

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 08/22/2014
--	---	--	---

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
--	--

(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
F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 18, 19, 20, 21, & 22, 2014</p> <p>Facility number: 000376 Provider number: 155717 AIM number: 100275510</p> <p>Survey team: Lora Brettnacher, RN-TC Kewanna Gordon, RN Mary Weyls, RN Vicki Nearhoof, RN Megan Burgess, RN (August 18 and 19, 2014)</p> <p>Census bed type: SNF/NF: 30 Total: 30</p> <p>Census Payor type: Medicare: 1 Medicaid: 28 Other: 1 Total: 30</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 21, 2014 to the annual licensure survey conducted on August 18, 2014 through August 22, 2014.</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.

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 08/22/2014
--	---	--	---

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
--	--

(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
F000161 SS=F	<p>Quality review completed 8/26/14 by Brenda Marshall, RN.</p> <p>483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.</p> <p>Based on interview and document review, the facility failed to ensure financial security of all resident funds deposited with the facility. This deficient practice had the potential to affect 30 of 30 residents who had funds deposited with the facility.</p> <p>Findings include:</p> <p>A document titled "Continuation Certificate Fidelity or Surety Bonds/Policies" identified as the facility's current surety bond by the Administrator on 8/20/14 at 9:36 A.M., was reviewed. The document indicated the facility had purchased \$32,000.00 of surety insurance to cover residents' funds deposited with the facility.</p> <p>A bank statement dated July 1, 2014 through July 31, 2014, indicated the current amount of residents' funds</p>	F000161	<p>It is the practice of this facility to assure that a Surety Bond is in place in an amount that adequately secures any monies in resident trust. The correction action taken for those residents found to be affected by the deficient practice include: No specific residents were identified in the 2567. Please see systems below and means of monitoring Other residents that have the potential to be affected have been identified by: All residents that have resident trusts have been reviewed. The facility will assure that the Surety Bond amount adequately covers the amount in resident trust. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The Administrator has contacted the company that provides Surety Bond coverage for the resident trust. The amount</p>	09/21/2014

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 08/22/2014
--	---	--	---

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
--	--

(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
F000242 SS=E	<p>deposited with the facility was \$52,016.89.</p> <p>During an interview on 8/20/14 at 1:04 P.M., the Administrator indicated he was not aware the facility needed to have a surety bond for the total amount of residents' funds deposited with the facility. He stated, "I have never had a surety bond more than \$32,000.00."</p> <p>3.1-6(j)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care</p>		<p>of coverage has been increased. The Business Office Manager is responsible for providing the total amount in resident trust on a monthly basis. If the balance of resident trust exceeds the amount of the Surety Bond the administrator will contact the company that provides the insurance to increase the coverage. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that will be utilized to assure that the Surety Bond amount of coverage equals or exceeds the amount in resident trust. The Administrator will complete this tool monthly as a review. Any identified issue will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meeting following the completion of the tool with recommendations as needed. The date the systemic changes will be completed: September 21, 2014 REASON FUNDS ACCOUNT -THE RESIDENT FUNDS ACCOUNTS ONLY HAS 12 RESIDENTS AND 4,300.00 DOLLARS IN IT.</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, interview, and record review the facility failed to ensure residents were given choices regarding shower preferences for 3 of 3 residents reviewed for choices (Residents #23, #24, and #43).</p> <p>Findings include:</p> <p>1. During an interview on 8/18/2014 at 10:40 A.M., Resident #23 indicated he had not been asked his preference for bathing or shower frequency. He indicated he wanted showers but was given "mostly" bed baths.</p> <p>Resident #23's record was reviewed on 8/21/14 at 3:03 P.M. The record lacked documentation which indicated Resident #23 had been assessed regarding his preference for bathing/shower frequency.</p> <p>An admission Minimum Data Assessment tool (MDS) dated July 23, 2014, indicated Resident #23 was cognitively intact with a Brief Interview for Mental Status (BIMS) of 13 out of 15, required assistance from staff for bathing, and had indicated to the facility it was</p>	F000242	<p>F242 It is the practice of this facility to assure that residents are treated in a dignified manner including honoring of choices. The correction action taken for those residents found to be affected by the deficient practice include: Residents #23, #24, and #43 have been assessed and their preferences for showers are being honored. Other residents that have the potential to be affected have been identified by: All residents are receiving services in accordance with their choices including showers. Please see below for measures implemented to prevent reoccurrence. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: At the time of admission, residents choices related to showers will be identified and implemented as part of the plan of care. As part of the quarterly assessment process their choices will be reviewed with any changes as needed per the resident preferences. The nursing staff has been in-serviced related to assuring that resident's choices</p>	09/21/2014

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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>somewhat important to him to make choices regarding bathing.</p> <p>2. During an interview on 8/18/14 at 11:50 A.M., Resident #24 indicated she had not been asked her preference for bathing or shower frequency. She indicated she preferred showers but had only been given bed baths recently.</p> <p>Resident #24's record was reviewed on 8/20/14 at 12:30 P.M. Resident #24 had diagnoses which included, but were not limited to, hypertension, Alzheimer's disease, and depression. The record lacked documentation which indicated Resident #24 had been assessed for her preference for bathing/shower frequency.</p> <p>A significant change MDS dated 5/16/2014, indicated Resident #24 had cognitive impairment with a BIMs score of 3 out of 15 and was unable to answer the preference assessment questions. This MDS indicated staff should complete the assessment of daily activity preference. The MDS lacked documentation staff had completed the assessment for daily activity preference for bathing. The MDS indicated Resident #24's family was involved in care decisions. The MDS lacked documentation family had been interviewed regarding Resident #24's</p>		<p>are honored as part of services provided. Please see below for means of monitoring through observation to assure that the policy is followed in accordance with the regulation. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly observes 5 residents for honoring of residents' wishes and choices related to showers. The tool reviews scheduled showers based on resident preferences as well as if applicable interviews the residents. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 21, 2014</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 08/22/2014
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		
(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	
	<p>bathing preferences.</p> <p>3. During an interview on 8/19/14 at 8:58 A.M., Resident #43 indicated she had not been asked her preference for bathing or shower frequency. She indicated she received a shower once or twice a week but would prefer more.</p> <p>Resident #43's record was reviewed on 8/20/14 at 1:35 P.M. Resident #43 had diagnoses which included, but were not limited to, dementia and legally blind. The record lacked documentation she had been assessed for her preference for bathing/shower frequency.</p> <p>An annual MDS dated 7/16/14, indicated Resident #43 had a BIMs score of 10 out of 15 but was unable to answer the preference assessment questions. This MDS indicated staff should complete the assessment of daily activity preference. The MDS lacked documentation which indicated staff completed the assessment of daily activity preference for bathing. The MDS indicated Resident #43's family was involved in care decisions. The MDS lacked documentation family had been interviewed regarding Resident #43's bathing preferences.</p> <p>During an interview on 8/21/14 at 1:40 P.M., The MDS/Care plan nurse</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 08/22/2014
--	---	--	---

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
--	--

(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
F000244 SS=E	<p>indicated she developed residents' care plans and residents were not assessed for preferences regarding bathing/shower frequency. She stated, "Residents were automatically care planned for the standard shower schedule which was two a week."</p> <p>During an interview on 8/22/14 at 2:00 P.M., the Administrator and the Director of Nursing (DoN) were asked to provide the facility's policy regarding resident choices. During the exit conference on 8/23/14 at 3:30 P.M., with the Administrator and DoN present, the DoN indicated the facility did not have a policy regarding resident choices.</p> <p>3.1-3(u)(3)</p> <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on interview and record review, the facility failed to address grievances in a manner which could be tracked for 5 of 5 months reviewed for grievance resolution of the Resident Council. This potentially affected all the residents who</p>	F000244	F244 It is the practice AlphaHome to respond and act on any concerns addressed during resident council. The correction action taken for those residents found to beaffected by the deficient	09/21/2014

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 08/22/2014
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		
(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	
	<p>attended the Resident Council.</p> <p>Findings include:</p> <p>Resident Council minutes were provided by the Administrator on 8/20/14 at 10:45 A.M. The minutes indicated the following concerns by the Resident Council:</p> <ol style="list-style-type: none"> 1. Missing laundry - March, April, May, & August 2014. 2. Not getting showers - March, April, May, & July 2014. 3. Beds not made- March & April 2014. 4. Dietary complaints/request - March, May, July, & August 2014. 5. Activity request- March, April, May, & July, August 2014. 6. Call lights not answered timely - May 2014. <p>During an interview on 8/21/14 at 10:15 A.M., the Resident Council President indicated the Activity Designee took minutes for the Resident Council meetings. She indicated the Administrator would occasionally attend the meetings to listen to their concerns but staff did not respond to the group's concerns and there was not any follow up from the facility.</p> <p>During an interview on 8/21/14 at 1:34</p>		<p>practice include: No specific residents were identified. However, the most recent resident councilminutes have been reviewed with the necessary actions to resolve any residentconcerns. Other residents that have the potential to be affected havebeen identified by: Potentially any resident could be affected. Please refer to systems below to preventreoccurrence. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur include: The ActivitiesDepartment will continue to be involved with the resident council meeting as isthe previous practice of the facility. The new system will include bringing the resident council minutes to theIDT review that occurs each business day. The IDT team will review any concerns that could be pertinent to theirdepartment. Actions will be taken by theappropriate departments to assure that any concern is resolved. The Administratorwill have the last review and will assure that there is follow-up with theresident(s) that had any concerns to assure they are satisfied with theresolution. The corrective action taken to monitor performance to assurecompliance through quality assurance is: The resident council minutes will have</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 08/22/2014	
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			
(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			
	<p>P.M., with the Administrator and the Activity Designee present, the Activity Designee indicated she took minutes for the meetings and verbally reported the concerns to the Department Heads. The Administrator indicated concerns were documented in a grievance book and given to the appropriate Department Heads. He indicated when the concerns had been resolved the Social Service Director would turn the form into him and he would sign off to ensure the concern had been addressed. During this interview the Administrator was asked to provide documentation Resident Council concerns had been addressed.</p> <p>During an interview on 8/21/14 at 1:50 P.M., the Administrator indicated he did not have documentation which indicated the Resident Councils concerns and/or request had been acted upon. When queried regarding the Resident Council's concerns and/or request for March, April, May, July, & August 2014, he stated, "Nope, no follow up."</p> <p>During an interview on 8/22/14 at 2:00 P.M., the Administrator and the Director of Nursing (DoN) were asked to provide the facility's policy regarding Resident Council grievance resolution.</p> <p>During an interview at the exit</p>		<p>a follow-up form that identifies correction of the concern as well as follow-up with the resident(s) to assure satisfaction with the resolution. The Administrator, or designee, is responsible for reviewing the completed form to assure that all components have been completed appropriately. This form will be reviewed by the Quality Assurance Committee at the regularly scheduled meetings. Any recommendations for change that may be made will be acted upon. The date the systemic changes will be completed: September 21, 2014</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 08/22/2014
--	---	--	---

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
--	--

(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
F000272 SS=D	<p>conference on 8/23/14 at 3:30 P.M., with the Administrator and DoN present, the DoN indicated the facility did not have a policy regarding Resident Council grievance resolution.</p> <p>3.1-3(l)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an accurate assessment of residents' vision needs for 2 of 3 residents reviewed for impaired vision without corrective lenses (Residents #1 and #9).</p> <p>Findings include:</p> <p>1. Resident #1's record was reviewed on 8/20/14 at 10:35 A.M. Resident #1 had diagnoses which included, but were not limited to, legally blind, hypertension, coronary pulmonary disease, osteoporoses, weight loss, diabetes, and dementia with behaviors.</p> <p>A quarterly Minimum Data Assessment Tool (MDS) dated 7/22/14, indicated Resident #1 had visual impairment and did not use corrective lenses.</p> <p>Resident #1 was observed out of bed in her wheel chair without glasses on the following dates:</p>	F000272	<p>F272 F272and 313 ADDENDUM An optometry appointment for Resident #9 has been scheduled for <u>October 8,2014</u> with Prime Source Healthcare It is the practice ofthis facility to assure that residents are assessed appropriately related tovisual impairment. The correction action taken for those residents found to be affectedby the deficient practice include: Resident #1 visual assessment has been reviewed and iswearing her glasses in accordance with the plan of care. Resident #9 has a scheduled appointment for a visualassessment. Other residents that have the potential to be affected havebeen identified by: All residents have been reviewed to assure that their visualstatus has been assessed and proper interventions/services are in place for theresident. The measures or systematic changes that have been put into placeto ensure that the deficient practice does</p>	09/21/2014

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 08/22/2014	
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			
(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			
	<p>8/18/2014- 10:30 A.M. and 11:45 A.M.</p> <p>8/20/14 - 9:45 A.M., 10:42 A.M., 11:20 A.M., and 1:46 P.M.</p> <p>8/21/14 - 9:31 A.M., 9:57 A.M., 10:13 A.M., 10:58 A.M., 11:45 A.M., and 1:40 P.M.</p> <p>During an interview on 8/22/14 at 10:23 A.M., the Minimum Data Assessment (MDS)/Care Plan Coordinator Nurse stated, "She use to have glasses. I don't know if she wears them or not. Social Services fills out that section on the MDS.</p> <p>During an interview on 8/22/14 at 2:00 P.M., the Social Services Designee stated, "I made an error on the MDS. She does wear glasses and wears them everyday." When queried regarding how he assessed residents for vision he stated, "I don't know. I just go by what they use to be."</p> <p>During an interview on 8/23/14 at 8:30 A.M., the Director of Nursing indicated Resident #1 had glasses and they were in her purse.2. A review of the Minimum Data Set, (MDS), on 7/29/14 at 10:15 a.m., indicated, Resident #9, had a "visual impairment" with which she could, "see large print, but not regular</p>		<p>not recur include: The assessment related to vision is completed at admission, quarterly, and if there is a significant change. Based on the assessment, the facility will determine what interventions/services are needed for the individual resident. If assistive devices are needed for the resident such as glasses, they will be incorporated as part of the plan of care. If additional professional services are needed, the appointments will be scheduled appropriately. The nursing staff has been in-service related to assuring that interventions/services are in place for the residents based on the assessment. The corrective action taken to monitor performance to assure compliance through quality assurance is: In addition to routine observations by the nurses on their designated shifts including weekends, a Performance Improvement Tool has been initiated that will be utilized to review resident's assessment related to vision and to assure that proper interventions/services are in place based on the assessment. This tool will randomly review 5 residents. The Director of Nursing, or designee, will complete the tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The</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 08/22/2014	
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			
(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			
	<p>print in newspapers/books." The MDS also indicated the resident did not have corrective lenses to improve her vision.</p> <p>During an interview on 8/22/14 at 10:24 a.m., the Social Services Designee, (SSD), indicated he did not have any evidence that the resident had been seen by the provider of the facility's vision services in regard to her vision. He indicated he was responsible for completing the visual assessment for the MDS record, and scheduling vision appointments, however he was unsure how Resident #9 had been assessed to have a vision impairment on the MDS, without having an exam by the vision provider. He further indicated resident #9 did not have corrective lenses.</p> <p>During an interview with the MDS Coordinator on 8/22/14 at 10:50 a.m., she indicated she does care plans, "as much as I can." She further indicated she did not have a care plan regarding Resident # 9's vision impairment.</p> <p>A document received from the SSD, on 7/22/14, at 1:30 p.m., entitled, "Schedule Report Optometry Visit," indicated, Resident #9, was in the hospital when the vision provider was in the facility on 7/2/14. Information indicating a follow up appointment or rescheduled visit was</p>		<p>QualityAssurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. The date the systemic changes will be completed: September 21, 2014</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 08/22/2014
--	---	--	---

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
--	--

(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
F000279 SS=E	<p>requested, however, not provided by the facility.</p> <p>3.1-31(a) 3.1-31(c)(4)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observations, interview, and record review, the facility failed to develop a plan of care to address decaying teeth and fall prevention for 3 of 22 care plans reviewed (Residents #24, #43, and #21).</p> <p>Findings include:</p>	F000279	F279 It is the practice of this facility to assure that the residents' careplans are developed/updated and address the needs identified by the comprehensive assessment. The correction action taken for those residents found to be affected by the deficient practice include: Residents #24 and #43 have a	09/21/2014

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 08/22/2014	
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			
(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			
	<p>1. Resident #24 was observed on 8/18/2014 at 11:55 A.M. Resident #24 had teeth that wore broken, jagged, and black in color. She had malodorous breath.</p> <p>During an interview on 8/18/14 at 11:55 A.M., Resident #24 stated, "All my teeth are bad... My teeth are hurting. I need them pulled out. I cant get anyone to do it. I need new teeth... I can't chew because of these teeth. All of them are going bad... My breath is bad..."</p> <p>Resident #24's record was reviewed on 8/20/14 at 12:30 P.M. Resident #24 had diagnoses which included. but were not limited to, hypertension, Alzheimer's disease, and depression. A significant change MDS dated 5/16/2014, indicated Resident #24 had cognitive impairment with a BIMS (Brief Interview for Mental Status) score of 3 out of 15. The record lacked documentation of a plan of care which addressed Resident #24's decayed and broken teeth.</p> <p>A dental consult dated 7/18/2014, indicated Resident #24 had several teeth with decayed. The record indicated, "...no further recommendations..."</p> <p>During an interview on 8/22/14 at 10:58 A.M., the Social Service Designee (SSD) and the Minimum Data Assessment/Care</p>		<p>careplan in place related to oral care. Resident #21 has a plan of care in place for the prevention of falls Other residents that have the potential to be affected have been identified by: All residents have been reviewed to assure that the plan of care addresses pertinent information related to the resident's current status. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: At the time of admission, quarterly, or if there is a significant change, the care plan will be completed based on the information obtained by the assessments. Interim changes and updates will be completed as they occur if the changes alter the plan of care. The IDT team which meets each business morning will also be reviewing new orders, changes in the resident's condition, and incidents and will also assure that the care plan has been updated properly. This would include assuring that interventions are added to the care plan if the resident has had a fall. An in-service has been conducted for nurses related to assuring that changes in resident status are identified/updated on the plan of care as needed. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance</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 08/22/2014	
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			
(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			
	<p>plan nurse indicated a plan of care was not developed for Resident #24's decayed teeth and potential related issues.</p> <p>2. During an interview on 8/19/2014 at 9:04 A.M., Resident #43 indicated her teeth were bad and they needed pulled.</p> <p>Resident #43's record was reviewed on 8/20/14 at 1:35 P.M. Resident #43 had diagnoses which included, but were not limited to, dementia and legally blind. The record lacked documentation of a plan of care which addressed Resident #43's decayed and broken teeth.</p> <p>A dental consult dated 7/18/14, indicated Resident #43 had dental decay in several teeth and had root tips that were decayed. This dental consult indicated a referral to an oral surgeon.</p> <p>During an interview on 8/22/14 at 11:15 A.M., Licensed Practical Nurse (LPN) #3 indicated she was aware of the referral however Resident #43's legal representative did not want her to have oral surgery unless she was complaining of pain. She indicated Resident #43 had recently began to complain of pain so they were in the process of getting consent for the surgery. LPN #3 was queried regarding a plan of care to address Resident #43's dental status and</p>		<p>Improvement Tool has been initiated that will be utilized to randomly review 5 residents related to the comprehensive assessment in correlation with the plan of care to assure that pertinent information is identified on the plan of care based on the assessment. It also assures that identified changes have been updated on the care plan. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. The date the systemic changes will be completed: September 21, 2014</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>potential related issues. LPN #3 indicated a plan of care was not available.</p> <p>3. During interview of Resident #21 on, 8/18/14 at 10:22 a.m., the resident indicated she had a fall recently and hit her head.</p> <p>During interview of LPN #10 on, 8/19/14 at 9:50 a.m., the LPN indicated the resident had a fall in the past 30 days.</p> <p>During review of the resident's clinical record on 8/21/14 at 10:25 a.m., documentation indicated the resident had a fall on 6/17/14, 6/23/14 and 8/18/14.</p> <p>A "care plan meeting form" was noted, dated 6/24/14, identifying the resident as "continues to be a fall risk." A plan of care, with interventions to address the resident as a risk for falls and /or having falls was lacking.</p> <p>During interview of the MDS (minimum data set) coordinator on, 8/21/14 at 2:20 p.m., the coordinator indicated a significant change in condition assessment had been completed on, 6/24/14, due to the resident's hospitalization after a fall on 6/17/14. The MDS coordinator, after looking in the careplan book and in the computer was unable to find a careplan addressing the resident with a risk of falls or with</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>current falls. The MDS coordinator presented a "Fall Risk Assessment", dated 6/24/14, identifying the resident as a high risk for falls.</p> <p>During interview of the DON (Director of Nursing) on 8/21/14 at 2:20 p.m. the DON indicated, "The only thing I can tell you is she is at risk for falls." As to approaches or interventions to address falls, the DON indicated "we ask her to use her call light."</p> <p>A policy titled "Resident Care Plan Policy," identified as a current policy by the DoN on 8/22/14 at 3:41 P.M., indicated, "Purpose: To provide an individualized plan of care for each resident. Responsibility: Administrator, Director of Nursing, RN/MDS Care Plan Coordinator, Licensed nurses, Activities Director, Social Services Director, Registered Dietitian, Specialized Therapists, and attending physicians. Policy: It is the policy of The Alpha Home that a comprehensive plan of care will be provided for each resident that includes measurable objectives and time frames to meet the medical, nursing, mental and psychosocial needs that are identified in the interdisciplinary assessments. An initial or interim care plan with pertinent aspects of care will be initiated at the</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>time of admission...The Director of Nursing or other disciplinary team member shall coordinate the care planning activities of the interdisciplinary team assessing the resident and attending care conferences. Each discipline will contribute to the plan of care. Disciplines shall include: Nursing, Dietary, Activities, Social Services, Specialized therapies, Attending physician, Resident, resident family or legal representative (as applicable)...All disciplines are responsible for updating the plan of care to assure the plan represents the resident's current status. Care plans will be periodically reviewed and revised by a team of qualified persons after each assessment. Care plan reviews shall include the signature, title and date of each reviewer present and show evidence that problems, goals and approaches are current in accordance with the resident's condition and assessed needs... Resident and their designated representative (S) are invited and encouraged to attend care conferences Attendance will be recorded on the Care Plan Attendance Record. Staff will provide assistance as needed to enable residents to participate in the conference.. The resident care plans available for use by all individual caring for the resident..."</p> <p>3.1-35(a)</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 08/22/2014	
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			
(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			
F000280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>A. Based on interview and record review the facility failed to include, to the extent practicable, the participation in the care plan development and/or revision, the resident, the resident's family or interested legal representative and failed to ensure residents care plans were developed, revised by a team of qualified persons determined by the residents' needs, and available for all staff caring for the resident for 3 of 3 residents reviewed for participation in and development/revision of care plans (Residents #23, #1, and #24).</p>	F000280	<p>F280 It is the practice of this facility to assure that resident needs are met and the residents and their families are invited to participate in the care plan conference. The correction action taken for those residents found to be affected by the deficient practice include: A care plan conference has been scheduled for residents #1, #23, and #24. The resident and/or interested family members have been invited to the conference. Resident #30 care plan has been updated related meeting the needs for pain and accidents. Other residents that have</p>	09/21/2014			

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 08/22/2014	
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			
(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			
	<p>B. Based on observation, interview, and record review the facility failed to ensure care plan interventions were appropriate to meet residents needs related to pain and accidents for 1 of 5 residents reviewed for care plan interventions (Resident #30).</p> <p>Findings include:</p> <p>A1. During an interview on 8/18/2014 at 10:40 A.M., Resident #23 indicated he had not been involved in or given choices about his daily care.</p> <p>Resident #23's record was reviewed on 8/21/14 at 3:03 P.M. The record indicated he was admitted to the facility on 7/17/14. Resident #23 had diagnoses which included, but were not limited to, a history of a stroke with paralysis, hypertension, senile dementia with delusional features, chronic airway obstruction, and neurogenic bladder. An admission Minimum Data Assessment tool (MDS) dated July 23, 2014, indicated Resident #23 was cognitively intact with a Brief Interview for Mental Status score (BIMS) of 13 out of 15. The record lacked evidence of a plan of care.</p> <p>During an interview on 8/22/14 2:30, the Minimum Data Assessment/Care Plan Coordinator nurse indicated Resident</p>		<p><i>thepotential to be affected have been identified by:</i> All resident plans of care have been reviewed to assure that residents are receiving care and services based on their individual interest. All residents and their families will be invited to participate in any upcoming care plan conferences. <i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i> The MDS Coordinator has been in-serviced related to assuring that the care plan identifies pertinent issues with correlating interventions to meet the resident needs. Their service will specifically address meeting the needs for pain and accident prevention. The Social Services Director will be in-serviced related to assuring that residents and their families are invited to participate in the care plan conferences. The in-service will also include working with the resident/families in establishing a better time for attendance if necessary. The Director of Social Services will schedule the conferences and assure that residents and their families are invited to attend with documentation to support the invitation. <i>The corrective action taken to monitor performance to assure compliance through quality assurance is:</i> A Performance Improvement Tool has been initiated that randomly</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 08/22/2014	
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			
(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			
	<p>#23's care plan was in her computer but the staff caring for him did not have access to the care plan. She indicated the computer was broken and she was unable to print the care plan.</p> <p>A care plan meeting sign in sheet dated 7/24/14, indicated Resident #23 was not present for his care plan meeting.</p> <p>During an interview on 8/20/14 at 10:12 A.M., the Social Service Designee (SSD) indicated it was his responsibility to ensure residents and/or their interested families were able to attend the care plan meetings. He indicated he did not always include residents in the care plan process and did not have documentation which indicated Resident #23 had been invited and/or participated.</p> <p>A2. During an interview on 8/18/14 at 11:46 A.M., Resident #1's legal representative/family member indicated she had previously participated in care plan meetings but the facility had not invited her to attend for "about a year."</p> <p>Resident #1's record was reviewed on 8/20/14 at 10:35 A.M. Resident #1 had diagnoses which included, but were not limited to, legally blind, hypertension, coronary pulmonary disease, osteoporoses, weight loss, diabetes, and</p>		<p>reviews 5 residents to assure that the care plan accurately identifies resident needs with correlating interventions including for pain and accident prevention. The tool will also review to assure there is documentation that the resident and/or interested family member has been invited to the care plan conferences. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tools. The date the systemic changes will be completed: September 21, 2014</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>dementia with behaviors.</p> <p>A care plan sign in sheet dated 11/21/13, indicated one staff member (MDS nurse) was present for the interdisciplinary care plan meeting. This record lacked documentation which indicated a staff from the activity department, dietary department, or social service department was present. The record lacked documentation the resident was present and/or documentation of when, what time, and if any accommodations were made to ensure interested family members were included in the care plan meeting. A decision was made to continue all care plan interventions for dietary, social service, activity, and nursing needs without the appropriate staff present.</p> <p>A care plan sign in sheet dated 2/6/14, indicated two staff members (dietary and a nurse) were present for Resident #1's interdisciplinary team care plan meeting. The record lacked documentation the resident was present and/or documentation of when, what time, and if any accommodations were made to ensure interested family members were included in the care plan meeting. The record lacked documentation staff from the activity department or social service department was involved in the care plan</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 08/22/2014	
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			
(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			
	<p>process. A decision to continue current care plan interventions to meet social service and activity needs was made without the appropriate staff present.</p> <p>A care plan sign in sheet dated 7/24/14, indicated three staff (two from nursing and one from social service) were present for Resident #1's interdisciplinary care plan meeting. The record indicated with a check mark that Resident #1's family was invited but did not attend. The record lacked documentation of when, what time, and if any, accommodations were made to ensure interested family members were included in the care plan meeting. The record lacked documentation staff from the activity department, dietary department, or social service department was involved in the care plan process. A decision to continue current care plan interventions to meet activity and dietary needs was made without the approbate staff present.</p> <p>During an interview on 8/20/14 at 11:05 A.M., the Minimum Data Set Assessment (MDS)/care plan nurse stated, "I make the MDS schedule and put the care plans on the schedule. (Social Service Designee named) notifies the families and sets up the meetings."</p> <p>A3. Resident #24's record was reviewed</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>on 8/20/14 at 12:30 P.M. Resident #24 had diagnoses which included, but were not limited to, hypertension, Alzheimer's disease, and depression.</p> <p>A significant change MDS dated 5/16/2014, indicated Resident #24 had cognitive impairment with a BIMS score of 3 out of 15 and was unable to answer the preference assessment questions. The MDS indicated Resident #24's family was involved in care decisions.</p> <p>A care plan sign in sheet dated 10/28/14, indicated three staff (two from nursing and one from social service) were present for Resident #24's interdisciplinary care plan meeting. The record indicated with a check mark that Resident #24's family was invited but did not attend. The record lacked documentation of when, what time, and if any, accommodations were made to ensure interested family members were included in the care plan meeting. The record lacked documentation staff from the activity department, dietary department, or social service department were involved in the care plan process. A decision to continue the current care plans interventions for problems with dietary and activity needs was made without the appropriate staff present.</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>A care plan sign in sheet dated 1/23/14, indicated two staff (both from nursing) were present for Resident #24's interdisciplinary care plan meeting. The record indicated with a check mark that Resident #24's family was invited but did not attend. The record lacked documentation of when, what time, and if any, accommodations were made to ensure interested family members were included in the care plan meeting. The record lacked documentation staff from the activity department, dietary department, or social service department were involved in the care plan process. A decision to continue the current care plans interventions for behavior and delusional needs, activity needs, and dietary needs without the appropriate staff present.</p> <p>A care plan sign in sheet dated 4/14/2104, indicated two staff (a nurse and a psychologist) were present for Resident #24's interdisciplinary care plan meeting. The record indicated with a check mark that Resident #24's family was invited but did not attend. The record lacked documentation of when, what time, and if any, accommodations were made to ensure interested family members were included in the care plan meeting. The record lacked documentation staff from the activity</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>department or the dietary department were involved in the care plan process. A decision was made to continue the current care plan interventions for activity and dietary needs without the appropriate staff present.</p> <p>A care plan sign in sheet dated 7/10/14, indicated three staff (two nurses and a psychologist) were present for Resident #24's interdisciplinary care plan meeting. The record indicated with a check mark that Resident #24's family was invited but did not attend. The record lacked documentation of when, what time, and if any, accommodations were made to ensure interested family members were included in the care plan meeting. The record lacked documentation staff from the activity department or the dietary department were involved in the care plan process. A decision was made to continue the current care plan interventions to meet activity and dietary needs without the appropriate staff present.</p> <p>During an interview on 8/20/14 at 11:37 A.M., the Social Service Designee (SSD) indicated the purpose of the care plan meetings was to address the residents needs. He stated, "It is suppose to address all areas." He indicated it was his responsibility to ensure residents</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>and/or their interested families were able to attend the care plan meetings. He indicated he did not document who he talked to, the date or time he attempted to contact them, or if he left a message. He indicated he did not change the date of the meeting to accommodate the family or if they could not be present attempt a phone conference care plan. He stated., "Sometimes we try to invite their POA. Sometimes we do and sometimes we don't. We sometimes invite residents and sometimes we don't."</p> <p>During an interview on 8/20/14 at 12:30 P.M., the Director of Nursing (DoN) indicated a representative from all departments should be present at residents' care plan meetings. She stated, "We do the best we can do."</p> <p>B1. During a review of Resident #30's chart on 8/21/14 at 8:56 a.m., he was noted to have had falls on 7/16/14, 7/26/14 and 8/2/14. A review of the residents care plans indicated, his care plan related to falls had not been revised since 11/13/13. Resident # 30's diagnosis included, but were not limited too, alcoholism, dementia, hypertension, gout, psychotic aggression, and diabetes type II.</p> <p>During a review of the on Minimum Data</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>Set, (MDS), on 8/21/14 at 9:15 a.m., Resident #30, was noted to have a Brief Interview for Mental Status of 3 out of 15.</p> <p>During an interview with the MDS Coordinator on 8/21/14 at 12:26 p.m., she indicated she had not revised the care plan since 11/13/13. She indicated the Interdisciplinary Team, (IDT) met once a month. She indicated falls were mentioned during the morning meeting with the Administrator (ADM), Director of Nursing Services, (DON), Social Services Designee, (SSD), and herself. this meeting occurs daily, however, they did not revise or adjust the resident's plan of care at this time. She indicated they say which residents have fallen and whether or not they were hurt, "but that is about it." She indicated she usually checks residents care plans every two weeks, however she had not done so for resident #30's care plans following his last couple of falls.</p> <p>During an interview on 8/12/14 at 11:15 a.m., the DON indicated IDT team meetings occur monthly. When asked what happened if a resident had a fall she she indicated, during the morning meeting with the ADM, SSD, MDS Coordinator and herself they "speak of it." She indicated they did not revise the</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>care plans at that time. She indicated she did a root cause analysis of the residents falls after the morning meeting. She indicated the staff did not have this information available to them, but it was saved on her computer. She indicated she had just completed a root cause analysis of the resident and had not placed it on the residents chart.</p> <p>A review of a record entitled, "Interdisciplinary Progress Note," indicated the last notation from an IDT meeting regarding Resident #30 was dated, 7/8/2013. Although they were requested from the DON and the MDS Coordinator no further information from recent IDT meetings was made available during the survey period.</p> <p>An untitled and undated policy identified as the facility's current care plan policy by the DoN on 8/22/14 at 11:57 A.M., indicated, "...It is the policy of this facility to ensure that the resident has a right to participate in planning of Care unless adjudged incompetent or otherwise found to be incapacitated according to the laws of the state. If the resident is unable to attend a legal representative or family member must be notified of the pending meeting..."</p> <p>A policy titled "Resident Care Plan</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>Policy" identified as a current policy by the DoN on 8/22/14 at 3:41 P.M., indicated, "Purpose: To provide an individualized plan of care for each resident. Responsibility: Administrator, Director of Nursing, RN/MDS Care Plan Coordinator, Licensed nurses, Activities Director, Social Services Director, Registered Dietitian, Specialized Therapists, and attending physicians. Policy: It is the policy of The Alpha Home that a comprehensive plan of care will be provided for each resident that includes measurable objectives and time frames to meet the medical, nursing, mental and psychosocial needs that are identified in the interdisciplinary assessments. An initial or interim care plan with pertinent aspects of care will be initiated at the time of admission...The Director of Nursing or other disciplinary team member shall coordinate the care planning activities of the interdisciplinary team assessing the resident and attending care conferences. Each discipline will contribute to the plan of care. Disciplines shall include: Nursing, Dietary, Activities, Social Services, Specialized therapies, Attending physician, Resident, resident family or legal representative (as applicable)...All disciplines are responsible for updating the plan of care to assure the plan represents the resident's</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 08/22/2014
--	---	--	---

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
--	--

(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
F000282 SS=D	<p>current status. Care plans will be periodically reviewed and revised by a team of qualified persons after each assessment. Care plan reviews shall include the signature, title and date of each reviewer present and show evidence that problems, goals and approaches are current in accordance with the resident's condition and assessed needs... Resident and their designated representative (S) are invited and encouraged to attend care conferences Attendance will be recorded on the Care Plan Attendance Record. Staff will provide assistance as needed to enable residents to participate in the conference.. The resident care plans available for use by all individual caring for the resident..."</p> <p>3.1-35(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 observation, interview, and record review, the facility failed to ensure resident were provided with care according to their plan of care for 2 of 22 residents reviewed for care plans (Resident(s) #1 and #9).</p>	F000282	F282 It is the practice of this facility to assure that all services that are provided are completed in a manner that is in accordance with the plan of care. The correction action taken for those residents found to be affected by the deficient practice include: Resident #1 is	09/21/2014

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 08/22/2014	
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			
(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			
	<p>Findings include:</p> <p>1. Resident #1's record was reviewed on 8/20/14 at 10:35 A.M. Resident #1 had diagnoses which included, but were not limited to, legally blind, hypertension, coronary pulmonary disease, osteoporoses, weight loss, diabetes, and dementia with behaviors. A quarterly Minimum Data Assessment Tool (MDS) dated 7/22/14, indicated Resident #1 had cognitive impairment.</p> <p>A care plan dated 7/14/14, indicated Resident #1 had impaired visual function related to diabetes, macular degeneration, and glaucoma. A goal indicated Resident #1 would not have indications of acute eye problems. Interventions to meet this goal included staff would encourage her to wear her eye glasses.</p> <p>Resident #1 was observed out of bed in her wheel chair without glasses on the following dates:</p> <p>8/18/2014- 10:30 A.M. and 11:45 A.M.</p> <p>8/20/14 - 9:45 A.M., 10:42 A.M., 11:20 A.M., and 1:46 P.M.</p> <p>8/21/14 - 9:31 A.M., 9:57 A.M., 10:13 A.M., 10:58 A.M., 11:45 A.M., and 1:40 P.M.</p>		<p>receiving services related to visual impairment in accordance with the plan of care. Resident #9 is receiving services for pain management in accordance with the plan of care. Other residents that have the potential to be affected have been identified by: All residents have been reviewed to assure that they are receiving services in accordance with the plan of care. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been conducted for all nursing staff related to the importance of following the plan of care when providing services to the residents. The in-service includes assuring that assistive devices are in place if indicated related to visual impairment and that pain regimens are followed appropriately. The CNA assignments sheets have been reviewed to assure that they accurately reflect the services to be provided to the residents in correlation with the plan of care. Nurses will be responsible for assuring that all services provided are completed in accordance with the care plans on their designated shifts via observation. Please see below for monitoring as part of the QA process. The corrective action taken to monitor performance to assure compliance through</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>During an interview on 8/22/14 at 10:23 A.M., the Minimum Data Assessment (MDS)/Care Plan Coordinator Nurse stated, "She use to have glasses. I don't know if she wears them or not. Social Services fills out that section on the MDS.</p> <p>During an interview on 8/22/14 at 2:00 P.M., the Social Services Designee stated, "I made an error on the MDS. She does wear glasses and wears them everyday." When queried regarding how he assessed residents for vision he stated, "I don't know. I just go by what they use to be."</p> <p>2. During an observation on 8/19/14 at 10:13 a.m., Resident #9 was lying in bed, with her eyes open. She was positioned with her legs swinging off the left side of the bed. Her incontinence brief was observed to be discolored, yellow and appeared moist. The resident was observed to use her mitt covered right hand to rub and hit at her right buttocks and thigh area. The resident was continuously fidgeting in bed. She did not respond to verbal cues, however her facial expression appeared troubled and distressed.</p> <p>During an observation of Resident # 9's dressing change on 8/21/14 at 10:15 a.m.,</p>		<p>quality assurance is: In addition to nurses assuring that services are provided in accordance to the plan of care on their designated shifts including weekends, aPerformance Improvement Tool has been initiated that randomly reviews 5residents related to providing services in accordance with the plans of care.The Director of Nursing, or designee, will complete this tool weekly x3,monthly x3, then quarterly x3. Anyissues identified will be immediately corrected. The Quality Assurance Committee will reviewthe tools at the scheduled meetings with recommendations as needed. The date the systemic changes will be completed: September 21, 2014</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 08/22/2014	
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			
(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			
	<p>the Wound Care Nurse indicated, "She must be feeling good today," because she is generally more agitated during her dressing change.</p> <p>During an interview with the Wound Care Nurse, on 8/21/14 at 1:58 p.m., she indicated the residents care plan had not been updated since she was last sent out to the hospital and returned to the facility. She indicated she previously had scheduled pain medication that she received prior to the wound dressing change everyday. She indicated the medication was changed to prn when the resident returned to the facility.</p> <p>During an interview with LPN # 2 on 8/21/2014 at 1:50 p.m., she indicated the Wound Care Nurse does Resident #9's treatment in the morning. She indicated, the resident usually pulled at her wound and she, "crinkles," [sic] her face. She indicated that although the resident got her pain medication on the morning of 8/21/14, sometimes she did not get pain medication prior to her dressing change. She indicated the resident did not get her prn pain medication on a daily basis. LPN #2 indicated, she did pain assessments in the morning and after lunch.</p> <p>During an interview with LPN #2 on</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>08/21/2014 at 2:28 p.m., she indicated she did not give Resident # 9, pain medication on the morning of 8/19/2014, because she had "forgot" to do so.</p> <p>A review of the Resident #9's Minimum Data Set, dated 7/29/14, indicated the resident was, "always incontinent of bowel/urine...had 3-4 indicators of pain over the last 5 days....makes non verbal sounds and facial expressions to indicate pain....residents body movement and rubbing of body parts to indicate pain."</p> <p>A review of Resident #9's chart on 8/20/14 at 11:04 a.m., indicated she was being treated for a stage 4 pressure ulcer to her buttocks. Her diagnosis included, but was not limited too, Type II Diabetes, Hyperparathyroidism, Alzheimer's, Dementia, and hypertension. A review of the MDS indicated the resident had a Brief Interview for Mental Status, (BIMS), score of 0/15.</p> <p>A review of the resident's care plan received from the Wound Care Nurse on, 8/21/14 at 2:34 p.m., indicated the need to provide pain control for the resident, with the goal the resident would remain free of pain during her daily dressing changes. The plan of care indicated, intervention #2 for maintaining this goal was to give the resident pain medication</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 08/22/2014
--	---	--	---

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
--	--

(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
F000309 SS=D	<p>daily at 9 a.m. and intervention #3 was to monitor for effectiveness before changing the residents dressing.</p> <p>A review of a record, entitled, "Individual Resident Control Medication Record Sheet," received from the, Wound Care Nurse on, 8/21/2014 at 2:34 p.m., indicated on the dates between 8/5/2014 and 8/21/14, Resident #9 only received pain medication during the administration window between 8 a.m. and 10 a.m. eleven of the seventeen days during that time period.</p> <p>3.1-35(g)(2)</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 the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review the facility failed to provide adequate pain control for Resident #9. This practice had the potential to affect 1 of 1 residents reviewed for pain.</p> <p>During an observation on 8/19/14 at</p>	F000309	F309 It is the practice of this facility to assure that our residents receive appropriate services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The correction action taken for those residents found to be affected by the deficient practice include: Resident #9	09/21/2014

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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>10:13 a.m., Resident #9 was lying in bed, with her eyes open. She was positioned with her legs swinging off the left side of the bed. Her incontinence brief was observed to be discolored, yellow and appeared moist. The resident was observed to use her mitt covered right hand to rub and hit at her right buttocks and thigh area. The resident was continuously fidgeting in bed. She did not respond to verbal cues, however her facial expression appeared troubled and distressed.</p> <p>During an observation of Resident # 9's dressing change on 8/21/14 at 10:15 a.m., the Wound Care Nurse indicated, "She must be feeling good today," because she is generally more agitated during her dressing change.</p> <p>During an interview with the Wound Care Nurse, on 8/21/14 at 1:58 p.m., she indicated the residents care plan had not been updated since she was last sent out to the hospital and returned to the facility. She indicated she had previously had scheduled pain medication that she received prior to the wound dressing change everyday. She indicated the medication was changed to prn when the resident returned to the facility.</p> <p>During an interview with LPN # 2 on</p>		<p>has been reviewed and interventions are in placeto address the resident's pain. Other residents that have the potential to be affected havebeen identified by: All residents havebeen reviewed to assure that any pain management issues have been identifiedand interventions implemented appropriately. It should be noted that this was not identified for any additionalresidents The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur include: Nurses have been in-serviced related to following of thefacility expectation related to pain management. It is the nurses' responsibility, on theirdesignated shifts, to assure that pain needs are anticipated and servicesrendered to assure proper pain management. The in-service included not only verbal complaints of pain, butassessments for non-verbal indicators of pain so that resident's needs can bemet appropriately. The corrective action taken to monitor performance to assurecompliance through quality assurance is: In addition to nurses assuring that all needs are met ontheir designated shifts including weekends, a Performance Improvement Tool hasbeen initiated that will be</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>8/21/2014 at 1:50 p.m., she indicated the Wound Care Nurse does Resident #9's treatment in the morning. She indicated, the resident usually pulled at her wound and she, "crinkles," [sic] her face. She indicated that although the resident got her pain medication on the morning of 8/21/14, sometimes she did not get pain medication prior to her dressing change. She indicated the resident did not get her prn pain medication on a daily basis. LPN #2 indicated, she did pain assessments in the morning and after lunch.</p> <p>During an interview with LPN #2 on 08/21/2014 at 2:28 p.m., she indicated she did not give Resident # 9, pain medication on the morning of 8/19/2014, because she had "forgot" to do so.</p> <p>A review of the Resident #9's Minimum Data Set, dated 7/29/14, indicated the resident was, "...had 3-4 indicators of pain over the last 5 days....makes non verbal sounds and facial expressions to indicate pain....residents body movement and rubbing of body parts to indicate pain."</p> <p>A review of Resident #9's chart on 8/20/14 at 11:04 a.m., indicated she was being treated for a stage 4 pressure ulcer to her buttocks. Her diagnosis included,</p>		<p>utilized review for proper pain management. The tool will randomly review 5 residents to assure that if there are any indicators of pain that proper interventions are in place. The Director of Nursing, or designee, will complete this audit weekly x3, monthly x3, then quarterly x3. Any issue identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed for the IDT team. The date the systemic changes will be completed: September 21, 2014</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 08/22/2014
--	---	--	---

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
--	--

(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
F000312	<p>but was not limited too, Type II Diabetes, Hyperparathyroidism, Alzheimer's, Dementia, and hypertension. A review of the MDS indicated the resident had a Brief Interview for Mental Status, (BIMS), score of 0/15.</p> <p>A review of the resident's care plan received from the Wound Care Nurse on, 8/21/14 at 2:34 p.m., indicated the need to provide pain control for the resident, with the goal the resident would remain free of pain during her daily dressing changes. The plan of care indicated, intervention #2 for maintaining this goal was to give the resident pain medication daily at 9 a.m. and intervention #3 was to monitor for effectiveness before changing the residents dressing.</p> <p>A review of a record, entitled, "Individual Resident Control Medication Record Sheet," received from the, Wound Care Nurse on, 8/21/2014 at 2:34 p.m., indicated on the dates between 8/5/2014 and 8/21/14, Resident #9 only received pain medication during the administration window between 8 a.m. and 10 a.m. eleven of the seventeen days during that time period.</p> <p>3.1-37(a) 483.25(a)(3)</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 08/22/2014
--	---	--	---

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
--	--

(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
--------------------	--	---------------	---	----------------------

SS=D	<p>ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview and record review the facility failed to ensure residents received services to maintain good grooming for 1 of 3 residents reviewed requiring assistance with grooming. (Resident #5)</p> <p>Findings include:</p> <p>On 8/19/14 at 9:17 a.m., Resident #5 was observed with a heavy growth of facial hair and long nails soiled with a dark black substance. During interview with the resident on 8/19/14 at 9:17 a.m. the resident indicated the staff shave him, but was unable to identify the last time he was shaved.</p> <p>On 8/20/14 at 8 a.m., Resident #5 was observed with long soiled nails. The resident was observed without facial hair.</p> <p>On 8/21/14 at 9:50 a.m., the resident was observed with long soiled nails and with a light facial growth of hair. At 12 noon, the resident was observed to feed himself, and nails to be long and soiled.</p>	F000312	<p>ADDENDUM: F-312 I.The resident was taken to his room and shaved. His hands were cleaned and his nails cut.</p> <p>II.This finding could affect all residents. III.Each direct care staff giver has been instructed to assess their residents for hand and nail cleanliness while doing ADL'S. IV.In servicing will be done to address ADL's,</p> <p>V.Charge nurse responsible to supervise direct staff . DON to monitor for compliance.</p> <p>F312 It is the practice of this facility to assure that the all residents receives necessary services to maintain good personal and oral hygiene. The correction action taken for those residents found to be affected by the deficient practice include: Resident #5 is receiving appropriate assistance related to daily grooming. Other residents that have the potential to be affected have been identified by: All residents have been reviewed to assure that they are receiving proper assistance as needed for daily grooming. The measures or systematic changes that have been put into place to ensure that the deficient practice does</p>	09/21/2014
------	--	---------	---	------------

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 08/22/2014
--	---	--	---

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
--	--

(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
F000313 SS=D	<p>During interview of LPN #11 on, 8/22/14 at 9:41 a.m., the LPN indicated the staff know who they are assigned to care for by looking at the assignment sheet posted at the nursing station. The LPN indicated the staff did not have information available to them concerning the type of assistance the resident needed.</p> <p>Resident #5's clinical record was reviewed on 8/20/14 at 9:57 a.m. An admission MDS (minimum data set), dated 5/9/14, indicated the resident with cognitive impairment, requiring limited assist of one person with personal hygiene needs.</p> <p>3.1-38(a)(3)</p> <p>483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain</p>		<p>not recur include: The nursing staff has been in-serviced related to assuringthat residents receive proper assistance for daily grooming. Please see monitoring systems below to assurethat this issue does not reoccur. The corrective action taken to monitor performance to assurecompliance through quality assurance is: In addition to the nurses assuring that residents arereceiving proper grooming on their designated shifts including weekends, aPerformance Improvement Tool has been initiated that will randomly reviews 5residents to assure that proper grooming is in place. The tool will utilize observation of theresidents to assure that proper grooming is in place. The Director of Nursing, or designee, willcomplete this review weekly x3, monthly x3, and then quarterly x3. Any issue identified will be immediatelycorrected. The Quality Assurance Committee will review the tool at thescheduled meeting following the completion of the tool with recommendations asneeded based on the outcome of the audit. The date the systemic changes will be completed: September 21, 2014</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were assisted with putting on their glasses and arrangements were made for consultation with an eye doctor. This deficient practice affected 2 of 3 residents reviewed for vision (Resident #1 and Resident #9).</p> <p>Findings include:</p> <p>1. Resident #1's record was reviewed on 8/20/14 at 10:35 A.M. Resident #1 had diagnoses which included, but were not limited to, legally blind, hypertension, coronary pulmonary disease, osteoporoses, weight loss, diabetes, and dementia with behaviors. A quarterly Minimum Data Assessment Tool (MDS) dated 7/22/14, indicated Resident #1 had cognitive impairment.</p> <p>A care plan dated 7/14/14, indicated Resident #1 had impaired visual function related to diabetes, macular degeneration, and glaucoma. A goal indicated Resident #1 would not have indications of acute</p>	F000313	<p>ADDENDUM F272and 313</p> <p>An optometry appointment for Resident #9 has been scheduled for <u>October 8,2014</u> with Prime Source Healthcare F313 It is the practice ofthis facility to assure that the all residents receives necessary treatmentsand devices for grooming and visual services. The correction action taken for those residents found to beaffected by the deficient practice include: Resident #1 is receiving assistance as needed with placementof glasses. Resident #9 has had an eye appointment scheduled. Other residents that have the potential to be affected havebeen identified by: All residents have been reviewed to assure that they arereceiving treatments and devices to meet their individual needs. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur include: The nursing staff has been in-serviced related to assuringthat residents receive proper assistance such as glasses placement as part ofthe</p>	09/21/2014

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 08/22/2014	
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			
(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			
	<p>eye problems. Interventions to meet this goal included staff would encourage her to wear her eye glasses.</p> <p>Resident #1 was observed out of bed in her wheelchair without her glasses on the following dates:</p> <p>8/18/2014- 10:30 A.M. and 11:45 A.M.</p> <p>8/20/14 - 9:45 A.M., 10:42 A.M., 11:20 A.M., and 1:46 P.M.</p> <p>8/21/14 - 9:31 A.M., 9:57 A.M., 10:13 A.M., 10:58 A.M., 11:45 A.M., and 1:40 P.M.</p> <p>During an interview on 8/22/14 at 10:23 A.M., the Minimum Data Assessment (MDS)/Care Plan Coordinator Nurse stated, "She use to have glasses. I don't know if she wears them or not.</p> <p>During an interview on 8/23/14 at 8:30 A.M., the Director of Nursing indicated Resident #1 had glasses and they were in her purse.</p> <p>2. A review of the Minimum Data Set, (MDS), on 7/29/14 at 10:15 a.m., indicated, Resident #9, had a "visual impairment" with which she could, "see large print, but not regular print in newspapers/books." The MDS also indicated the resident did not have</p>		<p>daily care. The in-service also included assuring that resident's visual needs are met and that appointments are scheduled as needed for those residents that are identified to be in need of that specialized service. Please see monitoring systems below to assure that this issue does not reoccur. The corrective action taken to monitor performance to assure compliance through quality assurance is: In addition to routine rounds by nurses on their designated shifts including weekends, A Performance Improvement Tool has been initiated that will randomly reviews 5 residents to that they are receiving services and assistance to meet their individual needs. The Director of Nursing, or designee, will complete this audit weekly x3, monthly x3, and then quarterly x3. Any issue identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the audit. The date the systemic changes will be completed: September 21, 2014</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>corrective lenses to improve her vision.</p> <p>During an interview on 8/22/14 at 10:24 a.m., the Social Services Designee, (SSD), indicated he he did not have any evidence that the resident had been seen by the provider of the faciliy's vision services in regard to her vision. He indicated he was responsible for completing the visual assessment for the MDS record, and scheduling vision appointments, however he was unsure how Resident #9 had been assessed to have a vision impairment on the MDS, without having an exam by the vision provider. He further indicated resident #9 did not have corrective lenses.</p> <p>During an interview with the MDS Coordinator on 8/22/14 at 10:50 a.m., she indicated she does care plans, "as much as I can." She further indicated she did not have a care plan regarding Resident # 9's vision impairment.</p> <p>A document received from the SSD, on 8/22/14, at 1:30 p.m., entitled, "Schedule Report Optometry Visit," indicated, Resident #9, was in the hospital when the vision provider was in the facility on 7/2/14. This document also indicated that on 7/15/14 the resident the resident was, "ILL-***ILL-PATIENT BECAME ILL BEFORE SEEING***" [SIC].</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 08/22/2014
--	---	--	---

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
--	--

(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
F000323 SS=G	<p>Information indicating a follow up appointment or rescheduled visit was requested, however, was not provided by the facility during the survey period.</p> <p>16.2-3.1-31(a) 16.2-3.1-31(c)(4)</p> <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, interview, and record review, the facility failed to ensure interventions to prevent a fall resulting in a large laceration to Resident #21's head, failed to ensure a wheelchair was maintained to safely transport Resident #40, and failed to ensure an environment free of potential hazards for 4 of 6 residents reviewed for accidents/hazards (Residents #21, #40, #28, and #25). This deficient practice had the potential to affect all residents who utilized handrails in the 200 and 300 hallway.</p> <p>Findings include:</p> <p>1. During interview of Resident #21 on, 8/18/14 at 10:22 a.m., the resident indicated she had a fall recently and hit</p>	F000323	<p>F323 It is the practice of this facility to assure that residents' environment is safe and free of hazards. The correction action taken for those residents found to be affected by the deficient practice include: There is no resident # 25 in the Alpha home population. Resident #21 has a care plan in place related to implemented fall interventions to assist with the prevention of future falls. Resident #40 has a wheelchair in place that meets the resident's individual needs. Residents #28 and #5 have appropriate water temperatures in the bathroom sink. Residents #21, #40, #28, and #25 are residing in an environment that is free from hazards. Other residents that have the potential to be affected have</p>	09/21/2014

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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>her head.</p> <p>During interview of LPN #10 on, 8/19/14 at 9:50 a.m., the LPN indicated the resident had a fall in the past 30 days.</p> <p>During review of Resident #21's clinical record on 8/21/14 at 10:25 a.m., documentation indicated on 6/17/14 at 7:50 p.m., "The nurse called to room [...] to find resident on floor [with] blood on floor. Dr [...] notified of fall and about a 2 inch gash on left side of face....Ambulance here to transfer." A nurses noted indicated the resident returned from the emergency room on, 6/18/14 at 12:40 a.m. Another nurses note on 6/18/14 at 2:30 a.m., indicated the resident "...has a 9.5 cm [centimeter] X .16 cm laceration left lateral brow on head from fall on 6/17/14."</p> <p>On 6/23/14 at 11:25 p.m., nurses notes documented "Call light answered, resident on floor on knees using 1/2 side rails to get up. Forehead against closet door. Noted sm [small] amt [amount] blood from raising hematoma with 2 cm [centimeter] laceration above right eye brow.."</p> <p>A nurses note on, 6/24/14 at 12:10 p.m. indicated "...No further bleeding but hematoma increasing in size [and] c/o</p>		<p>been identified by: All residents have been reviewed to assure that the environment is free from hazards including proper watertemperature, proper equipment placement such as wheelchair, proper fallinterventions, and general environment safety is in place such as properfunctioning hand rails. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The nursing staff has been in-serviced relatedto providing services to our residents in a manner that promotes safety. Wheelchair positioning and fall interventionimplementation was included in the in-service to be provided in accordance withthe plan of care. Maintenance will bechecking water temperatures routinely in accordance with the preventivemaintenance plan as well as assuring that hand rails are in good repair. The Maintenance Director has been in-servicedrelated to assuring the environment is free of hazards. There will be routine monitoring via roundsby Administrator, nursing administration, and nurses to assure that theenvironment is free from hazards, interventions are in place for fallpreventions, and that wheelchair positioning is appropriate for resident and inaccordance with the plan of</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 08/22/2014	
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			
(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			
	<p>[complaints of HA [headache] increasing. Call placed to Med Exchange again." 6/24/14 at 1:05 a.m., documentation indicated the resident was transferred to the emergency room and returned on 6/24/14 at 6:30 a.m. from the emergency room. A nurses note indicated on, 6/25/14 at 6:30 a.m., "Resident sitting [up] in w/c [wheel chair] alert and oriented to person and place. Hematoma above R [right] eye et [and] purplish discolorations [down] right eye. Discoloration (purple) on (L) [left] cheek area.."</p> <p>Documentation in the nurses notes on, 8/18/14 at 6 a.m., was noted of "Res [resident] screaming help-able to stand up and placed in bed.... no injuries noted - denies any pain or discomfort.."</p> <p>A "care plan meeting form" was noted, dated 6/24/14, identifying the resident as "continues to be a fall risk." A plan of care, with interventions to address the resident as a risk for falls and /or having falls was lacking.</p> <p>During interview of the MDS (minimum data set) coordinator on, 8/21/14 at 2:20 p.m., the coordinator indicated a significant change in condition assessment had been completed on, 6/24/14, due to the resident's</p>		<p>care. The corrective action taken to monitor performance to assure compliance through quality assurance is: In addition to routine rounds, including weekends and all shifts, a Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents/resident rooms related to a safe environment and appropriate interventions. The tool will specifically monitor for fall interventions, wheelchair appropriateness, water temperatures, and hand rail function. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3 in the areas related to nursing. The Maintenance Director will utilize a tool to review 5 resident rooms/areas for proper water temperatures and handrails. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. The date the systemic changes will be completed: September 21, 2014</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>hospitalization after a fall on 6/17/14. The MDS coordinator, after looking in the careplan book and in the computer, was unable to find a careplan addressing the resident with a risk of falls or with current falls. The MDS coordinator presented a "Fall Risk Assessment", dated 6/24/14, identifying the resident as a high risk for falls.</p> <p>During interview of the DON (Director of Nursing) on 8/21/14 at 2:20 p.m. the DON indicated, "The only thing I can tell you is she is at risk for falls." As to approaches or interventions to address falls, the DON indicated "we ask her to use her call light."</p> <p>2. On 8/22/14 9:15 a.m. CNA #6 was pushing Resident #40 in a wheelchair. Resident was heard saying, "Oh, Oh". The CNA stopped the wheelchair and repositioned the residents feet from under the w/c. The CNA stated, "You need to move your feet." Foot rests were lacking on the wheelchair. The CNA began pushing the wheelchair again and the resident's legs and feet were observed dragging under the wheel chair. The CNA stopped again, repositioned the resident's feet and began pushing the wheelchair..</p> <p>During review of Resident #40's clinical</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>record on 8/22/14 at 9:50 a.m., documentation indicated on the the resident's careplan as self-care deficit..requiring extensive assist with activities of daily living (ADL), cognitive function/dementia impaired thought process..dementia, ensure resident is wearing appropriate footwear when mobilizing in the wheel chair." Dates to identify when these approaches were initiated were lacking.</p> <p>A quarterly assessment, dated 6/2/14, indicated the resident's functional status as "need for extensive assist and one person physical assist in all areas.</p> <p>A Dermatological progress note, dated 8/7/14, indicated, "...muscle strength is decreased on right and left feet...range of motion was limited on right and left heel."</p> <p>3. During an observation, with the maintenance person present, on 8/19/14 at 10:15 p.m., water temperature in Resident #28's bathroom sink was 123.9 degrees Fahrenheit and was 123.4 degrees Fahrenheit in Resident #5's bathroom sink.</p> <p>During interview on 8/19/14 at 10:15 a.m., the maintenance person indicated "try to keep the water temperatures at 110</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>degrees Fahrenheit or less."</p> <p>Resident #28's clinical record was reviewed on 8/22/14 at 12 p.m. An annual MDS (minimum data set) dated, 6/19/14, indicated the resident as requiring total dependence with personal hygiene.</p> <p>Resident #5's clinical record was reviewed on 8/22/14 at 1 p.m. An admission date was noted of, 5/9/14. The resident admission assessment indicated the resident was independent with bed mobility, transfers, walking/locomotion, eating and toileting.</p> <p>During an interview on 8/22/14 at 11:38 A.M., with the Maintenance Supervisor and the Administrator present, the Maintenance Supervisor indicated he didn't have a system for ongoing maintenance repairs. He indicated if he saw something was broken he would fix it or if staff filled out a work order he would fix it. He indicated he did not have the observed broken/damaged items on a work order list to be repaired.</p> <p>4. During initial tour on 8/18/14 at 7:30 A.M. and during the environmental tour on 8/22/14 at 11:38 A.M., with the Maintenance Supervisor and the</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>Administrator present, the following observations were made:</p> <p>Observations of the 200 hall: The end cap of the hand rail outside of room 207 was missing from the left corner exposing sharp edges. The end caps were missing from the hand rails exposing sharp edges on the area between rooms 208 and 210.</p> <p>Observations of 300 hall: The end cap was missing from the handrail outside of room 310 exposing sharp ends.</p> <p>A policy titled "Preventive Maintenance Schedule Environmental Services" identified as current by the Administrator on 8/22/14 at 2:00 P.M., indicated, "It is the policy of the environmental services department to maintain a preventive maintenance schedule for each piece of equipment in the environmental service department. The preventive maintenance will be completed by the facility environmental service department or the facility designated service provider. It will be the responsibility of the environmental service supervisor to monitor regularly scheduled preventative maintenance on all equipment in the environmental service. It is the responsibility of the environmental service supervisor to insure that required repairs are completed in a timely manor.</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 08/22/2014
--	---	--	---

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
--	--

(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
F000329 SS=D	<p>3.1-45(a)(1) 3.1-45(a)(2)</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 residents were not administered medication unless necessary and without indication for use for 2 of 5 residents reviewed for unnecessary medications (Residents #1 and #43).</p> <p>Findings include:</p>	F000329	<p>F329ADDENDUM F 329- Prior to introducing or increasing amedication, the IDT team will review the resident to assure that the necessarynon-pharmacological interventions have been utilized. Only if nonpharmaceutical interventions have been unsuccessful will the increasing ofmedications occur.</p>	09/21/2014

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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>1. Resident #1's record was reviewed on 8/20/14 at 10:35 A.M. Resident #1 had diagnoses which included, but were not limited to, legally blind, hypertension, coronary pulmonary disease, osteoporoses, weight loss, diabetes, and dementia with behaviors.</p> <p>A physician's order dated 10/8/13, indicated Resident #1 was started on Trazodone (anti-depressant/anti-anxiety) 25 milligrams to be taken at bedtime due to insomnia.</p> <p>A document titled "Note To Attending Physician/Prescriber" dated 7/18/14, indicated, "(Resident #1 named) has an order for Trazodone 25 mg at bedtime for insomnia. The Behavior committee met today to discuss (Resident named) medications and report that (Resident named) does not fall asleep until early morning then sleeps until the afternoon, and request a small increase in (Resident named) Trazodone dose in an effort to help her fall asleep in the evening. Would you consider this increase? Thank you..." This note indicated the physician indicated yes to the increase in the Trazodone.</p> <p>The record lacked documentation of non-pharmacological interventions</p>		<p>It is the practice of this facility to assure that medications are reviewed for appropriateness and in accordance with the physician's order. The correction action taken for those residents found to be affected by the deficient practice include: Residents #1 and #43 have been reviewed and are receiving medications in accordance with the physician's orders. Other residents that have the potential to be affected have been identified by: All residents have been reviewed are receiving their medications in accordance with the physician's orders. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The nurses have been in-serviced related to the use of medications and their appropriateness. The in-service includes documentation to support the use of the medication as well as assuring that pharmacy recommendations are addressed with the physician for his determination related to the medication. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews 5 residents</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>attempted prior to the increase, or documentation which indicated Resident #1's sleep patterns were a harm to herself or any other resident.</p> <p>A care plan indicated Resident #1 had dementia with behavior disturbances. A goal indicated Resident #1 would not have behaviors or aggressive behaviors daily. Interventions to meet this goal included administering Trazodone at bedtime, monitor for mood changes, provide non-pharmacological interventions to assist with behaviors, and redirect to activities she enjoyed.</p> <p>During an interview on 8/20/14 at 2:30 P.M., the Director of Nursing (DoN) was queried why Resident #1's Trazodone was increased from 25 milligrams daily to 50 milligrams daily. She replied, "She really does have behaviors. Yeah, she is a sundowners. Ok, she sleeps until around 2:00 in the afternoon then she wakes up and then she gets started. She tries to get out of her chair. Her alarm goes off every 10 or 15 minutes. She is up greater part of the night. Sometimes she wants to go to work or fix dinner for her dad... No they haven't let her try to stay up. No they haven't helped her cook. They increased the Trazodone but it doesn't work." The DoN indicated the facility was open and provided care 24 hours a</p>		<p>medication regimens related to documentation to support medication usage and documentation to show that physician is aware of any recommendations related to medication changes. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed.</p> <p>The date the systemic changes will be completed: September 21, 2014</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 08/22/2014	
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			
(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			
	<p>day and Resident #1 was usually easily re-directed.</p> <p>An education in-service document provided to staff for care of residents with dementia was provided by the DoN on 8/21/14 at 9:55 A.M. This document indicated, "...Sundowning: Adjust activity and staff schedules providing more activities and staff to intervene at this time of day. Offer refreshments at this time of day. Educate staff relative to being very conscious and careful about the way in which they leave the unit at this time of day. Suggest family visits at this time if possible..."</p> <p>2. Resident #43's record was reviewed on 8/20/14 at 1:35 P.M. Resident #43 had diagnoses which included, but were not limited to, dementia, diabetes, and legally blind.</p> <p>A pharmacy recommendation dated 6/19/14, indicated, "(Resident #1 named) has an order for Amaryl (medication used to control blood sugar) 1 mg (milligram) daily for diabetes mellitus..." This recommendation indicated her labs were "well below" the guidelines recommended by the American Geriatric Society and the American Diabetics Association and asked the physician to consider discontinuing the medication.</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>This record indicated the Nurse Practitioner agreed to discontinue the Amaryl and signed the recommendation on 6/19/14.</p> <p>Resident #43's medication administration records for June, July, and August 2014 indicated she was still administered the Amaryl 1 mg daily.</p> <p>During an interview on 8/22/14 at 11:15 A.M., Licensed Practical nurse indicated the Amaryl was not discontinued per pharmacy recommendations. She indicated Resident #43 was currently getting the medication. She stated, "It got missed."</p> <p>A policy titled "Medication Monitoring" identified as current by the Director of Nursing (DoN) indicated, "...Residents receive a psychoactive medication only if designated medically necessary by the prescriber. The medical necessity is documented in the resident's medical record and in the care planning process... Non pharmacological interventions such as behavior modification or social services and their effects are documented as a part of the care planning process, and are utilized by the prescriber in assessing the continued need for psychoactive medications... Dose scheduling of the psychoactive medications takes into</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 08/22/2014
--	---	--	---

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
--	--

(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
F000428 SS=D	<p>account the resident's lifestyle and habits...The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' drug therapy are communicated to those with authority and/or responsibility to implement the recommendations, and responded to in an appropriate and timely fashion..."</p> <p>3.1-48(a) 3.1-48(4)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on interview and record review, the facility failed to ensure pharmacy recommendations were acted upon for 1 of 5 residents reviewed for pharmacy recommendations (Resident #43).</p>	F000428	F428 It is the practice of this facility to assure that the consulting pharmacist addresses medication issues as part of the monthly reviews. The correction action taken for	09/21/2014

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 08/22/2014
--	---	--	---

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
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>Findings include:</p> <p>Resident #43's record was reviewed on 8/20/14 at 1:35 P.M. Resident #43 had diagnoses which included, but were not limited to, dementia, diabetes, and legally blind.</p> <p>A pharmacy recommendation dated 6/19/14, indicated, "(Resident #1 named) has an order for Amaryl (medication used to control blood sugars) 1 mg (milligram) daily for diabetes mellitus..." This recommendation indicated her labs were "well below" the guidelines recommended by the American Geriatric Society and the American Diabetics Association and asked the physician to consider discontinuing the medication. This record indicated the Nurse Practitioner agreed to discontinue the Amaryl and signed the recommendation on 6/19/14.</p> <p>Resident #43's medication administration records for June, July, and August 2014 indicated she was still administered the Amaryl 1 mg daily.</p> <p>During an interview on 8/22/14 at 11:15 A.M., Licensed Practical nurse indicated the Amaryl was not discontinued per pharmacy recommendations. She</p>		<p>those residents found to beaffected by the deficient practice include: Resident #43 physician is aware of recommendations bypharmacy. Resident is medication inaccordance with the physician's order. Other residents that have the potential to be affected havebeen identified by: The most recent pharmacy recommendations have been reviewedto assure that all recommendations were shared with the physician for his finaldetermination. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur include: Nurses have been in-serviced related assuring that allpharmacy recommendations are submitted to the physician for furtherreview. The Director of Nursing isultimately responsible for assuring that the pharmacy recommendations receivephysician's review appropriately. The corrective action taken tomonitor performance to assure compliance through quality assurance is: A PerformanceImprovement tool has been established that will review the pharmacy report toassure that there is evidence that the physician has been made aware of therecommendations and has responded with a determination. The Director</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 08/22/2014
--	---	--	---

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
--	--

(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
F000465 SS=E	<p>indicated Resident #43 currently getting the medication. She stated, "It got missed."</p> <p>A policy titled "Medication Monitoring" identified as current by the Director of Nursing (DoN) indicated, "...The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' drug therapy are communicated to those with authority and/or responsibility to implement the recommendations, and responded to in an appropriate and timely fashion..."</p> <p>3.1-25(j)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide maintenance and housekeeping services to keep the facility clean and in good repair. This deficient practice had the potential to affect all residents in the building.</p>	F000465	<p>ofNursing, or designee, will complete the tool monthly x3, then quarterlyx3. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the tools. The date the systemic changes will be completed: September 21, 2014</p> <p>F465 It is the practice of this facility to assure that the environment is safe, functional, sanitary, and comfortable for out residents. The correction action taken for those residents found to be affected by the deficient practice</p>	09/21/2014

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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>Findings include:</p> <p>During initial tour on 8/18/14 at 7:30 A.M. and during the environmental tour on 8/22/14 at 11:38 A.M., with the Maintenance Supervisor and the Administrator present, the following observations were made:</p> <p>1. Observations of the 200 shower room hall: A strong odor of sewer gas was noted in the shower room. The grate in the shower was missing, exposing a grayish, slime-like substance inside the drain. A thick layer of dust covered the only vent to the exhaust fan. The sink was observed with standing water with the drain open. Caulking was missing at the exit from the shower room with brownish-black colored substance observed. A brownish-black substance was observed around the base of the shower and the base molding around the area nearest the shower.</p> <p>2. Observations of the 200 hall: The base molding was pulled away from the wall at the right and left corners outside room 207. The end cap of the hand rail outside of room 207 was missing from the left corner, exposing sharp edges. Floor tiles were missing, exposing concrete sub floor outside room 215. Measurements taken by the Maintenance Director</p>		<p>include: The g-tube stand for resident #28 has been cleaned. Resident #5 lounge chair has been cleaned as well as the handsink cleaned and the overbed table repaired. The water temperatures in the bathroom for residents #28 and#5 have been corrected. The specific areas identified in the 2567 including the 200hall shower room, the 200 hall molding, the hand rail, the floor tiles, thecaulking, and the dirt buildup. The 300hall was also addressed related to the hand rail, the base molds, the handrails, and the door frames. The ceilinghas also been addressed The hand rail outside of the nurses' station has beenrepaired and the push pad to the water fountain has been repaired. Other residents that have the potential to be affected havebeen identified by: Potentially all residents could be affected. Please see below for systematic changes toprevent reoccurrence. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur include: The maintenance department has been in-serviced related tofollowing of the preventive maintenance schedule. This assures that rooms arechecked on a routine basis for needed maintenance attention so that they can beaddressed. In addition, the areas ofhand rails,</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>indicated an area of 36.5 inches x 24 inches. A brownish-gray build up was observed around base boards on the floor. The end caps were missing from the hand rails exposing sharp edges on the area between rooms 208 and 210. The ceiling was cracked between rooms 201 and 203.</p> <p>During an interview on 8/20/14 at 1:13 p.m., the Maintenance Supervisor indicated the broken/missing floor tiles had been missing for "3-4 months." He indicated the missing tiles could cause a resident to fall.</p> <p>3. Observations of 300 hall: The hand rail on the right side at the beginning of 300 hall was loose. The corner base molding was pulled away from the wall outside of room 307 and room 309. The hand rail was loose and pulled away from the wall on the right side at the end of the 300 hall by the exit door. The end cap was missing from the handrail outside of room 310, exposing sharp ends and the plastic cover was loose and slid horizontally when grasped. The door frame molding was torn and pulled away from the frame on the outside, left of room 302. The hand rail was loose on the end closest to the double doors between room 302 and the medical records office.</p>		<p>water temperatures, floor bases, floor care, ceilings, and odorshave been added to the preventive maintenance schedule. Housekeeping staff has been in-servicedrelated to assuring that cleaning schedules are followed and that they alertmaintenance of any areas that may need repair as they are in the roomsdaily. All staff has been in-servicedrelated to filling out communication forms if areas that require maintenance orhousekeeping repairs are needed. The corrective action taken to monitor performance to assurecompliance through quality assurance is: In addition to routine administrative rounds, A PerformanceImprovement Tool has been initiated that randomly reviews 5 resident rooms/commonareas for housekeeping/maintenance issues. The Administrator, or designee, willcomplete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediatelycorrected. The Quality AssuranceCommittee will review the tools at the scheduled meetings with recommendationsas needed. The date the systemic changes will be completed: September 21, 2014</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>4. The hand rail outside of the nurse's station on the left side of the hallway leading to the library/chapel was loose.</p> <p>5. The right push pad was missing to the water fountain.</p> <p>6. On 8/19/14 at 10:11 a.m., Resident #28's g-tube pump and base of pole holding pump was covered with a dried on whitish material.</p> <p>7. On 8/19/14 at 9:29 a.m. the seat of Resident #5's overstuffed lounge chair had a large stain of light to dark brown substance. The bathroom had a brown substance around the base of the toilet. The inner bowl of the hand sink was soiled with a light to dark substance. The perimeter of the over bed table had the surface covering missing, and had exposure of particle board.</p> <p>8. During an observation, with the maintenance person present, on 8/19/14 at 10:15 p.m., water temperature in Resident #28's bathroom sink was 123.9 degrees Fahrenheit and was 123.4 degrees Fahrenheit in Resident #5's bathroom sink.</p> <p>During interview of the Maintenance person on 8/19/14 at 10:15 a.m., the maintenance person indicated "I try to</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>keep the water temperatures at 110 degrees Fahrenheit or less."</p> <p>During an interview on 8/18/14 at 1:30 P.M., the Administrator indicated the only functional shower room was the 200 hall shower room. He indicated the odor had been an on going problem since "last Fall." He indicated there were many repairs needed in the facility but due to the lack of finances he was unable to make the repairs needed.</p> <p>During an interview on 8/19/14 at 1:00 P.M., House Keeping Staff #5 indicated the odor in the 200 shower room had been there on and off for awhile and it did bother residents. She indicated she wasn't aware she was supposed to clean the vent in the shower room.</p> <p>During an interview on 8/22/14 at 11:38 A.M., with the Maintenance Supervisor and the Administrator present, the Maintenance Supervisor indicated he didn't have a system for ongoing maintenance repairs. He indicated if he saw something was broken he would fix it or if staff filled out a work order he would fix it. He indicated he did not have the observed broken/damaged items on a work order list to be repaired.</p> <p>A policy titled "Preventive Maintenance</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 08/22/2014
--	---	--	---

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
--	--

(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
F000468 SS=E	<p>Schedule Environmental Services" identified as current by the Administrator on 8/22/14 at 2:00 P.M., indicated, "It is the policy of the environmental services department to maintain a preventive maintenance schedule for each piece of equipment in the environmental service department. The preventive maintenance will be completed by the facility environmental service department or the facility designated service provider. It will be the responsibility of the environmental service supervisor to monitor regularly scheduled preventative maintenance on all equipment in the environmental service. It is the responsibility of the environmental service supervisor to insure that required repairs are completed in a timely manor.</p> <p>3.1-19(f)</p> <p>483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. Based on observation and interview, the facility failed to ensure side rails were firmly secured to the wall on 2 of 3 halls with hand rails observed.</p> <p>Findings include: During initial tour on 8/18/14 at 7:30</p>	F000468	F468 It is the practice of this facility to assure that hand rails are firmly secured for our resident's safety. The correction action taken for those residents found to be affected by the deficient practice include: The hand rails throughout the building have been	09/21/2014

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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>A.M. and during the environmental tour on 8/22/14 at 11:38 A.M., with the Maintenance Supervisor and the Administrator present, the following observations were made:</p> <p>1. Observations of 300 hall: The hand rail on the right side at the beginning of 300 hall was loose. The hand rail was loose and pulled away from the wall on the right side end of the 300 hall by the exit door. The handrail outside of room 310 had a plastic covering that was loose and slid horizontally when grasped. . The hand rail was loose on the end closest to the double doors between room 302 and the medical records office.</p> <p>4. The hand rail outside of the nurse's station on the left side of the hallway leading to the library/chapel was loose.</p> <p>During an interview on 8/22/14 at 11:38 A.M., with the Maintenance Supervisor and the Administrator present, the Maintenance Supervisor indicated he didn't have a system for ongoing maintenance repairs. He indicated if he saw something was broken he would fix it or if staff filled out a work order he would fix it. He indicated he did not have the observed broken/damaged items on a work order list to be repaired.</p>		<p>addressed including on the 200 hall, 300 hall, and outside the nurses' station. Other residents that have the potential to be affected have been identified by: Potentially all residents could be affected. Please see below for systematic changes to prevent reoccurrence. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The maintenance department has been in-serviced related to following of the preventive maintenance schedule. The proper repair and function of hand rail has been added to the preventive maintenance review. All staff has been in-serviced related to filling out communication forms related to handrails that may be in need of repair so that they can be addressed promptly by the Maintenance Director. The corrective action taken to assure compliance through quality assurance is: In addition to routine administrative rounds, A Performance Improvement Tool has been initiated that randomly reviews 5 resident rooms/common areas for maintenance issues related to hand rails. The Administrator, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be</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 08/22/2014
--	---	--	---

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
--	--

(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
F000520 SS=F	<p>A policy titled "Preventive Maintenance Schedule Environmental Services" identified as current by the Administrator on 8/22/14 at 2:00 P.M., indicated, "It is the policy of the environmental services department to maintain a preventive maintenance schedule for each piece of equipment in the environmental service department. The preventive maintenance will be completed by the facility environmental service department or the facility designated service provider. It will be the responsibility of the environmental service supervisor to monitor regularly scheduled preventative maintenance on all equipment in the environmental service. It is the responsibility of the environmental service supervisor to insure that required repairs are completed in a timely manor.</p> <p>3.1-19(f)(3)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at</p>		<p>immediatelycorrected. The Quality AssuranceCommittee will review the tools at the scheduled meetings with recommendationsas needed.</p> <p>The date the systemic changes will be completed: September 21, 2014</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, interview, and record review, the facility failed to identify and implement a process for quality improvement for staff non-compliance related to failure of staff to implement residents' grievances made known through the Resident Council Group minutes and housekeeping/maintenance concerns. This deficient practice had the potential to affect 30 of 30 residents in the facility.</p> <p>Findings include:</p> <p>Based on interview and record review, the facility failed to address grievances in a manner which could be tracked for 5 of 5 months reviewed for grievance resolution of the Resident council. This</p>	F000520	<p>F520 It is the practice of this facility to assure that Quality Assurance measures are in place with additional recommendations by the Quality Assurance Committee for continued promotion of quality of care. The correction action taken for those residents found to be affected by the deficient practice include: Each of the areas identified have been addressed previously in the plan of correction. Please refer to those specific areas for interventions for compliance. Each area not has a Performance Improvement tool that will be utilized for monitoring to assure ongoing compliance which will be reviewed by the QA committee with additional recommendations</p>	09/21/2014

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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>potentially affected all the residents who attended the Resident council.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident Council minutes were provided by the Administrator on 8/20/14 at 10:45 A.M. The minutes indicated the following concerns by the Resident Council: 1. Missing laundry - March, April, May, & August 2014. 2. Not getting showers - March, April, May, & July 2014. 3. Beds not made- March & April 2014. 4. Dietary complaints/request - March, May, July, & August 2014. 5. Activity request- March, April, May, & July, August 2014. 6. Call lights not answered timely - May 2014. <p>During an interview on 8/21/14 at 10:15 A.M., the Resident Council President indicated the Activity Designee took minutes for the Resident Council meetings. She indicated the Administrator would occasionally attend the meetings to listen to their concerns but staff did not respond to the group's concerns and there was not any follow up from the facility.</p>		<p>as needed. Other residents that have the potential to be affected have been identified by: Potentially all residents could be affected. The QA interdisciplinary committee will beroutinely identifying quality areas on an ongoing basis with ongoing recommendations for quality improvement. Please see below for system changes. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur include: The QA committee will meet a minimum of quarterly to reviewareas of concern with recommendations for improvement. As part of the process, if areas ofimprovement are needed, recommendations will be made with interventions andmeans of monitoring established. The QAcommittee will be reviewing the outcomes of any recommendations at the nextscheduled meeting. The Administrator isresponsible for assuring that the QA committee is functioning in a manner thatpromotes quality within the facility. The purpose of the committee is to continuously work towards higherquality of services for the resident. The corrective action taken to monitor performance to assurecompliance through quality assurance is: The Administrator, or designee, will be reviewing the minutesof any QA</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 08/22/2014	
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			
(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			
	<p>During an interview on 8/21/14 at 1:34 P.M., with the Administrator and the Activity Designee present, the Activity Designee indicated she took minutes for the meetings and verbally reported the concerns to the Department Heads. The Administrator indicated concerns were documented in a grievance book and given to the appropriate Department Heads. He indicated when the concerns had been resolved the Social Service Director would turn the form into him and he would sign off to ensure the concern had been addressed. During this interview the Administrator was asked to provide documentation Resident Council concerns had been addressed.</p> <p>During an interview on 8/21/14 at 1:50 P.M., the Administrator indicated he did not have documentation which indicated the Resident Councils concerns and/or request had been acted upon. When queried regarding the Resident Council's concerns and/or request for March, April, May, July, & August 2014, he stated, "Nope, no follow up."</p> <p>During an interview on 8/22/14 at 2:00 P.M., the Administrator and the Director of Nursing (DoN) were asked to provide the facility's policy regarding Resident Council grievance resolution.</p>		<p>meeting to assure that areas that have been identified with recommendations are being addressed appropriately by the interdisciplinary team. It will also be assured that any Performance Improvement Tools have been completed with positive outcomes. If any negative outcome is identified, it will be determined if additional recommendations need to be implemented to increase the quality of services provided to our residents. The date the systemic changes will be completed: September 21, 2014</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>During an interview at the exit conference on 8/23/14 at 3:30 P.M., with the Administrator and DoN present, the DoN indicated the facility did not have a policy regarding Resident Council grievance resolution.</p> <p>2. During initial tour on 8/18/14 at 7:30 A.M. and during the environmental tour on 8/22/14 at 11:38 A.M., with the Maintenance Supervisor and the Administrator present, the following observations were made:</p> <p>1. Observations of the 200 shower room hall: A strong odor of sewer gas was noted in the shower room. The grate in the shower was missing, exposing a grayish slime- like substance inside the drain. A thick layer of dust covered the only vent to the exhaust fan. The sink was observed with standing water with the drain open. Caulking was missing at the exit from the shower room with brownish-black colored substance observed. A brownish-black substance was observed around the base of the shower and the base molding around the area nearest the shower.</p> <p>2. Observations of the 200 hall: The base molding was pulled away from the wall at the right and left corners outside room</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>207. The end cap of the hand rail outside of room 207 was missing from the left corner exposing sharp edges. Floor tiles were missing, exposing concrete sub floor outside room 215. Measurements taken by the Maintenance Director indicated an area of 36.5 inches x 24 inches. A brownish-gray build up was observed around base boards on the floor. The end caps were missing from the hand rails exposing sharp edges on the area between rooms 208 and 210. The ceiling was cracked between rooms 201 and 203.</p> <p>During an interview on 8/20/14 at 1:13 p.m., the Maintenance Supervisor indicated the broken/missing floor tiles had been missing for "3-4 months." He indicated the missing tiles could cause a resident to fall.</p> <p>3. Observations of 300 hall: The hand rail on the right side at the beginning of 300 hall was loose. The corner base molding was pulled away from the wall outside of room 307 and room 309. The hand rail was loose and pulled away from the wall on the right side at the end of the 300 hall by the exit door. The end cap was missing from the handrail outside of room 310 exposing sharp ends and the plastic cover was loose and slid horizontally when grasped. The door frame molding was torn and pulled away</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>from the frame on the outside left of room 302. The hand rail was loose on the end closest to the double doors between room 302 and the medical records office.</p> <p>4. The hand rail outside of the nurse's station on the left side of the hallway leading to the library/chapel was loose.</p> <p>5. The right push pad was missing to the water fountain.</p> <p>6. On 8/19/14 at 10:11 a.m., Resident #28's g-tube pump and base of pole holding pump was covered with a dried on whitish material.</p> <p>7. On 8/19/14 at 9:29 a.m. the seat of Resident #5's overstuffed lounge chair had a large stain of light to dark brown substance. The bathroom had a brown substance around the base of the toilet. The inner bowl of the hand sink was soiled with a light to dark substance. The perimeter of the over bed table had the surface covering missing, and had exposure of particle board.</p> <p>8. During an observation, with the maintenance person present, on 8/19/14 at 10:15 p.m., water temperature in Resident #28's bathroom sink was 123.9 degrees Fahrenheit and was 123.4</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>degrees Fahrenheit in Resident #5's bathroom sink.</p> <p>During an interview on 8/18/14 at 1:30 P.M., the Administrator indicated the only functional shower room was the 200 hall shower room. He indicated the odor had been an on going problem since "last Fall." He indicated there were many repairs needed in the facility but due to the lack of finances he was unable to make the repairs needed.</p> <p>During interview of the Maintenance person on 8/19/14 at 10:15 a.m., the maintenance person indicated "I try to keep the water temperatures at 110 degrees Fahrenheit or less."</p> <p>During an interview on 8/19/14 at 1:00 P.M., House Keeping Staff #5 indicated the odor in the 200 shower room had been there on and off for awhile and it did bother residents. She indicated she wasn't aware she was supposed to clean the vent in the shower room.</p> <p>During an interview on 8/22/14 at 11:38 A.M., with the Maintenance Supervisor and the Administrator present, the Maintenance Supervisor indicated he didn't have a system for ongoing maintenance repairs. He indicated if he saw something was broken he would fix</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 08/22/2014
--	---	--	---

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
--	--

(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
	<p>it or if staff filled out a work order he would fix it. He indicated he did not have the observed broken/damaged items on a work order list to be repaired.</p> <p>A policy titled "Preventive Maintenance Schedule Environmental Services" identified as current by the Administrator on 8/22/14 at 2:00 P.M., indicated, "It is the policy of the environmental services department to maintain a preventive maintenance schedule for each piece of equipment in the environmental service department. The preventive maintenance will be completed by the facility environmental service department or the facility designated service provider. It will be the responsibility of the environmental service supervisor to monitor regularly scheduled preventative maintenance on all equipment in the environmental service. It is the responsibility of the environmental service supervisor to insure that required repairs are completed in a timely manor.</p> <p>During an interview on 8/23/14 at 3:20 P.M., the Administrator indicated he did not have documentation which indicated the QAA committee had identified a system failure with Resident Grievance Resolution.</p> <p>3.1-52(b)(2)</p>			

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

PRINTED: 10/08/2014
FORM APPROVED
OMB NO. 0938-0391

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 08/22/2014
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		
(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	