STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154063	A. BUILDING _____ B. WING _____	C 01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEUROPSYCHIATRIC HOSPITAL OF INDIANAPOLIS, LLC	6720 PARKDALE PLACE, SUITE 100 INDIANAPOLIS, IN 46254

(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: IN00446611 - Deficiencies related to the allegations are cited at A0395. Survey dates: 01/07/25 - 01/08/25 Facility Number: 013116 QA: 01/14/25	A 000		
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, observation, and interview nursing services failed to review medications with patient at discharge for 1 of 1 patient observed (P11), and failed to ensure that patient received a daily shower in 1 of 10 MR reviewed (P1). Findings include: 1. Review of policy/procedure "Medication Reconciliation (Admission and Discharge Medications)" PolicyStatID: 12197197, last approved 08/2022, indicates under Medication Reconciliation Procedure: D. Discharge Reconciliation: At the time of discharge the Medical Doctor or Registered Nurse will review the discharge medications with the Medication Reconciliation List that was	A 395		3/6/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/25/2025

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.

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A 395	Continued From page 1	A 395		

completed at the time of admission.
3. The Medication Reconciliation List will be reviewed with the patient and/or significant other at the time of discharge. During this education process, the nurse will review any changes to previous home medication dose or schedule, when the next dose is due, and all new medications that will be added to the patient's home medication regimen. Food and Drug interaction will also be discussed with the patient.
5. Provide the patient (or family as needed) with written information on the medication the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter. This will include name, dose, route, frequency, and purpose.

2. Review of policy/procedure titled, "Patient Personal Care," PolicyStatID: 12197137, last approved 08/2022, indicates under Policy:
All patients admitted to the hospital will be supported and educated in activities of daily living (ADLs), focusing on personal hygiene and grooming.
Under Procedure: Definition:
CMS defines ADLs as activities related to personal care, which includes the following:
Bathing/showering
Under Education:
All patients will be provided education upon admission regarding the process for ADLs, including but not limited to:
Bathing/showers will be offered daily
Under General Care:
All patients shall be encouraged or assisted in grooming daily or more often as needed.

3. Review of P1 MR lacked documentation of completed shower on 10/21/24. MR lacked

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A 395	Continued From page 2 documentation of refusal to shower on 10/21/24. 4. On 01/07/25 at approximately 2:30 p.m. this surveyor, accompanied by A1 (Project Chief Executive Officer, Interim Director), was escorted to the unit to observe the nurse, A5 (Director of Nursing [DON]), conduct the discharge of a current patient (P11). During this observation A5 failed to review the patient's discharge medications with the patient. 5. In interview with A8 (BHA) on 01/08/25 at approximately 1:10 p.m., indicated patients are asked every day in the a.m. and p.m. if they want to take a shower. A8 indicated the patient has the right to refuse. If the patient does refuse, A8 encourages the patient to wash up at the sink. Showering is documented on the 15-minute check sheet. If the patient refuses, A8 informs the nurse and documents it on the 15-minute check sheet.	A 395		