STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155717	A. BUILDING 00 B. WING	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALPHA HOME - A WATERS COMMUNITY	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00308423 and IN00308794. Complaint IN00308423 - Substantiated. Federal deficiencies related to the allegations are cited at F678 and F689. Complaint IN00308794 - Substantiated. Federal deficiencies related to the allegations are cited at F678 and F689. Survey dates: October 7, and 8, 2019 Facility number: 000376 Provider number: 155717 AIM number: 100275510 Census Bed Type: SNF/NF: 55 Total: 55 Census Payor Type: Medicare: 6 Medicaid: 40 Other: 9 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 16, 2019.	F 0000	In lieu of revisit, I would like to respectively request a desk review	
F 0678 SS=D Bldg. 00	483.24(a)(3) Cardio-Pulmonary Resuscitation (CPR) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and			

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

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	subject to related physician orders and the resident's advance directives. Based on interview and record review, the facility failed to ensure a resident's choice of code status was honored, and failed to follow the Cardio Pulmonary Resuscitation (CPR) procedure for an unresponsive resident for 1 of 3 residents reviewed for death (Resident B). Finding includes: A report, titled, "Admissions and Discharges", dated from 8/1/19 to 10/7/19, indicated Resident B had expired on 10/4/19. A record review was completed for Resident B on 10/7/19 at 2:42 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, paranoid schizophrenia, morbid obesity, chronic diastolic congestive heart failure, anxiety disorder, obstructive sleep apnea, acute pulmonary edema, and dependence on oxygen. Resident B's Physician's orders, dated 8/23/19, indicated, do not resuscitate (DNR). Antibiotics only if comfort measures cannot be achieved by other means and no artificial nutrition. No directions specified for the order. A Progress Note for Resident B, dated 10/4/2019 at 4:50 a.m., indicated a Certified Nursing Assistant (CNA) reported to Licensed Practical Nurse (LPN) 6 the resident was on the floor. "Resident was laying on the floor in her room, face first feet closest to the bed, and head towards the west of the room under her bedside table. There was a large amount of dark red fluid on the floor around her head. No pulse felt during the initial assessment. Writer with the assist of 1 staff	F 0678	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; It is the policy of this facility for personnel to provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel subject to related physician orders and the resident's advanced directives. Resident B no longer resides at the facility. ·how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents residing the in the facility have the potential to be affected. An audit of Advanced Directives was completed on 10.7.19 and 10.8.19 to ensure the facility was compliant with the policy. ·And what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Facility staff was initially	10/28/2019

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	repositioned resident onto her back and resumed assessing for a pulse and signs of breathing, neither of which were found. 911 called and CPR initiated. Paramedics and firefighters were on scene in approximately 10 min. They took over the monitoring and treatment. No vitals could be found and they called the time of death at 2356. MD [medical doctor], DON [Director of Nursing] and family notified. Family requested to be at bedside before notifying the funeral home...." An "eInteract" electronic communication form, dated 10/4/19, indicated Resident B fell and had been found unresponsive. She had a no code order. Resident B's Care Plans, indicated, "Focus: [resident's name] Code Status: do not resuscitate, antibiotics only if comfort measures cannot be achieved by other means, No artificial nutrition. Goal: [Resident's] wishes will be honored daily through next review. Interventions: Notify MD and family of any change in condition. Wishes will be honored ...2. Focus: Resident is at risk for falls due to debility. Goal: Resident will have no injuries due to falls through next review. Interventions: Attempt to keep areas free of clutter, keep call light in reach, maintain T Time [toileting times] as indicated, notify and update MD as needed, therapy screen as indicated, quarterly and prn ..." During an interview with the Assistant Director of Nursing (ADON) on 10/7/19 at 4:04 p.m., he indicated Resident B had been having difficulty breathing on the day she expired. LPN 6 entered a progress note on 10/4/19 at 4:50 a.m. with details of finding her unresponsive on the floor and subsequently expiring, but the events actually occurred on 10/3/19. The timeline of events were		in-serviced on 10.7.19 and 10.8.19 on the CPR policy by the DON. A second and third in-service was scheduled for 10.15.19 and 10.16.19 and completed to assure 100% attendance of all nursing staff. This in-service was conducted by both the DON and Administrator. Any staff who fail to comply with the material covered during the in-service will be further educated/or progressively disciplined as indicated. Furthermore, the facility will continue to cover and re-educate staff on CPR monthly during the all staff in-services. ·how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed. CPR/Advanced Directives orders will be monitored for 10 residents 3 days a week, on a rotating basis by DON/ADON/SSD. This will continue for 4 weeks. Afterwards, CPR/Advanced Directives orders will be monitored for 5 residents weekly on a rotating basis. In addition to monitoring of CPR/Advanced directives, orders will be reviewed daily at CQI meeting for newly admitted or re-admitted residents as well as	

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	unclear, LPN 6 should have back-timed the note to reflect the time of the fall, he did not put in the appropriate time. LPN 6 filled out an incident report that indicated Resident B had an unwitnessed fell on 10/3/19 at 11:40 p.m. CNA 9 had found the resident on the floor when she went to check on her, and reported to LPN 6. According to Resident B's nurse's note, she was found face down on the floor in her room, under the bedside table, blood around head, and upon assessment the nurse did not find a pulse. The resident was turned over onto her back, and the nurse still could not find a pulse. LPN 6 stayed with the resident while CNA 9 called 911. Emergency Medical Services (EMS) arrived within 10 minutes. The resident was pronounced at 11:56 p.m. as dead. The nurse initiated CPR, as he could not find a pulse. Any nurse would know if a resident was a code or no code, by looking at the electronic medical record (EMR) profile, or a Physician's Orders for Scope of Treatment (POST) form in the resident's chart. Resident B was a DNR, but LPN 6 failed to look at her orders at the time of the incident. During an interview with the Regional Nurse Consultant on 10/8/19 10:05 a.m., she indicated LPN 6 reported when Resident B was found there was uncertainty of signs of life still being present. LPN 6 got LPN 7 and together they turned the larger resident over onto her back, CPR was initiated, and 911 was called. The premise of thought being, a No Code would be honored if there was no hope of life, but if the resident had just fallen and could have been revived, then measures should have been taken to save her. During an interview with the Regional Nurse Consultant on 10/8/19 at 10:15 a.m., she presented a document for Resident B, titled, "Action Plan",		any new orders related to CPR/Advanced Directives. This will continue for a period of no less than 6 months to ensure ongoing compliance. Any concerns will be immediately addressed as found. The results of this monitoring will be presented at the monthly QAPI meetings. Any concerns will have been addressed. Any concerns will have been addressed. However, if any patterns are identified. If needed, an Action Plan will be written. Any needed Action Plan will be monitored weekly by the Administrator weekly until resolved. Corrections will be completed by 10.28.19	

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	dated 10/3/19. The document indicated, upon taking initial vital signs directly after finding the resident on the floor unresponsive, there was a faint pulse of 112. The decision was made to initiate CPR. During a phone interview with LPN 6 on 10/8/19 at 10:50 a.m., he indicated, Resident B was found unresponsive on the floor on 10/3/19 at approximately 11:40 p.m. by CNA 9, who ran to the nurse's station to report the resident was on the floor. Upon entering Resident B's room she was found to be lying face down next to the bed, with a lot of blood around her head. The resident was hard to assess for breathing due to the position, and there was no radial pulse found. LPN 6 went to get LPN 7 to help him turn the resident over to assess to see if she was still breathing. CNA 9 was asked to call 911. Resident B was turned over onto her back, and he could not find breath sounds. A pulse oximetry was applied to the resident and oxygen saturations read as 69%, and a pulse of 113, both for a few seconds then no signs of vitals could be detected. Due to being unsure if the resident had orders to be a DNR, he started CPR, and had LPN 7 went to the nurse's station to check the resident's physician's orders. Approximately 1 minute later LPN 7 returned and stated Resident B was a DNR, so LPN 6 stopped CPR. Coinciding with stopping compressions, the firemen arrived and continued the CPR efforts, to include hooking the resident up to machines, they also were unable to find any signs of life. LPN 6 retrieved paperwork to show the firemen the DNR documentation, and when the paramedics arrived a few minutes later, they pronounced the resident as dead. During a phone interview with LPN 7 on 10/8/19 at 11:05 a.m., she indicated, on the night of 10/3/19			

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	she was working memory care when CNA 8 came and got her to help LPN 6 with an issue. Upon entering Resident B's room with LPN 6, the resident was found face down with blood around her. She called the resident's name several times with no response. Both nurse's had no idea of Resident B's code status, so she went to the nurse's desk and found that the resident was a DNR. Due to taking around 10 minutes for the firemen to arrive, the 2 nurses and CNA 8 turned Resident B over to get a pulse oximetry reading. LPN 6 reported Resident B had a pulse over 100 and oxygen saturations in the 60's, so oxygen was applied to the resident. The firemen then arrived to take over. LPN 7 indicated, she did not perform CPR on Resident B, nor did she see LPN 6 initiate CPR. During an interview with CNA 8 on 10/8/19 at 11:15 a.m., she indicated, on 10/3/19 she started work at 11:00 p.m. and did resident rounds per her normal routine. A few minutes after 11:00 p.m., Resident B was observed sitting on the side of the bed, she requested a snack like she frequently did, and was told she could have those little sausages she liked. Resident B was observed again around 11:10 p.m. to 11:15 p.m. as CNA 8 came back up the hallway, and she told the resident she'd be back soon with her snack when she finished bed check. CNA 8 saw CNA 9 coming down the 300 hallway and asked her to go get briefs out of Resident B's closet. CNA 9 went into Resident B's room, then came running back down the hallway saying the resident was on the floor. CNA 8 ran to Resident B's room and found the resident face down on the floor. CNA 9 went to get LPN 6 and he returned. CNA 9 then went to get LPN 7 and she came also. CNA 8 called 911 due to the large amount of blood, which was their policy. LPN 6 started CPR after the 3 of them turned the resident			

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	over. Both LPN 6 and LPN 7 were observed assessing the resident. CNA 8 left the room to go answer an emergency light, then opened the back door for the firemen and directed them to Resident B's room. It took more than 5 minutes for the firemen to arrive. CNA 8 propped the back door, and directed the paramedics to Resident B's room. When the ambulance arrived, the firemen asked the paramedics for the heart monitor to check for vitals. During an interview with CNA 9 on 10/8/19 at 11:32 a.m., she indicated, on the night of 10/3/19 she was working the 300 hallway. After coming out of another room, she went to Resident B's room to get briefs, and found her on the floor. Resident B looked like she had fallen forward off the bed, as she was face down away from the bed towards the window. CNA 9 ran to the nurse's desk and told CNA 8, and she was instructed to go find LPN 6. LPN 6 and CNA 9 went to Resident B's room while CNA 8 stayed at the nurse's desk and called 911. LPN 7 and CNA 8 went to Resident B's room, and they assessed the resident. It was hard to tell where Resident B hit her head due to all the blood. The resident was rolled over, and there was blood everywhere. LPN 6 put oxygen on Resident B, and he started CPR. LPN 7 went to the nurse's desk to find the code status, and found out the resident was to be a no code, so LPN 6 stopped CPR. Firemen arrived within 5-10 minutes of LPN 6 stopping CPR. CNA 8 let the firemen in. CNA 9 did not go back down to the room with the firemen, she stayed at the desk to answer the call lights and the telephone. Resident B routinely used her call light often, but when she was found there had been no noise like a thump on the floor, and no call light. Resident B would usually use her call light about every 5 minutes.			

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	During a phone interview with LPN 6 on 10/8/19 at 11:44 a.m., he indicated, from the time he stopped CPR on Resident B until the firemen arrived, it was a few seconds. The firemen hooked Resident B up to the machines and she was flat lined. The firemen asked for and looked at paperwork to assure she was a no code status, and he did not remember the firemen doing CPR after they arrived. LPN 6 called the DON, when the fireman went back to room and took over scene. Paramedics had already arrived and hooked her up to their machines, and decided she had passed, and he was present when they called the time at about 11:56 p.m. On 10/7/9 at 5:16 p.m., the ADON provided a policy, titled, "Cardio-Pulmonary Resuscitation (CPR)" dated 9/1/15. The policy indicated, "It is the intent of the facility to ensure that all residents suffering a cardiac or respiratory arrest will receive the treatment of CPR unless the resident has a Do Not Resuscitate Order ...1. Check chart for code status on a resident Physician Orders for Scope of Treatment Form [POST] or the State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order Form. 2. Assess resident to determine respirations have ceased/palpate or auscultate for absence of pulse/heartbeat ...3. If a resident who wishes to be resuscitated or has no Advanced Directives, appears to be having an arrest, the licensed nurse will assess the resident for absence of heartbeat using a stethoscope or palpate pulses and assess for absence of respirations. Call for assistance ...10. Maintain basic life support until ambulance arrives for transport to hospital ...12. Complete documentation in the Nurse's Notes...." This Federal tag relates to Complaints IN00308423			

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	and IN00308794.			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to determine a root cause and ensure fall preventative interventions were implemented, and the care plan updated, for 1 of 2 residents reviewed for falls with significant injury (Residents C). Finding includes: During a random observation on 10/7/19 at 12:50 p.m., Resident C was observed on the secured memory care wing, ambulating independently down to the end of the hallway with his walker, his gait was slow and steady. The resident attempted to exit the end doors to an outside courtyard by shaking the door handle repeatedly, then ambulated back to the middle of the hallway and sat in a chair across from nurse's charting desk. A report for Resident C, titled, "Indiana State Department of Health Survey Report System", dated 9/10/19 at 11:45 a.m., indicated, "The therapy director heard a noise coming from the Memory Care dining room. She investigated the noise and found [Resident C] on the floor. During	F 0689	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; It is the policy of this facility to maintain an environment free of accidents, and hazards. Preventive measures were evaluated and care plans were updated as indicated for Resident C. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be impacted by this deficient practice. - what measures will be put into place and what systemic changes will be made to ensure	10/28/2019

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	his assessment he became nauseated and vomited ...Reported to [Nurse Practitioner] and new order received to send resident to [local hospital] ...9/14/19 investigation completed, resident returned from [area hospital] 9/12, alert with no negative outcomes. Care Plan was revised as indicated...." A record review was completed for Resident C, on 9/7/19 at 1:30 p.m. The record indicated, the resident was admitted on 9/5/19. Diagnoses included, but were not limited to, traumatic subdural hemorrhage without loss of consciousness, repeated falls, and vascular dementia without behavioral disturbance, anxiety disorder, and cognitive communication deficit. A Fall Assessment for Resident C, dated 9/5/19, indicated, the resident had no fall history within the last 3 months. A Fall Risk Review for Resident C, dated 9/14/19, indicated, the resident had a history of falls within the last 3 months. The assessment score of 14 indicated, Resident C was at high risk for falls. A History and Physical for Resident C, dated 9/10/19, the Assistant Director of Nursing (ADON) indicated, contained documentation from the hospital regarding the residents fall with significant injury. The report indicated, "Patient with vascular dementia who presents after a mechanical fall from standing at this facility with a new acute subdural hematoma with midline shift. He states he was walking and was trying to turn when he ran into another person, fell and hit his head on the pavement ...Computed Tomography [CT] Head: Acute subdural hematoma along the right frontal parietal convexity measuring 1.4 centimeters [cm] in greatest depth with associated		that the deficient practice does not recur Staff have been educated/ in-serviced by the Director of Nursing on the policy for Falls and Fall Interventions on 10.15.19 and 10.16.19. Facility staff was initially in serviced on 9.25.19, by the Director of Nursing on the facility's policies on "Personal Care items" and "Falls and Fall Interventions. A second and third in-service was scheduled for 10.15.19 and 10.16.19 and completed to assure 100% attendance of all nursing staff. This in-service will be conducted by both the DON and Administrator. Any staff who fail to comply with the information provided during the in-service will be further educated or progressively disciplined as indicated. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and DON/Designee will monitor falls daily that occur 5x weekly for 4 weeks. After that, monitoring will be done weekly for a period of not less than 6 months to ensure ongoing compliance. Any concerns will be addressed as discovered. DON/ADON will monitor falls daily in the morning clinical (CQI)	

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	right to left midline sift up to 3 millimeters [mm]. Given the hypo density within, active hemorrhage not excluded ..." An Interdisciplinary Team (IDT) note for resident C, dated 9/14/19 at 11:50 a.m., the Director of Nursing (DON) documented, "Resident had a fall while ambulating. Has a shuffling quick gait and forgets to use his walker. He is often looking for his car, or where to purchase a car, or a way to [get home]. This also prompts him to get up unassisted and go looking for things. Psych to follow up for the anxiety the resident is feeling related to his situation. He continues with PT for his shuffling gait and walker education. Care plan reviewed and updated." Resident C's care plans included, but were not limited to, "9/5/19 Focus: The resident is risk for falls related to confusion, deconditioning. Goal: The resident will be free of falls through the review date. Interventions: Anticipate and meet the resident's needs. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Follow facility fall protocol. PT [Physical Therapy] evaluate and treat as ordered or PRN [as needed] ..." During an interview on 10/7/19 at 4:32 p.m., the ADON indicated, Resident C fell on 9/12, and had an IDT note dated 9/14/19 that indicated, the resident care plan had been reviewed and updated. Review of Resident C's care plan indicated, he had an initial care plan dated 9/5/19 upon admission, but the care plan had not been updated with new interventions following his fall with significant injury on 9/10/19. The ADON indicated, the original care plan was not updated following his fall as therapy was already documented in the original care plan. The care		meeting and new intervenes will be added for each fall. Falls will be discussed to ensure that new and appropriate interventions are in place in anticipation of falls for residents at risk, and after each fall. The DON/ADON will use the FALLS QA Tool daily at the CQI meetings to follow each fall. The results of this monitoring will be presented at the monthly QAPI meetings. Any concerns will have been addressed. Any concerns will have been addressed. However, if any patterns are identified. If needed, an Action Plan will be written. Any needed Action Plan will be monitored weekly by the Administrator weekly until resolved. Corrections will be completed by 10/28/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. BUILDING 00 B. WING	10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALPHA HOME - A WATERS COMMUNITY	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

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	plan as written would not indicate Resident C had a fall, and did not reflect the resident's current status. During an interview on 10/7/19 at 4:45 p.m., the ADON indicated, if a resident fell, the nurse should have assessed the resident to include range of motion, neurological checks, a skin assessment and vital signs. If the resident was not hurt or had a fracture, he would be gotten up off of the floor. The family, physician, ADM, and DON were to be notified of the fall, and information regarding the fall thoroughly documented. New fall interventions were to immediately be put into place by the attending nurse. Administrative staff were responsible for reviewing the fall and care plan, and adding new interventions, and documenting on the fall. During the care plan clinical meeting, the fall would be reviewed, interventions put into place, and the care plan updated, as well as new orders being added as needed. During an interview on 10/8/19 at 10:15 a.m., the Minimum Data Set (MDS) nurse indicated, she was mostly responsible for writing the initial care plan, writing IDT notes, and updating care plans, although any nurse was allowed to update care plans as needed. Resident C had an initial care plan for risk of falls written upon admission 9/5/19. The MDS nurse reviewed the chart after Resident C's fall and as the nurse at the time of the incident did not add a new intervention in the progress notes, the MDS nurse did not update the care plan. It was not required that the MDS nurse only add what nurses put in the progress notes, but that was the process in that building. On 10/7/19 at 5:16 p.m., the ADON provided a policy, titled, "Incidents/Accidents/Falls",			

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	undated. The policy indicated, "The facility will ensure that incidents and accidents that occur involving residents are identified, reported, investigated and resolved ...11. All falls will have a site investigation by appropriate staff in an effort to define the [root cause] of the fall. This will help provide information to enable staff to roll out interventions to prevent another similar occurrence. Note: Each fall needs a new intervention rolled out ...12. Some occurrences will require a more extensive investigation process. These include but are not limited to ...falls with significant injury...15. Based on the results of the incident/accident/fall, the resident's care plan will be addressed to ensure that any needed points of focus have measurable goals with appropriate interventions in place...." This Federal tag relates to Complaints IN00308423 and IN00308794. 3.1-45(a)(2)			