

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  01/30/2015
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NAME OF PROVIDER OR SUPPLIER  ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 26, 27, 28, 29, &amp; 30, 2015.</p> <p>Facility number: 000376 Provider number: 155717 AIM number: 100275510</p> <p>Survey team: Lora Brettnacher, RN-TC Kewanna Gordon, RN Megan Burgess, RN Tracina Moody, RN</p> <p>Census bed type: SNF/NF: 29 Total: 29</p> <p>Census Payor type: Medicare: 2 Medicaid: 26 Other: 1 Total: 29</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 02/02/2015 by</p>	F000000		

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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F000329 SS=D	<p>Brenda Marshall, RN.</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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 medications (Resident #35).</p> <p>Findings include:</p> <p>Resident #35's record was reviewed on 1/28/15 at 10:30 a.m. Resident #34 had</p>	F000329	<p>F-329</p> <p>It is the practice of theAlpha House to ensure that each resident's drug regimen is free fromunnecessary drugs. Resident #35 has hadtheir med regimen reviewed.</p>	02/20/2015
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	<p>diagnoses which included, but were not limited to, senile dementia with delusional features, unspecified psychosis, legal blindness, and paranoid state.</p> <p>The January 2015 physician's recapitulation orders indicated Risperdal (antipsychotic medication) 12.5 milligram every 2 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>A behavior care plan, updated 12/31/14, indicated Resident #35 had experienced symptoms of paranoia prior to admission to the facility. A goal indicated she would remain free of psychotropic drug related complications including: movement disorder, discomfort, hypotension, gait disturbance, constipation, and cognitive impairment. Interventions to meet this goal included: administer anti-psychotic medications as ordered, consult pharmacy and physician to consider dosage reduction when clinically appropriate at least quarterly, and monitor and report as needed. The care plan did not include how the resident displayed symptoms of paranoia, delusions, or psychosis for monitoring/tracking frequency of</p>		<p>Further, Resident #35's psychologist has made a note regarding the contraindication for a dose reduction of the Risperdal. Resident #35's behaviors are being tracked/monitored. Resident #35 is also being monitored for signs/symptoms of side effects of antipsychotic meds. The facility has a policy in place for Gradual Dose Reduction of antipsychotic meds.</p> <p>Any resident receiving antipsychotic meds has the potential to be affected by this finding. All residents receiving antipsychotic meds ordered have been reviewed to be sure that they have the following:</p>	

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	<p>occurrence</p> <p>Behavior monitoring records for November and December 2014, and January 2015. The monitoring records did not indicate psychosis was tracked or documented during the monitoring period.</p> <p>A document titled "Note To Attending Physician/Prescriber," dated 1/28/15, indicated a request for the physician to review the use of Risperdal. The note indicated, "...current dose of medications benefiting resident... There have (sic) been improvement in her behavior allowing staff to perform ADLs [activity of daily living] compliance and psychosis... Staff report that she continues to suffer from psychosis..."</p> <p>During an interview on 1/30/15 at 12:10 p.m., the Director of Nursing (DON) indicated she could not locate evidence to indicate symptoms of psychosis were monitored/tracked and was unable to provide information regarding an attempt to reduce the dose of Risperdal since it was introduced on 7/13/13.</p> <p>During an interview on 1/30/15 at 2:30 p.m., Licensed Practical Nurse #1 indicated refusals of medications and refusals of care were tracked. She</p>		<p>a. Supporting acceptable diagnosis-validation of order</p> <p>b. Behavior tracking</p> <p>c. Signs/symptoms of side effects from antipsychotic meds tracking and monitoring</p> <p>d. Gradual Dose Reduction Program (unless clinically contraindicated documentation)</p> <p>e. Care planning</p> <p>The DON/Designee along with the SSD will monitor residents who receive antipsychotic medication at the monthly Behavior</p>	

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	<p>indicated Resident #35 did not have symptoms of psychosis.</p> <p>During an interview on 1/30/15 at 3:30 p.m., the Executive Director indicated he could not find a facility policy regarding unnecessary medication use.</p> <p>3.1-48(a)(4) 3.1-48(b)(2)</p>		<p>Management meetings to verify that these residents have theafore mentioned requirements implemented. Additionally, as ordersare received for antipsychotic meds, those residents will be added to thetargeted list of residents (who receive antipsychotic meds) which is kept bythe DON/Designee and SSD for monitoring and for possible dose reduction ifpossible.</p> <p>At the daily CQI meetingsresidents who have had a behavior on the 24 Hour Report or the shift to shiftreport or who have received a new order for an antipsychotic med will have thebehavior discussed to see that it was properly</p>		

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			<p>addressed. Further, any resident who receives a new antipsychotic medication order will be placed on the list of targeted residents kept by the DON/Designee and SSD for tracking and monitoring of behaviors/side effects of antipsychotic meds/gradual dose reduction attempts (unless clinically contraindicated documentation)/care planning.</p> <p>At an inservice held for all staff the following was reviewed:</p> <ul style="list-style-type: none"> <li>a. Supporting acceptable diagnosis-validation of order</li> <li>b. Behavior tracking</li> <li>c. Signs/symptoms</li> </ul>	

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			<p>side effects from antipsychotic meds</p> <p>tracking/monitoring</p> <p>d</p> <p>. Gradual Dose Reduction Program (unless clinically contraindicated documentation)</p> <p>e. Care planning</p> <p>Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated.</p> <p>At the monthly Quality Assurance meetings the minutes (discussion) of the DON/Designee and SSD's monthly Behavior Monitoring meetings will</p>	

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F000371 SS=E	<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 under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure dietary staff wore proper hair coverings and performed proper thermometer sanitation while food temperatures were monitored for 3 of 3 dietary observations. This practice had the potential to affect 26 of 29 residents who consumed food from the kitchen.</p> <p>Findings include:  During an observation of the kitchen on</p>	F000371	<p>be reviewed. Any patterns/concerns will be discussed. If necessary, an Action Plan will be written by the QA Committee. The plan will be monitored by the Administrator weekly until resolved.</p> <p>F-371</p> <p>It is the practice of the Alpha Home to ensure that food is procured from sources approved or considered satisfactory by Federal, State or local authorities and that food is prepared, distributed</p>	02/20/2015

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	<p>1/26/2015 at 10:41 a.m., the Dietary Manager was observed walking through the kitchen without a hair covering.</p> <p>During an observation of the kitchen on 1/26/2015 at 12:18 p.m., Kitchen Staff #10 performed temperature checks of food for lunch. She was not observed to sanitize the thermometer between checking temperatures of different food items.</p> <p>During observation of the kitchen on 1/30/2015 at 12:10 p.m., the Dietary Manager was observed walking through the kitchen without a hair covering.</p> <p>During an interview on 1/30/2015 at 12:17 p.m., the Dietary Manager indicated the thermometer should have sanitized between temperature checks for each different food and all staff should have worn hair coverings in the kitchen.</p> <p>During an interview on 1/30/2015 at 3:40 p.m., the Administrator indicated the facility did not have a policy for sanitizing food thermometers.</p> <p>An undated policy, titled "Personal Hygiene of Food Handlers," identified as current by the Administrator, was provided on 1/30/2015 at 3:00 p.m. The policy indicated "...Food handlers shall</p>		<p>and served under sanitary conditions.</p> <p>Currently, all dietary staff wear proper hair coverings while in the dietary department/area. Further, any thermometer used to test food temperatures is properly cleaned before and after use and between foods.</p> <p>All residents who receive food from the dietary department have the potential to be affected by this finding.</p> <p>The Dietary Manager/Designee will monitor daily 5 days weekly x 4 weeks then weekly x 4 weeks then randomly monthly ongoing to see that staff are wearing proper hair coverings. This</p>	

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	wear hair restraints such as hats, hair coverings or nets and beard restraints that are designed and worn to effectively keep hair from contacting or entering exposed food, clean equipment, utensils, linens and unwrapped single-service and single-use articles...."  3.1- 21(i)(3)		monitoring will be occurat various times (shifts) and will be documented. Any discrepancies will be correctedimmediately. Additionally, the DietaryManager/Design ee will monitor the temperature taking of foods for 5 meals a weekx 4 weeks then weekly x 4 weeks then randomly ongoing monthly. Any discrepancies will be addressedimmediately before a breech in policy is committed.  At an inservice held fordietary on 02/20/2015 , the following was reviewed: a. Hair covering in dietary department-Why?How?  b. How to properly "temp"	

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F000406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES		<p>food</p> <p>c. Food thermometer-use/cleaning/care/storage</p> <p>Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated.</p> <p>At the monthly Quality Assurance meetings the results of the monitoring of the Dietary Mgr/Designee will be reviewed. Any patterns will be discussed but any concerns will have been addressed/corrected as found.</p>		

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	<p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on record review and interview, the facility failed to ensure specialized rehabilitative services were provided to 1 of 1 resident assessed as needing physical therapy (Resident #25).</p> <p>Findings include:</p> <p>During an interview on 1/28/15 at 9:22 a.m., Resident # 25 indicated she had been admitted to the facility to receive rehabilitation services. She indicated she had not received any therapy services.</p> <p>Resident #25's record was reviewed on 1/28/15 at 11:55 a.m. A physician's order, dated 12/30/14 at 6:00 p.m., indicated the resident was to receive physical therapy services 3-5 times per week for neuromuscular reconditioning. The record did not include a therapy progress note.</p>	F000406	<p>F-406 It is the practice of theAlpha Home to ensure that each resident who has an order for specialized rehabservices is provided with the services as per order. Resident #25 has beendischarged from the facility. All residents who have anorder for specialized rehab services have the potential to be affected by thisfinding. A new therapy company hasbeen contracted and will monitor residents on caseload for specialized rehabservices weekly to see that the residents are receiving the specializedservices as per order and that the services are documented. This monitoring will be weekly x 4 weeks thenmonthly ongoing. Any discrepancies willbe addressed as discovered. At an inservice held fortherapy staff on 02/23/2014, the following was reviewed: a. Therapy orders-responsibility to initiate treatment b. Caseload-Plans of Treatment c. Accurate/Timely documentation of treatments Any staff who fail</p>	02/23/2015			

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	<p>During a phone interview on 1/29/15 at 3:11 p.m., the Physical Therapist contracted to provide rehabilitation services for the Alpha Home, indicated he had only seen Resident #25 once. He indicated he had not provided any further services to the resident as ordered by the physician. He indicated the therapy records were locked in the therapy room, and the facility would not be able to find them because he had not filed them yet.</p> <p>On 1/30/15 at 11:30 a.m., a policy and procedure regarding specialized rehabilitative services was requested from the Administrator. He indicated he did not have one to provide.</p> <p>16.2-3.1-23(a)(1)</p>		<p>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 of the newly contracted therapy company will be reviewed. Any patterns will be identified. If necessary, an Action Plan will be written by the QA Committee. The plan will be monitored by the Administrator weekly until resolved. F-406 It is the practice of the Alpha Home to ensure that each resident who has an order for specialized rehab services is provided with the services as per order. Resident #25 has been discharged from the facility. All residents who have an order for specialized rehab services have the potential to be affected by this finding. A new therapy company has been contracted and will monitor residents on caseload for specialized rehab services weekly to see that the residents are receiving the specialized services as per order and that the services are documented. This monitoring will be weekly x 4 weeks then monthly ongoing. Any discrepancies will be addressed as discovered. At an inservice held for therapy staff on 02/23/2014, the following was reviewed: a. Therapy orders-responsibility to initiate treatment b. Caseload-Plans of Treatment c.</p>	

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			Accurate/Timely documentation of treatments 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 of the newly contracted therapy company will be reviewed. Any patterns will be identified. If necessary, an Action Plan will be written by the QA Committee. The plan will be monitored by the Administrator weekly until resolved.		