STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154063	A. BUILDING 00 B. WING	03/29/2018

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

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A 0000 Bldg. 00	This visit was for three (3) Federal hospital complaint investigations. Date of Survey: 3/27/2018 through 3/29/2018 Facility Number: 013116 Complaint Numbers: IN00254835, IN00254377 and IN00253537 Substantiated: Deficiencies related to allegations cited QA: 4/9/18	A 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts for the conclusion set forth in the statement of deficiencies. The plan of correction provides a credible statement of compliance and acceptable evidence of correction.	
A 0129 Bldg. 00	482.13(b) PATIENT RIGHTS: EXERCISE OF RIGHTS Patient Rights: Exercise of Rights Based on document review and interview, the facility failed to ensure patient rights were adhered to related to personal belongings in three (patients 1, 2 and 8) of 10 patient's medical records (MR) reviewed . Findings include: 1. Review of facility policy, PERSONAL BELONGINGS INVENTORY, Revised: 2/2018, Policy No.: III-B.28, indicated the following, upon admission, a staff member will inventory all patient belongings, and sign the Personal Belongings Inventory Form or document in the patient record that belongings were sent with the patient upon discharge. 2. Patient 1's medical record (MR), PATIENT BELONGING INVENTORY indicated the	A 0129	All nursing staff and nursing aides will be educated regarding personal belongings inventory (patient belongings) as outlined in Policy No. III.B.28. At the time of admission the nursing aide assigned to the patient will inventory all patient belongings and document those items on the patient inventory form. The patients admitting nurse will then review the completed form to ensure all is documented, the nurse will then sign the form agreeing to the documentation. At the time of discharge, the nursing aide will gather all patient belongings and complete the	05/25/2018

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	following, inventory upon discharge, discharge staff signed and dated (02/20/18), but did not indicate inventory upon discharge. Patient 2's medical record (MR), PATIENT BELONGING INVENTORY indicated the following, inventory upon discharge, discharge staff signed and dated (12/28/17), but did not indicate inventory upon discharge. Patient 8's MR, PATIENT BELONGING INVENTORY indicated the following, inventory upon discharge, discharge staff signed and dated (01/06/18), but did not indicate inventory upon discharge. 3.Interview on 3/29/2018, at approximately 2:10 pm, with N1 (Chief Operating Officer) the following was confirmed, patients 1, 2 and 8's medical records unable to determine inventory on discharge.		discharge portion of the patient inventory form. The patients discharge nurse will review the inventory and sign signifying the items marked were present upon discharge. Staff will ensure that all belongings are taken from the safe at discharge and provided to the patient/POA/guardian. Should any patient belongings not be returned to the patient post discharge, hospital staff will make every attempt to return all belongings left at the hospital within 10 business days. 80% of patient charts will be reviewed, if compliance is shown for 30 days, a reduction to 50% of charts will be reviewed. If compliance is shown for 30 days, a reduction to 25% of charts will be reviewed for 30 days.	
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 care was supervised and evaluated in two (patient 3 and 5) of 10 patient's medical records (MR) reviewed and failed to develop policy for routine skin assessments. Findings include: 1. Review of facility policy, SKIN/PRESSURE ULCER ASSESSMENT AND PREVENTION, Revised 10/2017, Policy No.: II-D.2, indicated the following, 2. Patients with Moderate Risk and/or a Stage I Pressure Ulcer a. The patient will receive all interventions listed	A 0395	The following policies were reviewed and/or revised: Policy No. II.D.2 – Skin/Pressure Ulcer Assessments The admitting nurse or designee will complete a skin assessment upon the patient's admission or as soon as possible thereafter. Any issues identified regarding the patient's skin integrity will be documented on a wound/skin report as needed. Patients will be reassessed weekly and skin integrity will be documented on	05/25/2018

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	above, in addition to : i. The patient will be turned and repositioned (or cued to do so) at a minimum of every two hours, avoiding positioning patient on affected side. 2. Review of patient 3's medical record (MR) indicated, Nursing Care Plan-Impaired Skin Integrity date 8/12/2017, indicated decreased mobility, decreased activity, remind/assist patient with turning and repositioning a minimum of every two hours. Hourly Patient Observation Monitoring/Every 15 Minute Patient Observation Monitoring Rounds lacked indication of Q2Hrs (every 2 hours) positioning from 8/11/2017 through 9/13/2017. 3. Interview on 3/27/2018, at approximately 2:00 pm, with N2 (Chief Executive Officer) confirmed the facility has no skin assessment policy related to routine skin assessments. 4. Review of patient 5's MR indicated initial assessment 02/23/2018, 18:32. MR lacked documentation of additional skin assessments to determine skin integrity. Patient admitted on 2/23/2018 and discharged on 3/9/2018. 5. Interview on 3/29/2018, at approximately 11:15 am, with N1 (Chief Operating Officer) confirmed, patient 5's MR indicated initial skin assessment only. Interview on 3/29/2018, at 12:30 pm, with N11 (Director Health Information Management) confirmed patient 5's medical record contained only initial skin assessment. Interview on 3/29/2017, at approximately 9:52 am,with N2 (Chief Executive Officer) confirmed patient 3's MR, Hourly Patient Observation Monitoring Rounds/Every 15 Minute Patient Observation Monitoring Rounds from 8/11/2017, through 9/13/2017 lacked documentation of turning.		the skin/wound report. 80% of patient charts will be reviewed to ensure documentation is completed upon admission and weekly thereafter. If compliance is shown for 30 days, a reduction to 50% of charts will be reviewed. If compliance is shown after another 30 days, a reduction to 25% of charts will be reviewed for 30 more days and then stopped. If at any time charts do not meet compliance, a resumption of 80% of patients' charts will be audited. All nursing staff will be educated on completing skin assessments upon each admission and weekly thereafter by May 25, 2018. All nursing aides will be educated on appropriate positioning and movement of patients as needed by May 25, 2018	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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