessing the patient's

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A 188	Continued From page 8 response to the chemical restraint given on 9/11/2024.	A 188		
A 395	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on document review and interview, facility nursing staff failed to obtain an order for the continuation or discontinuation of 1:1 level of observation and lacked documentation of a medication given to a patient within his/her MAR (Medication Administration Record) for 1 of 11 medical records reviewed. (P1) Findings include: 1. Facility policy titled, "MEDICATION ADMINISTRATION AND DOCUMENTATION", no policy number, last reviewed 01/2024, indicated under PROCEDURE: 3. Administration. t. Document on the MAR the following information in the appropriate column: dose, time, route (if not PO), site (if appropriate), and initials. Sign the bottom of the MAR where indicated. 2. Facility policy titled, "OBSERVATION, PATIENT", no policy number, last revised 4/30/2024, indicated under PROCEDURE: 8. 1:1 Observation. c. The attending physician/designee order will specify continuous 1:1 and is reassessed daily and renewed if needed. f. Staff are to remain within an arms-length range of patients at all times. There should be nothing between the patients and assigned staff, i.e. furniture, nurses station counter, equipment, etc.	A 395		1/17/25

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A 395	Continued From page 9	A 395		

j. The Interdisciplinary Treatment Plan will include or be received to include the 1:1 observation. k. RN will assess patients a minimum of two times per shift and document patient condition in the progress note. Assessment will include the need for continued 1:1 observation. l. The RN will contact the attending physician/ designee if the RN assessment indicates continued 1:1 observation may not be necessary. m. The physician will then order a continuation of 1:1 observation of provide an order for a different level of observation.

3. Review of P1's medical records indicated a provider order dated 9/11/2024 placing P1 on 1:1 observation at 8:00 am. This order was written by NP1 (Nurse Practitioner) for patient safety. On 9/11/2024 at 5:20 pm N1(Registered Nurse) took a verbal order over the telephone from NP2 (Nurse Practitioner) to administer 5 mg (milligrams) IM (Intramuscular) of Diazepam x 1 (times one) Now. nursing note documentation dated 9/11/24 indicated this medication was administered by N1 to P1 on 9/11/2024 at approximately 5:25 pm. The indication for this order was agitation and aggression r/t (related to) P1 was an immediate danger to the safety of another. Patient observation rounding documentation indicated P1 remained on 1:1 observation from 9/11/2024 at 8:00 am until discharge on 9/13/2024 at approximately 11:30 am. P1's medical record lacked documentation of medication given in MAR, and lacked documentation of reassessment the need for continuation of 1:1 observation, lacked a documented conversation with the ordering provider addressing the need to continue the 1:1 level of observation, lacked a completed provider order to continue the 1:1 observation each day for

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A 395	Continued From page 10 P1 on 9/12/2024 and 9/13/2024. 4. In an interview on 11/22/24 at approximately 2:00 pm with A1 (Director of Quality) confirmed N1 did not complete MAR (Medication Administration Record) documentation of the IM injection of Diazepam on 9/11/24 for P1 but should have, and confirmed there was no documentation in P1's care plan and/or treatment plan related to 1:1 observation for P1 and no 1:1 order for P1 for dates 9/12/24 and 9/13/24 but should have been.	A 395		
A 398	SUPERVISION OF CONTRACT STAFF CFR(s): 482.23(b)(6) All licensed nurses who provide services in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of all nursing personnel which occur within the responsibility of the nursing service, regardless of the mechanism through which those personnel are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). This STANDARD is not met as evidenced by: Based on document review and interview, facility nursing staff failed to document complete incident reports for patient assault, physical confrontation, and/or chemical restraint for 1 of 11 medical records reviewed. (P1) Findings include: 1. Facility policy titled, "Incident Reporting", policy number RM 15.03, last reviewed 01/2023, indicated under 4.0 PROCEDURE: Any staff member who witnesses, discovers, or has direct	A 398		1/17/25

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A 398	Continued From page 11	A 398		

knowledge of an incident must complete an Incident Report before the end of the shift/workday. Under-reporting or failure to report a known incident is not acceptable. An "Incident" is an unanticipated event which results in, or nearly causes, a negative impact on patient care or visitor safety. Any harm caused can be temporary, long-term, or permanent and range in severity from no obvious or significant injury, up to death. 07. Physical Confrontation: Harm to Patient - Using self or object, patient succeeds in causing physical harm to another patient. Harm to Staff - Patient succeeds in causing physical harm to staff. Harm to Visitor - Patient succeeds in causing physical harm to visitor. 07 a. Patient Attacked Other Patient. 07 d. Patient Injured by Other Patient. 8.0 INCIDENT INTERVENTION: It is the expectation that part of reporting the incident includes describing the actions taken to mitigate damages and/or prevent further loss. Every incident report requires that the interventions be identified. For example, any time that law enforcement is contacted, the facility must document who contacted the police and the subsequent police involvement.

2. Review of P1's medical records indicated on 9/11/2024 at approximately 5:15 pm P1 physically assaulted a patient. On 9/11/2024 at 5:20 pm N1(Registered Nurse) took a verbal order over the telephone from NP2 (Nurse Practitioner) to administer 5 mg (milligrams) IM (Intramuscular) of Diazepam x 1 (times one) Now. Nursing note documentation dated 9/11/24 indicated this medication was administered by N1 to P1 on 9/11/2024 at approximately 5:25 pm.

3. Review of incident reports dated 6/1/24-12/1/24 lacked documentation of P1

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A 398	Continued From page 12 assault and administration of chemical restraint. 4. In an interview on 11/22/24 at approximately 2:00 pm with A1 (Director of Quality) confirmed nursing staff did not complete assault and/or restraint incident reports for P1, and the other patient that was assaulted by P1 but should have.	A 398		