

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/04/2015
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NAME OF PROVIDER OR SUPPLIER ALPHA HOME - A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 28, 29, 30, 31, and August 3 & 4, 2015</p> <p>Facility number: 000376 Provider number: 155717 AIM number: 100275510</p> <p>Census bed type: SNF: 0 SNF/NF: 30 Total: 30</p> <p>Census payor type: Medicare: 4 Medicaid: 24 Other: 2 Total: 30</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1</p>	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. The facility respectfully requests paper compliance for this citation.	
F 0170 SS=A Bldg. 00	<p>483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL</p> <p>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.</p>			

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

TITLE

(X6) DATE

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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	<p>Based on interview and record review, the facility failed to provide a system to ensure residents received mail on Saturdays for 2 of 2 residents interviewed regarding weekend mail services (Resident #10 and #33).</p> <p>Findings include:</p> <p>During an interview on 8/3/15 at 3:05 p.m., Resident #10 indicated she had not received her mail on Saturdays.</p> <p>During an interview on 8/3/15 at 3:15 p.m., Resident #33 indicated she had not received her mail on Saturdays.</p> <p>During an interview on 8/3/15 at 3:50 p.m., the Director of Nursing (DON) indicated the facility had not received mail on Saturdays.</p> <p>During an interview on 8/3/15 at 4:05 p.m., the Activities Director indicated she delivered mail to residents Monday through Friday. She indicated the facility had not received mail on Saturdays.</p> <p>During an interview on 8/3/15 at 4:08 p.m., the Administrator indicated the facility had not received mail on Saturdays.</p> <p>During a telephone interview on 8/4/15 at</p>	F 0170	<p>F-170 Residents #10 and #33 and all other residents who live in the facility receive mail on Saturday as well as Monday through Friday. There was never a time (verified by the Post Office) that the facility had any type of a "hold" on Saturday delivery of mail for the facility. Further, there has always been timely, same day delivery of mail to the residents whenever mail was delivered for them to the facility. Resident #10, nor Resident#33 nor any other resident has ever expressed a concern in regards to not receiving mail on Saturday. There is no record of any concern with mail delivery being brought up in a Resident Council meeting. Note: Resident #33 stated after the survey that she has only received one piece of mail in the three months she has lived in the facility. All residents residing in the facility have the potential to be affected by this finding. As stated previously, the Administrator went in person to the Post Office and made certain that going forward, any mail scheduled by the Post Office to be delivered on a Saturday to the facility will, in fact, be delivered to the facility. Further, this delivered mail will be distributed to the residents in a timely fashion on that same day. At an inservice held for the staff 8/24/15 the fact that residents have the right to have mail delivered to them on Saturdays,</p>	09/03/2015

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F 0309 SS=D Bldg. 00	<p>11:30 a.m., Postal Employee #4 indicated mail was delivered to the facility and available for delivery 6 days a week.</p> <p>During an interview on 8/4/15 at 4:27 p.m., the Administrator indicated the postal service had informed him mail is delivered to the facility on Saturdays to the nurse's station. He indicated he expected his nursing staff to deliver mail to the residents on Saturdays.</p> <p>A policy titled "Mail and Telephone Policy," dated July 2015, and identified as current by the DON on 8/4/15 at 2:15 p.m., indicated, "It is the policy of the this facility that the residents will have the following rights:...the right to send and receive mail that is unopened...the Administrator will ensure the residents will have unopened mail delivered to them...."</p> <p>3.1- 3(s)(1)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with</p>		<p>just like the residents who reside in the surrounding community. This mail delivery will be the responsibility of the Activity Department with nursing staff as a "backup." Any staff who fail to comply with their role in delivery of mail on Saturdays will be further educated and/or progressively disciplined as indicated. The Activity Director will keep a log that will indicate which residents received mail on any given Saturday and also will verify that the mail was delivered to that resident. The log will be reviewed on Monday mornings at the morning CQI (Department Head) meetings. Any concerns will be addressed. The monitoring will continue for at least 6 months to ensure ongoing compliance. Afterwards, random monitoring will continue as part of the Quality Assurance program. Any concerns will have been addressed as found. Face to face IDR requested on this finding. Alpha Home does not prohibit mail delivery to residents on the weekend, Post office only deliver mail 6 days a week</p>	

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	<p>the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure a system for communicating care and health status during and following hemodialysis was provided for 1 of 1 resident reviewed for dialysis care (Resident #33).</p> <p>Findings include:</p> <p>Resident #33's record was reviewed on 8/3/15 at 9:37 a.m. The physician order summary, dated 6/11/15, indicated the resident's diagnosis included, but was not limited to, end stage renal disease and the record indicated the resident received Hemodialysis three days a week.</p> <p>The forms titled, "Dialysis/Nursing Facility Communication Form," did not have the "Dialysis Unit" section completed post dialysis for the following dates: 7/14/15, 7/16/15, 7/18/15, 7/28/15, 7/30/15, and 8/1/15. The form's instructions indicated the "Dialysis Unit" portion of the form was to be completed at the end of the resident's dialysis treatment and the form was to be returned to the nursing facility with the resident. The "Dialysis Unit" portion of the form requested the following information: access site assessment, pre-dialysis and</p>	F 0309	<p>F-309 Resident #33 has their care and health status communicated between the facility and the provider during and following dialysis treatments.</p> <p>Any resident who receives dialysis has the potential to be affected by this finding. Going forward, upon return of each resident from receiving their dialysis treatment the receiving facility nurse will check to see that the communication form and all required information accompanies the resident. If there is any lacking information, the nurse will immediately notify the dialysis provider and request the needed information be fax'd immediately to the facility. The name and title of the person contacted will be documented. Further, the receiving nurse is documenting on the MAR that the communication form was returned with the resident. The DON/Designee will monitor the medical records of all residents who receive dialysis from an outside provider 3 days weekly to verify that all needed information is/was received on the communication form (fax'd if necessary). This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Then monitoring will continue weekly for a period of not less than 6 months to ensure ongoing compliance. Afterwards,</p>	09/03/2015

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	<p>post-dialysis weight and vital signs, and orders or changes made during dialysis.</p> <p>The instructions on the form titled, "Dialysis Communication Form," faxed from the dialysis center on 8/4/15 at 8:03 a.m., stated, "This form is to be completed by the dialysis staff and returned to the facility with the resident." The form requested the following information to be provided to the nursing facility post-dialysis: if the resident received medication, if the resident required oxygen during dialysis, if the resident had abnormal bleeding, and if the resident experienced hypotension or hypertension.</p> <p>A form titled, "Resident Transfer" was completed on 7/14/15, for Resident #33 and indicated the resident was transferring from the nursing facility to the dialysis center. No other transfer forms were found in the dialysis binder.</p> <p>The nurse's notes, dated 7/28/15 at 9 p.m. and 8/1/15 at 4:30 p.m., indicated Resident #33 had returned from Hemodialysis.</p> <p>During an interview on 8/3/15 at 3:53 p.m., Licensed Practical Nurse (LPN) #3 indicated the dialysis center did not always fill out their section of the</p>		<p>random monitorings will continue. Any concerns will be addressed as found. At an inservice held 8/24/15 for nurses, the policy and procedures for dialysis as well as the communication form and the nurses' role in the process were reviewed. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly Quality Assurance meetings the results of the monitoring will be reviewed, however, any concerns will be addressed and corrected as found.</p>	

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	<p>communication form.</p> <p>During an interview on 8/3/15 at 4:33 p.m., the Director of Nursing (DON) indicated the dialysis center did not send the communication form back to the facility with the resident. The DON indicated the communication form was supposed to provide necessary updates on the resident's condition after dialysis and was to be with the resident when she returned to the nursing facility.</p> <p>On 7/29/15 at 4:00 p.m., the DON provided the dialysis contract titled, "SNF [Skilled Nursing Facility] Outpatient Dialysis Services Agreement." The services agreement indicated the nursing facility and the dialysis center were to collaborate care for the resident. The services agreement stated, "Both parties shall ensure that there is documented evidence of collaboration of care and communication between the Nursing facility and ESRD [End Stage Renal Disease] Dialysis Unit."</p> <p>On 7/29/15 at 4:00 p.m., the DON provided the dialysis contract titled, "Nursing Home Dialysis Transfer Agreement." The transfer agreement stated, the "Center shall maintain reports of all services rendered..." and, " Facility shall have the right to photocopy of any</p>			

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F 0314 SS=D Bldg. 00	<p>such reports, records or documents for inclusion in its records."</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to implement recommended pressure reducing devices to promote healing and prevention of pressure ulcers for 1 of 2 residents reviewed for pressure ulcers (Resident #31).</p> <p>Findings include:</p> <p>During an observation on 07/30/2015 at 10:14:a.m., Resident #31 was observed lying in her bed on a standard mattress. Her wheel chair was observed to have a</p>	F 0314	<p>On 8/12/15 the pressure ulcer referred to in the survey was found to be healed. Resident #31 has a quality cushion in her wheelchair. Resident #31 was not happy with her air mattress and when it developed a functional problem, she was placed on an anti-pressure mattress. The condition of her open area was much improved at that time and her physician who was aware of this, ordered the new mattress. The resident's right not to be placed on the air mattress which she did not like was honored. The mattress that she was placed on was highly rated for</p>	09/03/2015	

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	<p>thin, standard wheel chair cushion. The bed and wheel chair were not observed to have pressure reducing devices in place.</p> <p>During an observation on 8/03/2015 at 3:00 p.m., with Licensed Practical Nurse (LPN) #3 and Certified Nursing Assistant (CNA) #11 present, Resident #31's pressure ulcer was observed. The wound bed was pink, peri-wound intact, edges macerated, no drainage noted. LPN #11 measured the pressure ulcer and indicated the pressure ulcer measured 0.7 centimeters by 0.5 centimeters with zero depth. She indicated the wound bed was pink with maceration around the edges, had no drainage, and was slowly healing.</p> <p>Resident #31's record was reviewed on 7/30/15 at 12:45 p.m. A nurse's note, dated 4/13/15 at 2:00 p.m., indicated open areas on Resident #31's sacrum had "reoccurred." The note indicated both areas were "stage II (Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister.)."</p> <p>A physician's telephone order, dated 4/15/15, indicated an order for resident Resident #31 to be evaluated and treated by the wound clinic, a wheel chair</p>		<p>anti-pressure. According to the literature, it was rated as a "4" on a 1-4 scale, 4 being the highest. The therapist does not recall commenting to the surveyor about the specifics of the mattress and was not in possession of the literature on the mattress to use as a point of reference. The Wound Clinic recommended the low air loss mattress when the wound was a Stage 3. As it healed, it was still designated as a Stage 3 by the Wound Clinic and therefore continued to have the original recommendations in place for all Stage 3 wounds. The facility placed the resident on her current mattress for the following reasons: a The resident disliked the air mattress b. The wound was healing c. The new mattress was clinically appropriate d. The new mattress was ordered by the doctor As previously stated, the wound healed as of 8/19/15. Residents who have pressure areas have the potential to be affected by this finding. Upon admission residents will be assessed as to their "needs" including any skin related needs/interventions to address current issues and to prevent new skin issues. These interventions will be discussed with the physician and the IDT team to make certain a comprehensive care plan is in place. At the daily CQI meetings, new orders and changes in</p>	

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	<p>cushion, up only for meals, and to ensure resident remained off of her pressure site as much as possible.</p> <p>A wound clinic progress note, dated 4/28/15, indicated, "...please ensure that this patient has a low air loss mattress and it is working properly...."</p> <p>A nurse's note, dated 4/29/15, indicated Resident #31 had an air mattress in place.</p> <p>A nurse's note, dated 5/18/15, indicated Resident #31 no longer had a low air loss mattress in place but rather had anti pressure reduction mattress.</p> <p>A wound clinic progress note, dated 5/19/15, indicated, "...please ensure that this patient has a low air loss mattress and it is working properly...."</p> <p>A physician's order, dated 6/16/15, indicated orders to discontinue wound care at the wound care center.</p> <p>An Occupational Therapy (OT) note, dated 6/18/15 at 8:29 p.m., indicated a plan of care for Resident #31 was developed.</p> <p>An Occupational Therapy note, dated 6/22/15 at 4:30 p.m. indicated, "...Resident currently on a 2 in foam</p>		<p>condition will be addressed to make sure all required assessments are completed including skin assessments so that appropriate interventions can be implemented. All residents were assessed to see that all appropriate interventions for pressure ulcer prevention and healing were in place. Care plans were reviewed and updated. The DON/designee will make rounds weekly to see that all interventions to either address (current) or prevent (potential) skin breakdown are in place as per the plan of care. All recommendations will be discussed and implemented as indicated. Any concerns will be addressed/corrected as found. This monitoring will continue ongoing as part of the continuing QA process. The results of the monitoring will be discussed at the monthly QA meetings, however as stated previously, any concerns will be addressed and corrected as found. Any patterns will be identified and Addressed via an Action Plan written by the committee and reviewed by the Administrator weekly until resolved. There was an inservice held for nursing, at which time the following was reviewed: a. Admission skin assessment for baseline b. Appropriate interventions to prevent or address breakdown, based on the assessment c. What predisposes residents to</p>	

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	<p>cushion that is worn down and most likely no longer pressure relieving, resident would benefit from more appropriate pressure relieving cushion like ROHO as she is not able to adequately weight shift without staff assistance..."</p> <p>During an interview on 7/29/15 at Licensed Practical Nurse (LPN) #10 indicated Resident #31 had a "healing" pressure ulcer.</p> <p>During an interview on 7/30/15 at 10:25 a.m., the Director of Nursing (DON) indicated Resident 31's mattress was a standard pressure reducing mattress and not the recommended low air loss mattress.</p> <p>During an interview on Monday 8/3/15 at 12:46 p.m., Occupational Therapist (OT) #5 indicated when she began working with Resident #31 approximately "four weeks ago" she had a foam cushion in her chair. She indicated "two" weeks ago she recommended a ROHO cushion for her wheel chair to help relieve pressure but it had not arrived.. She further indicated "last Thursday" she found a ROHO cushion in a closet and put it in Resident #31's chair. OT #5 indicated before last Thursday (8/6/15) Resident #31 was on a foam mattress which was</p>		<p>skin breakdown?(Discussion) d. When to perform skin assessments (admission,readmission, weekly, change of condition, or as indicated) e. Care planning interventions related to skin issues (Discussion) f. S.W.A.T (Skin Weight Assessment) Policy and Procedure review g. Discussion of each nursing staff's role in skin care/interventions including CNAs reporting any changes in a resident's skin to their charge nurse for assessment Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. Face to face IDR requested for this finding. Facility followed recommendation of Doctor Resident wound healed. The new mattress was clinically appropriate New mattress was ordered by the doctor Followed resident choice since the resident disliked the mattress</p>	

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	<p>"one of the least effective pressure relieving mattresses." She indicated as long as the facility had a "good" turning program the resident would be ok.</p> <p>During an interview on 8/03/2015 at 3:00 p.m., LPN #3 indicated if therapy made recommendations for pressure ulcer treatment the facility would order it.</p> <p>During an interview on 8/03/2015 at 4:01 p.m., Licensed Practical Nurse #4 indicated a the facility had a low air loss mattress and the mattress was placed on Resident #31's bed. She indicated Resident #31 was on the air loss mattress for "awhile" but it became defective. She further indicated she informed administration but was not able to get another low air loss mattress so she contacted the physician and obtained an order for a "universal foam pressure relieving mattress."</p> <p>During an interview on 8/03/2015 at 4:34 p.m., the DON indicated the cushion had not been ordered until therapy informed her of the need last week, but a cushion had been located.</p> <p>During an interview on 8/04/2015 at 1:57 p.m., the wound clinic's Clinical Manager indicated Resident #31 was treated at their clinic for stage three pressure ulcers</p>			

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	<p>on her left and right buttock. She indicated she was discharged from the clinic in June 2015. She indicated a low air loss mattress was recommended for all stage three pressures and wouldn't have recommended it if it were not necessary.</p> <p>During an interview on 8/4/2015 at 4:25 p.m., the Director of Nursing indicated she assessed Resident #31's wounds and because the wounds were healing she determined a low air loss bed was not necessary. She further indicated therapy recommendations and wound clinic recommendations were "just recommendations" and the facility was not required to follow all recommendations.</p> <p>A policy titled "Pressure Ulcer Assessment and Staging" identified as current by the DON on August 4, 2015 at 4:00 p.m., indicated, "When a pressure area is identified, an accurate assessment will be completed; a treatment program will be initiated and monitored...."</p> <p>3.1-40(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/04/2015
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NAME OF PROVIDER OR SUPPLIER ALPHA HOME - A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222
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F 0329 SS=D Bldg. 00	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure excessive duration or lowest possible dose for an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medication (Resident #31).</p> <p>Findings include:</p> <p>Resident #31's record was reviewed on</p>	F 0329	F-329 F-329 Resident #33 is still on the ordered dose of Risperdal as at the time of the survey. During the survey the surveyor spoke to both doctors handling the case of Resident#33. Both doctors explained to the surveyor that a dose reduction for Resident #33 was contraindicated. One of the doctors told the surveyor that Resident #33 had expressed hallucinations to the doctor at the	09/03/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/04/2015
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	<p>7/30/15 at 12:45 p.m. The record indicated Resident #31 had diagnoses which included, but were not limited to, senile dementia with delusional features, unspecified psychosis, legal blindness, and paranoid state.</p> <p>The July 2015, physician's recapitulation orders indicated Risperdal (antipsychotic medication) 12.5 milligram (mg) injection administered ever two weeks was originally ordered on 7/13/13, for psychotic disorder. The record did not indicate the facility had attempted a gradual dose reduction of Risperdal since the medication was prescribed.</p> <p>Behavior monitoring records for February, March, April, May, and June 2015, indicated Resident #31 had not exhibited behaviors.</p> <p>An untimed nurse's note dated, 3/18/15, indicated Resident #31 reported to staff, "...her husband stood over her and was chopped into pieces like how you chopped a hog with an ax...."</p> <p>A psychology progress note, dated 6/19/15, indicated Resident #31 presented with delusional and depressed mood.</p>		<p>bedside during a recent interview. For this reason, the dose was not changed. Further, Resident#33 was the subject of a survey in January of this year, at which time (3/2/15)the psychologist faxed an expansion of her last progress note to include a statement that states a dose reduction of Risperdal would cause acute exacerbation of existing psychosis s/s (delusional thinking) therefore a dose reduction is clinically contraindicated. It was felt that tapering was clinically contraindicated and this response had been satisfactory on the Plan of Correction for that survey(earlier this year). All behaviors and monitoring for behaviors and side effects of antipsychotic medication usage will continue for Resident #33. All residents who receive antipsychotic medications have the potential to be affected by this finding. Any residents who are admitted and who are receiving antipsychotic medications will immediately be assessed for the need (supporting diagnosis) for this medication. Further,they will be placed on the roster of residents to be reviewed and discussed at the monthly Behavior Management meetings. The protocol will be followed, including all the necessary tracking of behaviors and side effects of the meds. Additionally, GDRs will be</p>	

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	<p>During an interview on 8/4/15 at 4:00 p.m., Licensed Practical Nurse #31 indicated Resident #31 had occasional hallucinations which included feeling distressed because she thought she was on the titanic and couldn't get off and hallucinating about her dead husband who appeared in her room and was cut to pieces. She indicated Resident #31 was easily redirected. She further indicated she failed to consistently document these delusions.</p> <p>During an interview on 8/4/15 at 4:25 p.m., the Director of Nursing (DON) indicated a gradual dose reduction of the Risperdal had not been attempted because it was contraindicated due to Resident #31 exhibited hallucinations "all the time." She further indicated the issue was not that she didn't need the medication but rather a lack of documentation.</p> <p>A Gradual Dose Reduction (GDR) policy titled "Behavior Program Policy and Procedure" identified as current by the DON on 8/14/15 at 4:00 p.m., indicated, "Within the first year in which a resident is admitted on an antipsychotic medication after the physician has initiated an antipsychotic, the facility must attempt in two separate quarters with at least a month in between attempts</p>		<p>attempted as per policy and regulation with the results clearly documented including outcomes and action taken as a result of the attempts. Any new orders for antipsychotic drugs will place that resident on the list to be reviewed and followed at the Behavior Management meetings as well. Any concerns will be addressed at the meetings with the physician(s) in attendance. The DON/Designee will monitor 5 residents who receive antipsychotic meds weekly to see that all appropriate documentation and followup as related to antipsychotic meds is in place. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, monitoring will continue for 2 residents weekly for a period of 6 months to ensure ongoing compliance. After that, random audits will be done, as well as the reviews at the monthly Behavior Meetings. At an inservice held 8/24/15 the policy on Behavior Management was reviewed. All staff were informed of their "roles" in the process. Nursing staff was reminded of their duties as far as documenting and tracking behaviors and side effects as well as the importance of non-pharmacological Interventions and GDRs. Any staff who fail to comply with the points of the inservice will be further educated and/or</p>	

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F 0371 SS=D Bldg. 00	<p>unless clinically contraindicated. After the first year, a GDR must be attempted annually unless contraindicated if: Target symptoms returned or worsened after the most recent attempt at a GDR within the facility. When the physician has documented the clinical rationale for why any additional attempted dose reductions would likely impair the residents functioning, increase distressed behavior or cause psychiatric instability. For as long as the resident remains on a hypnotic that is used routinely during the previous quarter, the facility should attempt to taper the medication at least quarterly. Before one can conclude that tapering is clinically contraindicated for the remainder of the year, tapering must be attempted during the three previous quarters...."</p> <p>3.1-48(b)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food</p>		<p>progressively disciplined as indicated. At the monthly Behavior Management meetings any concerns or patterns from the monitoring will be discussed, however any concerns will have been addressed as found. Any patterns will be identified and addressed via an Action Plan written by the committee and reviewed weekly by the Administrator until resolved. Face to face IDR requested for this finding. Both doctors stated dose reduction contraindicated Resident was having recent hallucinations Resident #33 was the subject of a survey in January of this year, at which time (3/2/15) the psychologist faxed an expansion of her last progress note to include a statement that states a dose reduction of Risperdal would cause acute exacerbation of existing psychosis s/s (delusional thinking) therefore a dose reduction is clinically It was felt that tapering was clinically contraindicated and this response had been satisfactory on the Plan of Correction for that survey (earlier this year).</p>	

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	<p>under sanitary conditions</p> <p>Based on observation and interview, the facility failed to ensure employees' personal food was stored in the walk-in freezer for 1 of 1 kitchen observation.</p> <p>Findings include:</p> <p>During the initial kitchen tour on 7/28/15 at 10:15 a.m., eight 10 pound plastic tubs of pork chitterlings were observed in the walk-in freezer. Each tub had been dated between 10/29/14 and 11/13/14 with freezer burn accumulated on the pork.</p> <p>During an interview on 7/28/15 at 10:23 a.m., the Dietary Manager indicated the pork chitterlings belonged to a former employee and the facility had been storing them in the walk-in freezer for her.</p> <p>During an interview on 8/3/15 at 4:15 p.m., the Director of Nursing (DON) indicated the facility should not store foods in the walk-in freezer for employees.</p> <p>During an interview on 8/4/15 at 10:32 a.m., the DON indicated the facility did not have a policy that addressed storage of employee food within the facility's walk-in freezer.</p>	F 0371	<p>F-371 The food identified during the survey has been removed and discarded. No food belonging to staff is currently stored in the dietary walk-in freezer, nor will it be going forward. All residents who consume food/drink from the dietary kitchen have the potential to be affected by this finding. The dietary walk-in freezer will be inventoried daily by the Dietary Manger or designee to see that the contents are dated/labeled and appropriate and that no food belonging to staff is being kept there. Any such food will be immediately discarded and the fact that it was found there will be investigated so that appropriate educational/disciplinary action can be taken. This monitoring will take place daily and it will continue ongoing. At an inservice held 8/24/15 the dietary staff was reminded of the policy on food storage and the fact that food belonging to the staff is not to be stored in the walk-in freezer. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the results of the monitoring will be reviewed, however any negative findings will have been addressed and corrected as found.</p>	09/03/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/04/2015
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F 0465 SS=E Bldg. 00	<p>3.1-21(i)(1) 3.1-21(i)(3)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a functional and sanitary environment for 5 of 21 resident rooms observed (Resident # 22, Room #306, Room #202, Room #210, and Room #212) and maintenance of a resident's wheelchair (Resident #30).</p> <p>Findings include:</p> <p>1. During an interview on 7/29/15 at 2:29 p.m., Resident #22 indicated his bathroom sink's cold water did not work, and the hot water took a long time to get hot. At 2:30 p.m., the cold water handle on the faucet was unable to be turned.</p> <p>During an environmental tour observation with the Maintenance</p>	F 0465	F-465 The facility provides a safe, sanitary environment for the residents. This includes Resident#22's water in their bathroom (both hot and cold) properly functioning including use of the faucets. Also, room #306 sink no longer leaks water. Room #202 has the wardrobe repaired including a door and a new hinge. The room (#202) has a thermostat cover as well as a new window treatment (blind). The door jamb and tiles in rooms #212 and #210 are clean with no build up present. Resident #30 has arms on her wheelchair that are in good repair. All residents who reside in the facility have the potential to be affected by these findings. A full facility environmental tour of resident rooms has been completed and all necessary repairs are listed and are on a schedule to be repaired timely. The	09/03/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/04/2015
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NAME OF PROVIDER OR SUPPLIER ALPHA HOME - A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222
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	<p>Supervisor (MS), the Housekeeping Consultant (HC), and the Administrator on 8/4/15 from 1:43 p.m. to 2 p.m., the MS was observed to be unable to turn the cold water handle on the faucet.</p> <p>2. During an observation of resident room #306 on 7/29/15 at 2:56 p.m. and an environmental tour observation with the Maintenance Supervisor (MS), the Housekeeping Consultant (HC), and the Administrator on 8/4/15 from 1:43 p.m. to 2 p.m., room #306's bathroom sink continuously leaked water and would not turn off completely.</p> <p>3. During an observation of resident room #202 on 7/29/15 at 3:26 p.m. and 7/30/15 at 10:53 a.m., and an environmental tour observation with the Maintenance Supervisor (MS), the Housekeeping Consultant (HC), and the Administrator on 8/4/15 from 1:43 p.m. to 2 p.m., room #202 was observed to have a wardrobe with a missing door, a wardrobe with a broken bottom hinge, a missing thermostat cover, and bent and torn blinds on the window.</p> <p>4. During an observation of resident room #210 on 7/29/15 at 10:58 a.m., a black substance was observed along the right side of the floor and baseboard from the entry of the room.</p>		<p>Administrator/Housekeeping Supervisor/Maintenance Director will review the list weekly noting progress made. The progress will be documented. Any concerns that threaten to prohibit timely completion of the renovations will be shared in a weekly update to the Regional VP of Operations so that guidance can be given as how to proceed. At an inservice held for Housekeeping/Maintenance staff on 8/24/15 the requirement of a safe and functional environment was reviewed as stated in the regulation. Their roles and responsibilities were discussed. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated.</p>	

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	<p>During an observation of resident room #212 on 7/29/15 at 11:06 a.m., a black substance was observed built up around the door jam and tiles.</p> <p>During an environmental tour observation with the Maintenance Supervisor (MS), the Housekeeping Consultant (HC), and the Administrator on 8/4/15 from 1:43 p.m. to 2 p.m., a black substance was observed on the floor of room #210 and room #212.</p> <p>5. On 7/29/15 at 3:06 p.m., Resident #30's left armrest on her wheelchair was observed to have 2 to 3 inches of exposed foam.</p> <p>On 8/4/15 at 4:35 p.m., the Administrator provided a plumbing service quote for the replacement of lavatory faucets, dated 7/20/15 .</p> <p>On 8/4/15 at 4:35 p.m., the Administrator provided an invoice that indicated 12 lavatory faucets and 4 sink basins and pedestals had been ordered on 7/31/15.</p> <p>On 8/4/15 at 4:35 p.m., the Administrator provided an invoice that indicated armrest pads and handrails had been ordered on 7/14/15.</p>			

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NAME OF PROVIDER OR SUPPLIER ALPHA HOME - A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222
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	<p>During an interview on 8/4/15 at 1:45 p.m., the Maintenance Supervisor (MS) and the Housekeeping Consultant (HC) indicated they were unaware of the 2 broken closets in room #202. The HC indicated all resident rooms would be getting new wardrobes, but the new furniture had not been ordered. The HC indicated she was unaware of the bent blinds and would measure the window for new ones. The MS indicated the thermostat and cooling unit were going to be replaced with a new system and he had the new system on site. He indicated the thermostat and cooling unit would be replaced soon, but did not provide a specific date.</p> <p>During an interview on 8/4/15 at 1:55 p.m., the MS indicated he was unaware of the broken cold water handle in Resident #22's room and the leaking sink in room 306. He indicated all of the resident's bathrooms would be getting new sinks during the room renovations, and he had the new sinks on site.</p> <p>During an interview on 8/4/15 at 1:57 p.m., the HC indicated the black substance on the floors in room #210 and room #212 was wax build up and could be removed.</p> <p>During an interview on 8/4/15 at 2:00</p>			

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NAME OF PROVIDER OR SUPPLIER ALPHA HOME - A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222
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F 0468 SS=D Bldg. 00	<p>p.m., the Administrator indicated the resident's rooms and bathrooms were going to be renovated 4 at a time, so only 4 sinks would be replaced at a time. He indicated it may be a while before rooms #306 and Resident #22 had new sinks installed.</p> <p>During an interview on 8/4/15 at 2:02 p.m., the MS indicated he was unaware of Resident #30's wheelchair arm being exposed. He indicated he and therapy took care of wheelchair maintenance and he had a whole box of new arms for wheelchairs in his office.</p> <p>On 8/4/15 at 4:00 p.m., the Director of Nursing (DON) provided a form titled, "Walking Rounds," as the current policy for environment. The form indicated the staff was to observe that floors were clean, resident's personal items were out of view, rooms were clean, and care could be done in private.</p> <p>3.1-19(f)</p> <p>483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly</p>			

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NAME OF PROVIDER OR SUPPLIER ALPHA HOME - A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222
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	<p>secured handrails on each side.</p> <p>Based on observation, interview, and record review, the facility failed to ensure handrails were firmly secured to the wall on 1 of 3 halls with handrails observed.</p> <p>Findings include:</p> <p>During an initial tour on 7/28/15 at 10:00 a.m., a wall approximately two feet long was observed without a handrail in the hallway from the lobby to the nurse's station between the housekeeping office door and a door with a sign titled "staff only." Two holes were observed in the wall at the same height of the other handrails observed in the hallway.</p> <p>During an environmental tour and interview on 8/4/15 at 2:39 p.m., the Maintenance Director observed the wall and indicated he had been unaware of the missing handrail, but did see the holes in the wall were it had previously been attached. He indicated he would retrieve a replacement handrail to put on the wall.</p> <p>On 8/4/15 at 4:00 p.m., the Director of Nursing (DON) provided a form titled, "Walking Rounds," as the current policy regarding handrails. The form indicated the staff was to observe that walls were in good repair.</p>	F 0468	F-468 All 3 halls currently have secure handrails in place. Any resident who uses the handrails has the potential to be affected by this finding. Going forward, the handrails on all 3 halls will be tested for secure anchoring weekly ongoing as part of the preventative maintenance rounds. Any concerns will be addressed as found. At an inservice held 8/24/15 the maintenance staff was reminded of the need for safe and secure anchoring of the handrails for resident safety. Any failure to comply with the points of the inservice will result in further education and/or progressive discipline as indicated. Note: The Administrator will randomly check handrails for secure placement on the walls as their rounds are made weekly. This too will be ongoing. At the monthly QA meeting, the results of the monitoring of handrails will be reviewed. Any concerns will have been addressed as discovered.	09/03/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/04/2015
NAME OF PROVIDER OR SUPPLIER ALPHA HOME - A WATERS COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222		
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	3.1-19(f)(3)				