STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 00 B. WING	07/30/2021

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ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND ST INDIANAPOLIS, IN 46250

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00358375, IN00358511, IN00359288, and IN00359406. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00358375 - Substantiated. Federal/state deficiencies related to the allegations are cited at F842 and F880. Complaint IN00358511 - Unsubstantiated due to lack of evidence. Complaint IN00359288 - Unsubstantiated due to lack of evidence. Complaint IN00359406 - Substantiated. Federal/state deficiencies related to the allegations are cited at F692. Survey dates: July 29 and 30, 2021 Facility number: 000172 Provider number: 155272 AIM number: 100267130 Census Bed Type: SNF/NF: 124 Total: 124 Census Payor Type: Medicare: 6 Medicaid: 103 Other: 15 Total: 124 These deficiencies reflect State Findings cited in	F 0000	The Plan of Correction is the center's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. The facility respectfully requests a desk review for this plan of correction.	

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

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	accordance with 410 IAC 16.2-3.1. Quality review completed August 4, 2021			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview and record review, the facility failed to ensure daily weights and/or routine weights were obtained and accurately document meal intake for 3 of 5 residents reviewed for nutrition. (Resident C, Resident K and Resident M) Findings include: 1. The clinical record for Resident C was reviewed on 7/29/21 at 2:30 p.m. The diagnoses included,	F 0692	1) Resident C is part of a confidential survey and could not be identified. Resident K is part of a confidential survey and could not be identified. Resident M is part of a confidential survey and could not be identified. 2) All residents that reside in the facility have the potential to be affected. An audit was conducted on the all	08/26/2021

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	but were not limited to, tracheostomy status, congestive heart failure and lymphedema. A nutrition care plan, initiated on 5/28/21, indicated the following, " ...Resident has nutritional problem/potential nutrition problem Disease process, Effects of diuretic; acute + chronic RF [respiratory failure] ...CHF [congestive heart failure] ...Interventions ...Obtain daily weights for residents as needed per medical conditions ...." A hospital discharge summary, dated 5/26/21, indicated the following, " ...DISCHARGE INSTRUCTIONS ...SELF-CARE/DAILY WEIGHT INSTRUCTIONS ...Weigh yourself at the same time with the same scale every day ...Weight gain of more than 3 pounds in one day or 5 pounds in five days, you need to call your Health Care Provider ...." There was no physician order for initiation of daily weights during Resident C's stay at the facility. The following weights were noted in Resident C's clinical record: 5/26/21 of 348.5 pounds, 6/6/21 of 348.3 pounds, 6/10/21 of 348.3 pounds, & 7/1/21 of 340.5 pounds. 2. The clinical record for Resident K was reviewed on 7/30/21 at 5:18 p.m. The diagnoses included, but were not limited to, Parkinson's disease, dementia, and diabetes mellitus. An Annual Minimum Data Set (MDS) assessment, dated 6/23/21, noted Resident K needing		the residents for the last 30 days to identify if their daily/routine weight was obtained. Those residents identified as not having their physician ordered weight obtained were weighed immediately and the physician, family, and registered dietician would notified of the omission and the new weight. An audit of the last 14 days meal intake was conducted and those residents identified as having omissions in their meal intake documentation had their physician and family notified of the omission and a reweight obtained to ensure no weight loss occurred. 3) The DON/Designee has in-serviced nursing staff on the facility's policies identified as, "Resident Height and Weight", "Clinical Documentation" and "Physician Orders" with emphasis on obtaining and recording physician ordered weights and documentation of meal intake. 4) The DON/Registered Dietician/Designee will audit 20 residents weekly x 4 weeks, then 15 residents weekly x 4 weeks, then 10 residents weekly times 4 weeks for documentation of meal intake. The DON/Registered Dietician/Designee will audit 10 residents weekly x 4 weeks, then 5 residents weekly x 4 weeks, then 3 residents weekly x 4 weeks to ensure daily/routine weights	

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	extensive assistance with 1 staff person for eating. An Activities of Daily Living (ADL) care plan, revised 2/19/21, indicated Resident K may require 1 staff person assistance with meal setup. A nutrition care plan, revised 7/23/21, indicated the following, " ...[Name of Resident K] is at risk for nutritional decline r/t [related to] dementia, DM [diabetes mellitus], obesity, and Parkinson's diagnosis ...Interventions ...Monitor and evaluate food/beverage intake via meal intake records and observation ...Monitor and evaluate weight/weight change ...." The following weights were noted for Resident K: 1/1/21 of 203.3 pounds, 2/2/21 of 203.3 pounds, 3/3/21 of 206 pounds, 4/4/21 of 212 pounds, 5/3/21 of 215 pounds, No weight noted for June of 2021, 7/13/21 of 148.2 pounds, & 7/22/21 of 152 pounds. An observation conducted of Resident K's meal tray, on 7/30/21 at 5:45 p.m., noted only a few bites were taken and multiple cans of soda and wrappers of snacks were noted on the tray as well. Interview conducted with Certified Nursing Assistant (CNA) 2 indicated Resident K mostly drinks soda and eats candy. She hasn't eaten much food for meals since CNA 2 has been working with her since May of 2020. An interview conducted with CNA 6, on 7/30/21 at 5:48 p.m., indicated Resident K does not have much of an appetite. She enjoys her soda, candy and ensure supplement.		have been obtained and recorded. 5)	

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A document including the meal intakes for Resident K indicated she consumed 76-100% of dinner eaten for 7/30/21.

An interview conducted with Corporate Nurse 4, on 7/30/21 at 6:11 p.m., indicated there was a bad cell in the scale and it was fixed in July of 2021. The scales are usually calibrated every 6 months but unsure of when the last time the scale was calibrated.

An invoice, dated 7/16/21, indicated a "load cell" was replaced in the scale and the scale was calibrated on such date.

3. The clinical record for Resident M was reviewed on 7/30/21 at 6:00 p.m. The diagnoses included, but were not limited to, cerebral infarction and congestive heart failure.

A nutrition care plan, revised 3/19/21, indicated the following, " ...[Name of Resident M] is at risk for nutritional decline related to: oral/dental problems ...CHF [congestive heart failure], wt [weight] refusal, and major depressive disorder ...Interventions ...Monitor & evaluate weight/weight changes ...."

The following weights were noted for Resident M:

7/9/2020- 126 pounds,
8/7/2020- 127.4 pounds,
9/7/2020- 125.5 pounds,
4/2/2021- 118.2 pounds, &
5/3/2021- 120 pounds.

There were no other weights located in Resident M's clinical record. There was no documentation that Resident M refused the weights on the

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	months where there was no weight obtained or documented. A policy titled "Resident Height and Weight", revised 7/16/21, was provided by Corporate Nurse 4 on 7/30/21 at 5:47 p.m. The policy indicated the following, " ...It is the policy of this facility that a resident's height and weight will be accurately obtained within 24 hours of admission if the resident is able. Weights will be obtained with changes in condition or as ordered by the physician or practitioner ...Procedure for obtaining weight ...Obtain weight on scales that have been calibrated per the manufacturing recommendations ...9) Reweight Parameters ...a) A plus/minus of 5 pounds of weight in one week will result in ...i) Reweight within 24 hours ...(1) Validation with nurse for accurate weight ...(2) Notify IDT [interdisciplinary team] team/doctor/family, if indicated ...10) Monthly Weights ...Obtain monthly weights by the 7th day of the month in order to effect changes if indicated ...." This Federal tag relates to Complaint IN00359406. 3.1-46(a)(1)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.			

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	§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge			

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	when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on observation, interview and record review, the facility failed to ensure accuracy of documentation that reflected orders for transmission-based precautions (TPB) that were observed not to be in use for 2 of 3 residents reviewed for TBP. (Resident J and Resident H) Findings include: 1. The clinical record for Resident J was reviewed on 7/30/21 at 11:39 a.m. The diagnoses included, but were not limited to, arthritis, muscle weakness and obesity. Resident J was admitted to the facility on 7/2/21. A physician order, dated 7/2/21, indicated to place Resident J in droplet precautions every shift with no stop date noted. The order was still current. An observation was conducted of Resident J's room, on 7/30/21 at 10:15 a.m. There was no	F 0842	1) Resident H is part of a confidential survey and could not be identified. Resident J is part of a confidential survey and could not be identified. 2) All residents that reside in the facility on transmission based precautions (TBP) have the potential to be affected by the alleged deficient practice. An audit was conducted on all residents that have orders for TBP to ensure the order is current, accurate, and implemented. Any resident identified as having a discrepancy with their TBP orders has had their physician and family notified and plan of care updated accordingly. 3) All licensed nursing staff has been educated on the facilities policies identified as, “Physician Orders” and “Criteria for COVID-19	08/26/2021

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	signage on the door nor personal protective equipment located outside the room. Certified Nursing Assistant (CNA) 8 answered Resident J's call light and entered the room without donning personal protective equipment (PPE). 2. The clinical record for Resident H was reviewed on 7/30/21 at 11:20 a.m. The diagnoses included, but were not limited to, fracture of nasal bones, emphysema, and dislocation of jaw. Resident H was admitted to the facility on 7/28/21. A physician order, dated 7/28/21, indicated to place Resident H in droplet precautions every shift for new admission. The order was still current. An observation was conducted of Resident H's room on 7/30/21 at 9:35 a.m. There was no signage posted on the door and/or PPE located outside of the room to indicate the need for TBP. Resident H was interviewed at the time, and he indicated he was fully vaccinated against COVID-19. An interview conducted with the Director of Nursing (DON), on 7/30/21 at 6:25 p.m., indicated the orders for droplet precautions come up automatically for each newly admitted resident. It's up to the staff to discontinue that specific order if it doesn't apply to the resident or put a stop date for the certain duration. The COVID-19 LTC (long-term care) Facility Infection Control Guidance Standard Operating Procedure, revised 7/21/21, indicated the following, " ...Unknown COVID-19 status (Yellow) ...Symptom Observation - Residents in yellow status who do not undergo testing can be transferred to the COVID-19 negative areas of the facility if they remain afebrile and without		Isolation" with emphasis on TBP implementation and discontinuation. 4) The DON/Designee will audit TBP orders and through observation will validate if TBP are in place/not in place per physician order per the following schedule: 5 residents weekly x 8 weeks, 5 residents monthly x 4 months. 5) The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. ="" p="">	

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	symptoms for 14 days after their exposure (or admission) ...." This Federal tag relates to Complaint IN00358375. 3.1-50(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other			

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	persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 0880	**F 880**	08/26/2021

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	Based on observation, interview and record review, the facility failed to prevent and/or contain the spread of COVID-19 by failure to complete a full 14-day quarantine for an unvaccinated newly admitted resident, not conducting hand hygiene with soiled gloves touching items in a room during perineal care, and not covering and/or containing a bedpan while not in use for 1 of 1 observation for perineal care and 1 of 3 residents reviewed for transmission-based precautions. (Resident C and Resident J) Findings include: 1. The clinical record for Resident C was reviewed on 7/29/21 at 2:30 p.m. The diagnoses included, but were not limited to, tracheostomy status, congestive heart failure and lymphedema. Resident C was admitted to the facility on 5/26/21. A physician order, dated 5/27/21, indicated to place Resident C in droplet precautions. The order was discontinued on 6/4/21 when Resident C went out to the hospital, and he then returned on 6/5/21. There were no further orders for Resident C to be on droplet precautions during his stay. 2. An observation was conducted of perineal care for Resident J on 7/30/21 at 10:15 a.m. Certified Nursing Assistant (CNA) 8 was attempting to find a bed pan to place Resident J on. Writer pointed out there was a light green colored bed pan located within the footboard and a rail where it fit securely without a cover present. CNA 8 donned gloves and proceeded to remove the front of Resident J's brief and turned Resident J onto her left side to place the light green colored bed pan under Resident J. CNA 8 removed a liner that was in Resident J's brief prior to placing the bed pan. She had the liner in her soiled gloved hand and		**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** The residents identified are confidential related to complaint investigation. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice. The DON or designee will complete the following: ·Ensure resident/residents affected/potential affected are isolated in Transmission Based Precautions according to CDC and IP recommendations and ensure care giving staff are educated on isolation procedures. Ensure all staff are aware of who is on isolation and appropriate signage implemented. Policy: Criteria for Covid 19 isolation ·Ensure staff involved are educated on how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, and eye	

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	used the other soiled gloved hand to open 2 cabinet drawers in Resident J's room in attempt to locate something. CNA 8 then opened the bathroom door with the soiled gloved hands and placed the liner in the trash can. CNA 8 then proceeded to remove the bed pan from Resident J and conduct perineal care. She placed the bed pan within a bag in the bathroom, placed trash in the trash can, and then doffed her gloves to take the trash out of the room. No hand hygiene was performed prior to donning and after doffing gloves. An interview conducted with the Director of Nursing (DON), on 7/30/21 at 6:25 p.m., indicated the orders for transmission-based precautions (TBP) come up automatically for each newly admitted resident. It would be up to the staff to put a stop date on the order for the certain time they are to be on TBP. The bed pans should be contained and covered when not in use. Hand hygiene should be conducted before and after donning/doffing gloves and remove gloves when they are soiled. The COVID-19 LTC (long-term care) Facility Infection Control Guidance Standard Operating Procedure, revised 7/21/21, indicated the following, " ...Unknown COVID-19 status (Yellow) ...Symptom Observation - Residents in yellow status who do not undergo testing can be transferred to the COVID-19 negative areas of the facility if they remain afebrile and without symptoms for 14 days after their exposure (or admission) ...." A policy titled "Standard Precautions", revised 4/1/17, was provided by the DON on 7/30/21 at 5:51 p.m. The policy indicated the following, " ...Policy ...When hands are not visibly soiled,		protection. Follow CDC and facility policy. Policy: USE OF PPE WHILE IN THE FACIITY CDC: PPE sequence Competency: AAPACN Personal-Protective-Equipment-PPE-Donning-and-Doffing ·Ensure staff involved are educated, with return demonstration, for hand hygiene (hand washing and ABHS) and understand when to perform hand hygiene. Follow CDC guidance and facility policy. Ensure Hand Hygiene items, including soap and water or ABHS are available at all times. Policy: General Hand Hygiene Competency: AAPACN Hand Hygiene Competency ·Ensure are reusable personal care items such as bedpan and urinals are covered and properly identified for personal use per resident. Policy: regarding appropriate storage of personal care items such as bedpan and urinals	

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	155272	A. BUILDING 00 B. WING	07/30/2021

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	alcohol-based hand sanitizers are the preferred method for cleaning hands in this healthcare setting ...II. When to perform Hand Hygiene ...B. Before and after direct contact with a resident's intact skin ...1. Examples include but not limited to taking B/P [blood pressure], lifting, repositioning in bed, taking pulse, etc ...C. After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings ...G. After glove removal ...." This Federal tag relates to Complaint IN00358375. 3.1-18(b)(2) 3.1-18(l)		**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** A Root Cause Analysis (RCA) was conducted with the Infection Preventionist (IP) and input from the IDT and the facility Medical Director/IP/DON. The root cause was identified resulting in the facility's failure. Solutions were developed and systemic changes were identified that need to be taken to address the root cause. The Infection Preventionist and IDT reviewed the LTC infection control self-assessment and identified changes to make accurate **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** After the IDT and Infection Preventionist completed the RCA and LTC infection control assessment, training identified above was implemented to facility staff. The training will be conducted by the DON, IP or Medical Director with documentation of completion. To ensure Infection Control Practices are maintained, the	

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			following monitoring will be implemented. 1. The IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA and as noted above, daily or more often as necessary for 6 weeks and until compliance is maintained. ensure a complete full 14 day quarantine is implemented for unvaccinated newly admitted residents, staff is are aware of who is on isolation and appropriate signage implemented. ensure execute proper donning and doffing of PPE, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection ensure staff execute proper hand hygiene prior to donning and after doffing ensure reusable personal care items such as bedpan and urinals are covered and properly identified for personal use per resident 2. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions	

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			identified in B1 as above. This will occur for 6 weeks and until compliance is maintained. Infection Control Practices ensure a complete full 14 day quarantine is implemented for unvaccinated newly admitted residents, staff is are aware of who is on isolation and appropriate signage implemented. ensure execute proper donning and doffing of PPE, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection ensure staff execute proper hand hygiene prior to donning and after doffing ensure reusable personal care items such as bedpan and urinals are covered and properly identified for personal use per resident **Quality Assurance and Performance Improvement (QAPI):** The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	