PRINTED: 02/05/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		154057	B. WING		11	C / 25/2024
	ROVIDER OR SUPPLIER BEHAVIORAL HEALTH	SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 5602 CAITO DRIVE INDIANAPOLIS, IN 46226	•	720/2024
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CORSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS	3	A 00	00		
	This visit was for the Hospital Complaint.	e investigation of a Federal				
	related to the allegat	N00445891 - Deficiencies ions are cited A 0115, A 9, A 0186, A 0188, A 0395				
Survey Date: 11/21/24, 11/22/24, and 11/25/24						
	Facility Number: 012	773				
A 115	QA: 12/4/24 PATIENT RIGHTS CFR(s): 482.13		A 1	15		
	A hospital must prote patient's rights.	ect and promote each				
	Based on document nursing staff failed to restrictive methods p chemical restraint; fa that included restrain conduct a 1 hour fac patient within one ho failed to document threstraint prior to adm restraint; and failed reaction to a chemical records reviewed. (P A0179, A0186, and A	to document the patient's al restraint in 1 of 11 medical 1) See Tags A0164, A0166, A0188.				
		ct of this systemic problem or in the control of th				
ABORATORY	I DIRECTOR'S OR PROVIDERA	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

01/22/2025

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		,	, ,	IPLE CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
		154057	B. WING _			C 11/25/2024	
	ROVIDER OR SUPPLIER BEHAVIORAL HEALTH	SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CC 5602 CAITO DRIVE INDIANAPOLIS, IN 46226		23/2027	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
A 164	less restrictive interved determined to be inefa a staff member, or other a staff failed to restrictive methods prochemical restraint in reviewed. (P1) Findings include: 1. Facility policy titled number, last reviewed POLICY: 1. Restraint hold, physical or medequipment that immoof a patient to move a freely; OR a drug or as a restriction to ma or restrict the patient is not a standard treat patient's condition. 2. for the management obehavior that jeopard safety of the patient, after less restrictive in or ruled-out. 2. Review of P1's med 9/11/24 at 8:00 am Propositional defiant. The staff of the patient of the positional defiant. The staff of the patient of the positional defiant. The staff of the patient of the patient, after less restrictive in or ruled-out.	n may only be used when entions have been fective to protect the patient, hers from harm. not met as evidenced by: review and interview, facility document of a lesser for to implementing a of 11 medical records , "Restraint", no policy do 1/2023, indicated under means the use of manual hanical device, material, or bilizes or reduces the ability his arms, legs, body, or head medication when it is used hage the patient's behavior is freedom of movement and the tor dosage for the Restraint may only be used of violent or self-destructive izes the immediate physical a staff member or others interventions are ineffective	A1	64			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		154057	B. WING _			C 11/25/2024
	ROVIDER OR SUPPLIER BEHAVIORAL HEALTH S	SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 5602 CAITO DRIVE INDIANAPOLIS, IN 46226	'	1112012024
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 164	altercation with anoth 5: 15 pm. At 5:20 pm a verbal order over the (Nurse Practitioner) to (milligrams) IM (Intrar (Valium) x 1 (times or this order was agitation (related to) P1 was all safety of another. P1 was given 5 mg Diaze administered by N1 of 5:25 pm. P1 was on of the altercation. The lacked documentation methods such as verificativity, voluntary time distraction utilized or a chemical restraint.	roughts. P1 had a physical er patient at approximately N1(Registered Nurse) took e telephone from NP2 of administer 5 mg muscular) of Diazepam ne) Now. The indication for on and aggression r/t in immediate danger to the ris parents were notified. P1 epam (Valium) IM n 9/11/24 at approximately 1:1 observation at the time er medical record for P1 n of lesser restrictive or or oal deescalating, relaxation er out, redirection and/or attempted prior to the use of	A 1	64		
A 166	nursing staff did not of documentation included used prior to the use but should have. PATIENT RIGHTS: R SECLUSION CFR(s): 482.13(e)(4)(1) The use of restraint of (i) in accordance with patient's plan of care. This STANDARD is r Based on document staff failed to update as	(i) r seclusion must be a written modification to the	A 1	66		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER BEHAVIORAL HEALTH S	SYSTEM	1	STREET ADDRESS, CITY, STATE, ZIP CODE 5602 CAITO DRIVE INDIANAPOLIS, IN 46226	'	11/20/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 166	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		A 1	66		
A 179	2:00 pm with A1 (Dire there was no docume and/or treatment plan and should have been PATIENT RIGHTS: R SECLUSION CFR(s): 482.13(e)(12	ntation in P1's care plan related to restraint for P1 n. ESTRAINT OR) een face-to-face within 1 n of the intervention]	A 1	79		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
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	ROVIDER OR SUPPLIER BEHAVIORAL HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5602 CAITO DRIVE INDIANAPOLIS, IN 46226	11123/2024
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
A 179	3. The patient's merand 4. The need to contor seclusion. This STANDARD is Based on documer staff failed to conducted evaluation of the page.		A 179		
	number, last review PROCEDURE: 8. A registered nurse sh evaluation of the painitiation of restraint psychological status includes the patient reaction to the interbehavioral condition terminate the interview be completed even been discontinued pevaluation. 2. Review of MR (Mindicated on 9/11/20	ed, "Restraint", no policy red 01/2023, indicated under a practitioner or trained all conduct an in-person attent within one hour of a to assess physical and as. The in-person evaluation is immediate situation, vention, medical and in and the need to continue or ention. The evaluation must if the physical restraint has perior to the in-person			
	indicated on 9/11/20 Nurse) took a verba from NP2 (Nurse Pi (milligrams) IM (Intr (Valium) x 1 (times	024 at 5:20 pm, N1(Registered			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		154057	B. WING _		11/3	25/2024
	ROVIDER OR SUPPLIER BEHAVIORAL HEALTH S	SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 5602 CAITO DRIVE INDIANAPOLIS, IN 46226		
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A 179	safety of another. P1 (Valium) IM administer record lacked docume face debriefing with P to interventions and/o	n immediate danger to the was given 5 mg Diazepam ared by N1. P1's medical entation of a 1 hour face to 1 addressing P1's response r medications used. 11/22/24 at approximately ctor of Quality) confirmed a 1 hour face-to face have.	A 1			
	SECLUSION CFR(s): 482.13(e)(16) [there must be documedical record of] Alternatives or other I attempted (as applical records applical records applical records reviewed at the second records reviewed records r	ess restrictive interventions ble); not met as evidenced by: review and interview, facility document the least restraint prior to ical restraint in 1 or 11 wed. (P1) "Restraint", no policy to 1/2023, indicated under may only be used for the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		154057	B. WING			C I 1/25/2024
	ROVIDER OR SUPPLIER BEHAVIORAL HEALTH	SYSTEM		STREET ADDRESS, CITY, STATE, ZIP COD 5602 CAITO DRIVE INDIANAPOLIS, IN 46226	•	11/25/2524
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 186	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 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 18	36		
A 188			A 18	38		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		154057	B. WING		C 11/25/2	2024
	ROVIDER OR SUPPLIER BEHAVIORAL HEALTH	SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 5602 CAITO DRIVE INDIANAPOLIS, IN 46226		
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A 188		ge 7 se to the intervention(s) ationale for continued use of	A 18	8		
	Based on document nursing staff failed to reaction to a chemic records reviewed. (P	not met as evidenced by: tation and interview, facility document the patient's al restraint in 1 of 11 medical 21)				
	number, last reviewed PROCEDURE: 8. A registered nurse sha evaluation of the pat initiation of restraint psychological status includes the patient's reaction to the interview behavioral condition terminate the intervented process.	and the need to continue or ention. The evaluation must f the physical restraint has				
	indicated on 9/11/20 mg Diazepam (Valiu P1's medical record hour assessment an debriefing with P1 ac interventions and/or 3. In an interview on 2:00 pm with A1 (Dir there was no docum	edical Record) for P1 24 at 5:20 pm P1 was given 5 m) IM administered by N1. lacked documentation of a 1 d 1 hour face to face ddressing P1's response to medications used. 11/22/24 at approximately rector of Quality) confirmed entation in P1's MR of an assessing the patient's				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
A 188	Continued From page	e 8	A 18	8	
A 395	response to the chem 9/11/2024. RN SUPERVISION C CFR(s): 482.23(b)(3)	nical restraint given on	A 39	5	1/17/25
	A registered nurse me the nursing care for e	ust supervise and evaluate ach patient.			
	Based on document nursing staff failed to continuation or discor observation and lacked medication given to a	not met as evidenced by: review and interview, facility obtain an order for the ntinuation of 1:1 level of ed documentation of a patient within his/her MAR ration Record) for 1 of 11 ewed. (P1)			
	Findings include:				
	policy number, last re under PROCEDURE: Document on the MA in the appropriate col	ND DOCUMENTATION", no eviewed 01/2024, indicated : 3. Administration. t. R the following information umn: dose, time, route (if priate), and initials. Sign the			
	Observation. c. The a order will specify con reassessed daily and are to remain within a patients at all times. between the patients	number, last revised under PROCEDURE: 8. 1:1 attending physician/designee			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		154057	B. WING			C 11/25/2024
	ROVIDER OR SUPPLIER BEHAVIORAL HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5602 CAITO DRIVE INDIANAPOLIS, IN 46226	<u> </u>	11/23/2024
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 395	or be received to inc RN will assess patie per shift and docum progress note. Asse for continued 1:1 ob contact the attendin RN assessment ind observation may no physician will then cobservation of provilevel of observation. 3. Review of P1's m provider order date observation at 8:00 NP1 (Nurse Practition 9/11/2024 at 5:20 pia verbal order over (Nurse Practitioner) (milligrams) IM (Intractimes one) Now. nudated 9/11/24 indicated administered by N1 approximately 5:25 order was agitation P1 was an immediated another. Patient observation from 9/discharge on 9/13/2 am. P1's medical remedication given in documentation of recontinuation of 1:1 of documented converprovider addressing level of observation.	ary Treatment Plan will include clude the 1:1 observation. k. Ints a minimum of two times ent patient condition in the issment will include the need servation. I. The RN will g physician/ designee if the cates continued 1:1 to be necessary. m. The order a continuation of 1:1 de an order for a different dedical records indicated a d 9/11/2024 placing P1 on 1:1 am. This order was written by oner) for patient safety. On m N1(Registered Nurse) took the telephone from NP2 to administer 5 mg amuscular) of Diazepam x 1 arsing note documentation and aggression r/t (related to) the danger to the safety of servation rounding sated P1 remained on 1:1 and 1/2024 at 8:00 am until 024 at approximately 11:30 cord lacked documentation of	A 39	05		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		154057	B. WING	B. WING			C 25/2024
	ROVIDER OR SUPPLIER BEHAVIORAL HEALTH	SYSTEM	1	56	REET ADDRESS, CITY, STATE, ZIP CODE 02 CAITO DRIVE IDIANAPOLIS, IN 46226		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE
A 398	2:00 pm with A1 (Dir N1 did not complete Administration Recorninjection of Diazepam should have, and cordocumentation in P1 plan related to 1:1 oborder for P1 for dates should have been. SUPERVISION OF CCFR(s): 482.23(b)(6) All licensed nurses whospital must adhere procedures of the hornursing service must supervision and evalupersonnel which occuthe nursing service, rthrough which those services (that is, hosplease, other agreement This STANDARD is Based on document nursing staff failed to reports for patient as and/or chemical restrictories reviewed. (PFindings include: 1. Facility policy titled number RM 15.03, la indicated under 4.0 Findings includer 4.0 Findings records reviewed.	9/13/2024. 11/22/24 at approximately ector of Quality) confirmed MAR (Medication d) documentation of the IM on 9/11/24 for P1 but offirmed there was no scare plan and/or treatment eservation for P1 and no 1:1 s 9/12/24 and 9/13/24 but CONTRACT STAFF The provide services in the to the policies and spital. The director of provide for the adequate uation of all nursing ur within the responsibility of egardless of the mechanism personnel are providing bital employee, contract, ent, or volunteer). The mot met as evidenced by: review and interview, facility document complete incident sault, physical confrontation, raint for 1 of 11 medical 1).		395			1/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER BEHAVIORAL HEALTH	SYSTEM	•	STREET ADDRESS, CITY, STATE, ZIP CODE 5602 CAITO DRIVE INDIANAPOLIS, IN 46226	,	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 398	Incident Report before shift/workday. Under a known incident is n is an unanticipated e	dent must complete an re the end of the -reporting or failure to report ot acceptable. An "Incident" vent which results in, or ative impact on patient care	A 39	3		
	temporary, long-term severity from no obvito death. 07. Physical Patient - Using self of causing physical harm Staff - Patient succeed to staff. Harm to Visit causing physical harm Attacked Other Patient. 8.0 IN is the expectation that incident includes desimitigate damages and Every incident report interventions be identified to be several to the s	ous or significant injury, up all Confrontation: Harm to robject, patient succeeds in mote to another patient. Harm to eds in causing physical harm for - Patient succeeds in mote to visitor. 07 a. Patient nt. 07 d. Patient Injured by CIDENT INTERVENTION: It at part of reporting the partial of the patient further loss. requires that the tified. For example, any time it is contacted, the facility contacted the police and the				
	9/11/2024 at approximassaulted a patient. On N1 (Registered Nurse the telephone from Nadminister 5 mg (mill of Diazepam x 1 (time documentation dated medication was adm 9/11/2024 at approximals.)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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NAME OF D	20//DED OD 01/DD1/ED	154057	B. WING_		TREET ADDRESS SITV STATE ZID SODE	11/	25/2024
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE		
OPTIONS BEHAVIORAL HEALTH SYSTEM				INDIANAPOLIS, IN 46226			
CHAMADY CTATEMENT OF DEFICIENCIES						(VE)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 398	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		A 39				
	patient that was assa	ulted by P1 but should have.					