

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  10/29/2013
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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 the Investigation of Complaint IN00138422.</p> <p>Complaint IN00138422 unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: October 28, 29, 2013</p> <p>Facility number: 000376 Provider number: 155717 AIM number: 100275510</p> <p>Survey team: Connie Landman RN-TC</p> <p>Census bed type: SNF/NF: 36 Total: 36</p> <p>Census payor type: Medicare: 2 Medicaid: 32 Other: 2 Total: 36</p> <p>Sample: 3</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</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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	Quality review completed on 11/01/2013 by Brenda Marshall Nunan, RN.			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a care plan for unsafe behavior was followed resulting in an escalation of aggressive behavior for 1 of 1 residents reviewed for care plans in a sample of 3 (Resident B, LPN #3).</p> <p>Findings include:</p> <p>The record for Resident B was reviewed on 10/28/13 at 11:55 A.M.</p> <p>Diagnoses for Resident B included, but were not limited to, hypertension, dementia, hepatitis C, partial epilepsy, polyneuropathy, and history of traumatic head injury.</p> <p>A care plan, dated 7/20/13, indicated a problem of resisting redirection that will keep him safe. Interventions included, but were not limited to, attempt redirection if performing unsafe acts, and walk away and reapproach later if resident becomes agitated.</p> <p>A facility investigation of an incident</p>	F000282	ALPHA HOMEPLAN OF CORRECTION FOR SURVEY COMPLETED ON 10-29-13 Complaint Survey #IN00138422 F282-The resident has been discharged from the facility. Other residents have been identified and their care plan reviewed to assure the proper measures were in place to manage someone who has the potential for becoming aggressive to staff or other residents. Staff education will be provided to discuss the proper way to handle an aggressive resident by using the interventions documented in the resident's care plan. Social services and nursing services will be responsible for monitoring residents at risk for demonstrating aggressive behavior. DON and SS will monitor for compliance; reporting no less than quarterly the findings to the QAA committee for any recommendations if indicated. CompletionDate 11-8-13	11/08/2013			

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	<p>involving Resident B and LPN #3 was provided by the Administrator on 10/28/13 at 1:00 P.M. The investigation indicated Resident B had pushed another resident in his wheel chair out onto the patio area. LPN #3 was present on the patio, and reminded Resident B he was not supposed to push other residents in their wheel chairs outside as it was unsafe for both of them. Resident B cursed LPN #3 and indicated he was tired of LPN #3 telling him what he couldn't do. At that point, LPN #3 placed his hand on the wheel chair to push the resident inside, Resident B then put a "choke hold" on LPN #3, causing them both to fall.</p> <p>Review of LPN #3's employee file on 10/29/13 at 1:00 P.M. indicated LPN #3 had initialed he had reviewed a document titled "Strategies For Dealing With The Aggressive Residents." This document indicated:</p> <p>"1. When a resident is angry and becoming increasingly agitated, behave in a calm non-threatening manner....</p> <p>4. Allow sufficient space between you and the resident. Standing too near may be interpreted as threatening and may encourage the resident to strike out at you.</p> <p>5. If you feel you are about to lose</p>						

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	<p>control, walk away from the resident...."</p> <p>During an interview with the Administrator on 10/29/13 at 10:30 A.M., he indicated LPN #3 should have given Resident B space instead of trying to push the other resident into the building, that was where it had gotten out of control.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=D	<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 the comprehensive assessment and plan of care.</p> <p>1. Based on record review and interview, the facility failed to ensure a resident who had incurred a fall following an altercation had received an initial assessment and follow up after the fall for 1 of 2 residents reviewed in a sample of 3 (Resident B).</p> <p>2. Based on record review and interview the facility failed to ensure a physician's order had been followed or implemented with the orthopedic clinic for 1 of 2 residents reviewed for physician's orders following a fall in a sample of 3 (Resident B).</p> <p>Findings include:</p> <p>1. The record for Resident B was reviewed on 10/28/13 at 11:55 A.M.</p> <p>Diagnoses for Resident B included, but were not limited to, hypertension, dementia, hepatitis C, partial epilepsy, polyneuropathy, and history of traumatic head injury.</p>	F000309	ALPHA HOMEPLAN OF CORRECTION FOR SURVEY COMPLETED ON 10-29-13 Complaint Survey #IN00138422 F 309Resident B has been discharged from the facility.No other residents were identified or found to be affected by this finding.An in-service was held to address the importance of following physicians' orders in a timely manner.The charge nurses will remain responsible for facilitating the policy regarding physicians' orders be adhered to. The DON will monitor for compliance; reporting to the QAA committee no less than quarterly for any recommendations if indicated..Completion Date 11-8-13	11/08/2013			

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	<p>During review of incidents and investigations, provided by the Administrator on 10/28/13 at 11:00 A.M., an incident of an altercation on the patio involving Resident B and LPN #3. Resident B had fallen to the ground during the altercation.</p> <p>Resident B's Nurses Notes documented the fall occurred on 10/8/13 at 4:45 P.M. During an interview with CNA #1 on 10/28/13 at 3:00 P.M., she indicated she had witnessed the fall, and assisted Resident B back to his feet.</p> <p>Nurses Notes, 10/8/13 at 7:00 P.M., indicated Resident B had been up walking around the facility and been encouraged 3 times to use his assistive device as he had an unsteady gait. He was assisted to his room to relax at that time, and he had no complaints of pain or discomfort.</p> <p>The "Incident/Accident Report and Investigation" dated 10/8/13 at 8:00 P.M. indicated under "Type of Injury" under "Other: ankle (symbol for left) leg" with a circle and "x" over the left ankle on the diagram. This report lacked documentation to indicate an assessment regarding the type of injury to his foot/ankle.</p>			

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	<p>Nurses Notes on 10/8/13 at 9:00 P.M. indicated Resident B had not been assessed for any injury after the fall until he complained of pain and discomfort to his left ankle 4-1/4 hours after the fall. The notes also indicated the resident had wrapped his ankle but had not reported discomfort to the nurse. The nurse received an order for an x-ray at that time and made arrangements for it to be done.</p> <p>Nurses Notes on 10/9/13 at 6:00 A.M. indicated the "resident has wrapped (left) ft/ankle [foot/ankle] [symbol for with] ace wrap. Ft. is swollen &amp; he c/o [complained of] pain in ankle..."</p> <p>The x-ray, 10/9/13, indicated "There is a hairline fracture involving the distal fibula with no displacement. The joint alignment is maintained. There is associated soft tissue swelling. There is osteopenia. Bony fragment is seen off the medial malleolus with no displacement, possibly from old injury."</p> <p>Nurses Note, 10/9/13 at 2:00 P.M., indicated the resident denied any pain or discomfort to his left ankle. The note also indicated he had non-pitting edema noted. The MD was notified, and an order was received to make</p>			

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	<p>an appointment at an orthopedic clinic. The resident was unable to move toes to the left ankle, his foot warm and dry.</p> <p>10/9/13 at 8:30 P.M. Nurses Notes lacked documentation of his ankle or his pain.</p> <p>The next documentation was undated and untimed, and indicated he slept well during the night, his left foot was swollen and warm to touch, and his toes were warm and mobile.</p> <p>The next nursing entry was dated 10/10/13, untimed, and indicated he was up ambulating, his ankle was swollen, his toes warm to touch, able to wiggle toes, and he was medicated for pain with relief.</p> <p>On 10/10/13 at 10:50 P.M., Nurses Notes indicated "[symbol for no] complaints of any kind" to bilateral lower extremities.</p> <p>During an interview with LPN #2 on 10/29/13 at 4:45 P.M., she indicated she had not done an immediate assessment of Resident B after the fall since she observed him walking, turning his head, and reaching out to hand over his telephone, and did not seem to be having a problem with his</p>			
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	<p>range of motion.</p> <p>2. Nurses Notes, 10/10/13 at 2:30 P.M., indicated "Res [Resident B] has a [sic] issue at this time with his Medicaid. Writer contacted [name of orthopedic clinic employee]. Writer was informed that resident no longer has Medicaid and [name of clinic] does not accept Medicare...."</p> <p>No other documentation of attempts to send the resident to another orthopedic physician or of notifying the physician was provided by the facility. During an interview with the Administrator on 10/29/13 at 10:30 A.M., he indicated there "should have been follow up of another sort, even if it was a trip to the emergency room" to be seen by an orthopedic physician. During the same interview, the Administrator indicated the Incident Report should have included more information and a thorough assessment of the resident after the fall.</p> <p>During an interview with LPN #2 on 10/29/13 at 4:45 P.M., she indicated the resident walked back into the building after the fall, went into the dining room for dinner, and she went to his room to do his assessment later. She also indicated she would</p>						

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	<p>normally do range of motion, however, she had observed him walking, using his arms to hand her a telephone, he turned his head, and he sat up in bed, so she did not do range of motion. She indicated he said his ankle hurt, so she did inspect his ankle at that time and discovered he had an ace wrap on it.</p> <p>A current facility policy, undated, titled "Falls Policy" was provided by the Medical Records Director on 10/29/13 at 9:55 A.M. It indicated: "Procedure: ...3. If a fall occurs the resident must be assessed immediately for injury...."</p> <p>3.1-37(a)</p>				

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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure chemicals were safely secured when staff was not present. This practice had the potential to affect the 1 resident with dementia residing on the unit (Resident C).</p> <p>Findings include:</p> <p>Resident C's record was reviewed on 10/29/13 at 3:40 P.M.</p> <p>Resident C had diagnoses including, but not limited to, dementia, hypertension, atrial tachycardia, hypothyroidism, and rheumatoid arthritis.</p> <p>During a tour of the 200 Hallway on 10/29/13 at 2:15 P.M., a door labeled "Housekeeping" was next to Resident C's room. Resident C was observed opening the housekeeping door and looking inside. Resident C then closed the door and proceeded into her room. There were no staff present in the hallway at that time.</p>	F000323	<p>F 323 – Free Of AccidentsIt is the policy of the Alpha Home that the resident environment remains as free of accident hazards as is possible and each resident receive adequate supervision and assistance devices to prevent accidents. Corrective Action Taken Related to this Finding:Housekeeper #4 received corrective action specific to locking doors while working in resident care area.Maintenance Director has provided retaining and provided the staff with a key to ensure locked area is kept locked when leaving area that must remain locked.Staff utilizing log sheets to follow up with locking of the doors.Locks were checked to ensure that the locks are locking properly.II. Other Residents with Potential to be affected by this finding will be identified by:Other residents were identified with assessments of their mobility from ambulatory, wheelchairs, and walkers. No others residents were affected by these findings. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows:Put in place doors that lock when opened and</p>	11/04/2013

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	<p>Observation of the room at that time indicated shelving behind a housekeeping cart contained a bottle containing liquid calcium/lime/rust remover. The label on the bottle indicated "Caution: Keep out of reach of children. Harmful if swallowed. Eye irritant. Vapor may be harmful. Do not mix with other harmful chemicals or bleach as toxic fumes may result..."</p> <p>During an interview with Housekeeper #4 on 10/29/13 at 2:20 P.M., he validated the door was unlocked because they were working on the ceiling and were in and out of the closet all afternoon.</p> <p>A current undated facility policy, titled "Locked Door Policy", was provided by the DON (Director of Nursing) on 10/29/13 at 5:50 P.M. The policy indicated: "This policy is produced to provide a guide to staff who has: A duty of care to prevent persons who may enter areas presenting harm to themselves or others when entering or leaving the area. A responsibility to ensure security of locked areas due to safety of resident but made accessible to staff. These locked door areas are intended as a</p>		<p>closed staff must have a key to gain access. Policy provided for all staff for locking of doors and ensuring safety of the residents. The Quality assurance has reviewed the 2567 and the plan of correction associated with the finding. The facility is utilizing the audit tools. The QA committee will begin reviewing the audit tools with additional changes and recommendations. The Quality Assurance team has reviewed the regulation so they are knowledgeable of their responsibilities as their training guide. The administrator leads the committee and will work diligently to assure that area identified are corrected and remain in compliance. IV. Corrective Actions will be monitored to Ensure Compliance by: The Quality Assurance team will be reviewing progress and audit tools with additional recommendations as needed to assure compliance, The administrator overall is responsible for assuring that the area identified are corrected and remain in compliance. Completion Date 11 04 2013</p>		

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	<p>guide to good practice for all working staff in a clinical area who may by necessity be required to lock the door as a result of code of practice on ensuring security and safety...All staff needing access to the room must have available keys to enter and exit the room and relock the door."</p> <p>3.1-45(a)(1)</p>			