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

FORM APPROVED
OMB NO. 0938-039

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	09/18/2019

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00304533. Complaint IN00304533- Unsubstantiated due to lack of evidence. Survey dates: September 12, 13, 16, 17, and 18, 2019. Facility number: 000376 Provider number: 155717 AIM number: 100275510 Census Bed Type: SNF/NF: 57 Total: 57 Census Payor Type: Medicare: 7 Medicaid: 36 Other: 14 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 26, 2019.	F 0000	In lieu of revisit, I would like respectively request a desk review ="" p="">	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, interview, and record review, the facility failed to ensure a resident was dressed and positioned in the chair during lunch service, in the dining room for 1 of 1 random	F 0550	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	10/18/2019

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	observation (Resident 9). Staff failed to knock on doors before entering resident rooms for 8 of 8 random observations (Residents 1, 23, 9, 52, 46, 45, 24, 25). Findings include: 1. On 9/16/19, a continuous observation from 12:20 p.m. to 12:58 p.m., Resident 9 was observed in the dining room, with 15 other residents present. He was not wearing pants. At 12:25 p.m., Resident 9 put his legs over the arm of the chair, toward the rest of the dining room, his legs were apart exposing his soiled brief. No staff member intervened. At 12:38 p.m., Resident 9 put his legs over the arm of the chair, toward the rest of the dining room, his legs were apart exposing his soiled brief. No staff member intervened. At 12:55 p.m., Resident 9 put his legs over the arm of the chair, toward the rest of the dining room, his legs were apart exposing his soiled brief. No staff member intervened. At 12:58 p.m., Licensed Practical Nurse (LPN) 9 asked Resident 9 to get up to get some pants on. On 9/17/19 at 11:54 a.m., the Administrator indicated it was his expectation staff members should have stopped what they were doing to make sure Resident 9 was properly dressed in front of his peers. A current policy, titled, "Resident Rights," with no date, was provided by the Administrator on 9/18/19 at 9:05 a.m. A review of the policy indicated, " ...the facility will treat you with dignity		It is the expectation of this facility to follow the policy and procedure regarding our resident rights/exercise of rights policy. This includes knocking on doors before entering a resident's room and ensuring the dignity and care for each resident is promoted to maintain or enhance his or her quality of life. Resident 9 is appropriately dressed and positioned in their chair for meals. Residents 1. 23, 9, 52, 46, 45, 24 and 25 have the privacy respected and staff knock on the door, announce themselves and ask permission to come into the residents' rooms prior to entry. - 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 can be negatively impacted by this deficient practice. - 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 in-serviced on 9/25/2019 on the "resident rights/dignity" policy by the DON. A second and third in-service is scheduled for	

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	and respect ...." 2. On 9/12/19 at 10:36 a.m., the Maintenance Director (MM) did not knock when entering Resident 1's room. Resident 1 was in the room, sitting in his wheelchair. On 9/12/19 at 10:39 a.m., the MM walked into Resident 23's room, he did not knock when entering. Resident 23 was lying in bed. On 9/12/19 at 10:42 a.m., the MM, Licensed Practical Nurse (LPN) 10, and Certified Nursing Aide (CNA) 11 walked into Resident 1's room, no one knocked on his door. On 9/12/19 at 11:25 a.m., the MM walked into Resident 9 and Resident 23's room, he did not knock when entering. Both residents were in the room. On 9/12/19 at 9:56 a.m., during an interview with Resident 52, a Housekeeping Aide, (HK 21), entered the Resident's room without knocking on the door. At that time, Resident 52 had been describing his complications from constipation, and needed to stop and wait for the staff member to finish. Shortly after HK 21 walked in, the Housekeeping Supervisor (HKS) walked in without knocking. The two finished cleaning and replaced an air filter before leaving he Resident's room so the interview could continue. Resident 52 indicated, normally it did not bother him if staff entered his room without knocking, but becuase he was not feeling good, and had to get on and off the bedside commode, he prefered them to knock so he could ask them to stay out if we was on the toilet. On 9/12/19 at 10:01 a.m., during an interview with Resident 46, the HKS walked into the room		10/15/19 and 10/16/19 on the “resident rights/dignity” policy to assure 100% attendance of all facility staff. This in-service will be 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 resident rights/dignity 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 The DON/ADON/SSD or designee will be responsible for implementing QA tool titled “F550” for 5 days a week for four weeks, 3 days a week for four weeks. Then monitoring will occur 2 days a week for a period of no less than 6 months to ensure ongoing compliance. This tool will be used to monitor compliance as it relates to proper attire and positioning at mealtimes as well as proper procedure to maintain dignity prior to entering a resident’s room. The results of the monitoring will be presented to the QAPI Committee at the monthly meetings. Any concerns will have been	

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	without knocking. She gathered a few things and then atempted to help fix the Resident's T.V. remote. The private interview could not be completed at this time. On 9/12/19 at 2:33 p.m., during an interview with Resident 45, the Assistant Director of Nursing (ADON) walked into the room without knocking. He began to put on gloves and change the Residents sheets. The private interview could not be completed at this time. On 9/13/19 at 10:14 a.m., during an interview with Resident 24, (while her roommate, Resident 25, laid in bed) Certified Nursing Assistant (CNA) 22 walked into the room without knocking. At that time, Resident 24 had been describing complications with incontinence and a sore area on her bottom. CNA 22 walked to the foot of the Resident's bed, and indicated, he would be right back to help her, he was with another resident at the moment. When he left the room Resident 24 indicated she did not have her call light on and did not need assistance. Several moments later, CNA 22 entered the room a second time without knocking, came to the foot of Resident 24's bed and indicated, he was still waiting for the lady next door, who had an accident, and needed to be cleaned up before he could come help Residnet 24. When CNA 22 left, Resident 24 shrugged her shoulders, and indicated, "must be because of you." Residnet 25 indicated, staff never knocked before coming into the rooms. During an interview, with the Administrator, on 9/17/19 at 11:02 a.m., he indicated staff should be knocking on resident's door before entering rooms. At this time he provided current, undated facility policies. The first policy was titled, "Dignity" and indicated, "...staff will be polite and		addressed. However, if any patterns are identified. If needed, an Action Plan will be written by the QAPI committee. Any written Acton Plan will be monitored by the Administrator weekly until resolved. - by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Corrections will be completed by October 18, 2019.	

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	respectful at all times... staff wil knock prior to entering a resident's room. They will announce themselves and ask permission to enter...." The second policy was titled, "Resident Rights" and it indicated, "...Privacy- your privacy will include: personal care, medical treatments, telephone use, visits, letters, and meetings of family and resident groups... Dignity- the facility will treat you with dignity and respect in full recognition of your individuality...." 3.1-3(p)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to accurately complete a comprehensive assessment for 1 of 3 residents reviewed for closed records, (Resident 57). Findings include: On 9/17/19 at 10:57 a.m., Resident 57's medical record was reviewed. Resident 57 was admitted on 6/21/2019, on Hospice care, with diagnoses to include, but were not limited to: vascular dementia, anxiety, and heart disease. A nursing progress note, dated 6/25/19 at 7:48 a.m., indicated, "...alert to self with confusion...Hospice continues...." A comprehensive admission MDS (Minimum Data Set) assessment, dated 6/29/19 did not reflect Resident 57's chronic health condition, which had the potential to result in a life expectancy of less	F 0641	Resident 57 no longer resides in the facility All residents who are on hospice have the potential to be impacted by this deficient practice The MDS Coordinator was in-serviced on accurately completing comprehensive assessments by the Regional MDS consultant on 9/17/19, once the mistake was identified and bought to the facility's attention. The Regional MDS consultant will follow up and review all hospice comprehensive assessments monthly for 6 months to ensure compliance. Any concerns will be addressed if found.	10/18/2019

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	than 6 months, on section J1400, and the assessments did not identify Resident 57 was receiving Hospice services, on section O, question k. During an interview on 9/17/19 at 1:30 p.m., the MDS Coordinator indicated Resident 57 was a Hospice patient, and should have been coded as such, on MDS following the RAI (Resident Assessment Manual) requirements. She follwed the RAI Manual to complete resident assessments accurately.		The results of the monitoring will be presented to the QAPI Committee at the monthly meetings. Any concerns will have been addressed. If any patterns are identified. If needed, an Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored weekly by the Administrator until resolved.	
F 0645 SS=D Bldg. 00	483.20(k)(1)-(3) PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to			

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	admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an			

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	intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.			
	Based on interview, and record review, the facility failed to obtain a Preadmission Screening and Resident Review (PASARR) Level II assessment for 2 of 2 residents with a Level I screening assessment, who required a Level II assessment (Residents 54 and 45). Findings include: 1. On 09/13/19 at 02:35 p.m., Resident 54's medical record was reviewed. The diagnoses included, but were not limited to delusional disorders. The comprehensive admission Minimum Data Set (MDS) assessment, dated 5/18/19, indicated Resident 54 did not have a PASARR Level II assessment, with a qualifying mental illness diagnosis. A PASARR Level I assessment, dated 12/13/16, was scanned into the resident records. This screen indicated Resident 54's diagnoses included psychotic/ delusional disorder, anxiety disorder, and psychosis. It indicated "...Your health care professional and (Name of Company) completed a Preadmission Screening and Resident Review Level I screen for you. The screen shows that you need a face-to-face Level II evaluation...." A PASARR Level II was not found in Resident 54's medical record. On 9/16/19 at 11:15 a.m., the Director of Nursing provided a copy of Resident 54's PASARR Level I screen. She indicated the Level I was the only	F 0645	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; In accordance with the regulation criteria for preadmission screening for individuals with a mental disorder and individuals with intellectual disability, the (PASARR) assessment/document for residents 54 and 45 has been completed and added to both resident's files. Resident 54 is a dementia exclusion, and does not require the (PASARR) level 2. All residents will have completed (PASARR) document prior to admitting to nursing facility per regulation. - 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 who are currently residing in the facility have the potential to be impacted by this deficient practice. A facility wide audit was conducted to ensure that any needed PASARRs were completed. - what measures will be put	10/18/2019

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	PASARR screen she found in the record. On 9/16 19 at 1:21 p.m., during an interview, the Administrator indicated Resident 54 came from another facility. He should have had a PASARR Level II. The document was not provided on admission. They had reached out to the transferring facility several times to get a copy of his Level II, and it was never provided. Resident 54 would need a new evaluation completed. They did not have a facility policy on PASARR, but followed the recommendations of (Name of Company) when a Level I assessment was required. Normally a Level II would then be scheduled. 2. On 9/16/19 at 1:06 p.m., Residnt 45's medical record was reviewed. Resident 45 had an admitting diagnoses to include, but were not limited to: paranoid schizophrenia, bipolar disorder, anxiety, borderline personality disrder, and suicidal ideations. A Pre-Admission Screening Resident Review (PASARR) Level I dated, 12/26/18 indicated Resident 45 required an onsite Level II assessment. No Level II was on the Resident's record. On 9/17/19 at 10:00 a.m., the Administrator provided a copy of Resident 45's Level II assessment and indicated it had been completed at her previous facility, but staff had failed to obtain the document upon the resident's admission.		into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff members that handle marketing and admissions for the facility were in-serviced on October 2, 2019 by the administrator, and informed that the facility will not admit any patients that require (PASARR) paperwork that is not completed prior to admitting to the facility. All required (PASARR) paperwork must be completed and sent to the facility for approval from the SSD/Administrator or designee before any potential admission can be accepted. At the morning meetings, pending admissions will be reviewed and the determination will be made related to need of a PASARR. The SSD/Designee will make any needs known to Admissions staff. - 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 The Administrator and SSD will monitor all admissions weekly for a period of 4 weeks, then 2 admissions weekly for a period of not less than 6 months to ensure that all needed PASARR	

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			paperwork has been obtained. This review by SSD/Designee of pending admissions will become an ongoing part of the CQI morning meeting agenda going forward. Any concerns will be addressed if found. The results of the monitoring will be presented to the QAPI Committee at the monthly QAPI meetings. Any concerns will have been addressed. However, if any patterns are identified. If needed, an Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. - by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Corrections will be completed by October 18, 2019	
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents.			

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	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 ensure the memory care area was free of potential accidents when a prescription medication was left on top of the medication cart (Resident 9) for 1 of 1 random observation, treatment medications and hygiene products were left in resident rooms for 1 of 1 tours of the unit (Resident 51, 23, 9, and 29), pills were found on the floor (Resident 45) during 1 of 1 random observation, and a resident who was determined to be a fall risk did not have a fall intervention in place for 1 of 1 observation (Resident 40). Findings include: 1. On 9/16/19 at 1:21 p.m., an observation of a medication card for Resident 9 was on top of the medication cart. It had one prescription pill in it for Xarelto (blood thinner) 20 mg. There was no nurse in line of sight of the medication cart. She was in the memory care dining room. Licensed Practical Nurse (LPN) 9 indicated she thought the medication card was empty, and if it had medication in it, the medication card should have been locked up. She put it back into the medication cart and locked it. On 9/17/19 at 11:38 a.m., the Administrator indicated prescription medications should not	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. The med cart located on memory care has been checked and cleared of potential accidents. All body wash and peri care items have been removed from the resident bathrooms, and moved to a secure location, that only staff has access to. A fall intervention has been in place for Resident 40. Residents 9, 51, 23, and 29 have no access to meds unattended or stored improperly. - 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	10/18/2019

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	have been left on top of the medication cart. It was concerning because it happened in the memory care area, where residents could have taken the medication off the medication cart and consumed it. 2. On 9/12/19 at 10:12 a.m., Resident 51's bathroom had a tube of Polident on the sink. The administrator provided the Safety Data Sheet (SDS) for Polident, it indicated for, "Ingestion: never attempt to induce vomiting. Obtain medical attention." On 9/12/19 at 11:30 a.m., the Administrator indicated the Polident should not have been in the resident's bathroom. 3. On 9/12/19 at 10:28 a.m., Resident 23 had a tube of Poligrip on his bedside table. He was in his bed. Resident 9, who also resided in that room was present. The administrator provided the SDS for Poligrip, it indicated for, "Ingestion: never attempt to induce vomiting. Obtain medical attention." On 9/17/18 at 11:47 a.m., the Administrator indicated the Poligrip should not have been in the reach of the memory care residents. 4. On 9/12/19 at 11:07 a.m., Resident 29's bathroom had a pink tub on the sink. It contained uncapped Calmoseptine with a pharmacy label for Resident 44, a tub of treatment medication for Resident 106 labeled as nyst/zno/a+d/dibu/benzoin tinc (nystatin: antifungal, zinc oxide: for skin irritations, Vitamins A and D, dibucaine: for skin irritations, benzoin tincture: skin antiseptic), and a small container of Mouth Rinse.		that the deficient practice does not recur The licensed nurse that was responsible for the Med Cart where the prescription medication was left on top of the cart has been educated/ in-serviced by the Director of Nursing on the policy for “Medication Administration” on 10/2/19. 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 is scheduled for 10/15/19 and 10/16/19 to educate staff on the facility’s policies on “Medication Administration”, “Personal Items”, and “Falls and Fall Inventions” to assure 100% attendance of all facility 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 med passes 5 med passes weekly on a rotating basis of nurses on various shifts to include some weekend shifts for a period of 4	

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	The administrator provided the SDS for the Calmoseptine and Mouth Rinse. The Calmoseptine indicated, " ...In case of accidental ingestion seek profession assistance or contact a Poison Control Center immediately ...." For the Mouth Rinse, it indicated for, "...ingestion call a physician or Poison Control Center. On 9/12/19 at 11:49 a.m., the Administrator indicated there should not have been any prescription medications in resident rooms, along with any other products like Mouth Rinse, Poligrip, or Polident. On 9/13/19 at 10:08 a.m., the Administration indicated Resident 15 wandered in the memory care area. A current policy, titled, "Homelike Environment," dated August 17, was provided by the Administrator on 9/18/19 at 9:05 a.m. A review of the policy indicated, " ...It is the policy of the facility to ensure that the environment provided by the facility is safe, sanitary, functional and comfortable ...Items that say "Keep out of reach of children" will be kept in a secure area for for [sic] safety for resident who have Dementia or who are confused as to the used of these products." 5. On 9/12/19 11:30 a.m., Resident 45's room was observed. A large white oblong pill was observed on the second bed in the room. Resident 45 indicated she did not have a roommate and the pill was hers. Resident 45 indicated she spit the pill out because it gave her diarrhea. On 9/12/19 at 11:32 a.m., Licensed Practical Nurse (LPN) 23 observed the pill on the bed. When she bent to pick it up, she found three more identical		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. Further, during Guardian Angel Rounds, at least 3 days weekly—hazardous items that have a “Keep Out of the Reach of Children” labels will be placed in a secure location for the residents as appropriate. The DON/ADON/Charge Nurses will assist with this. This will be an ongoing practice of the Guardian Angel Program. The results of the Guardian Angel Rounds will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified. If needed, an Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the QAPI Committee weekly until resolution. DON/ADON will monitor falls daily in the morning clinical (CQI) meeting. 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	

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	pills on the floor, behind the bed. On 9/12/19 at 11:35 a.m., LPN 23 identified the pills as Resident 45's Metformin (a diabetic medication that helps lower the amount of sugar in the bloodstream), and indicated Resident 45 was supposed to take one pill, twice a day, 4 pills meant she missed 4 doses of medication, but there was no way to tell when. LPN indicated Resident 45 was a diabetic and the medication was important for her to take especially considering her morbid obesity, and the pills probably weren't found because it did not look like the room had been cleaned. On 9/16/19 at 1:06 p.m., Resident 45's medical record was reviewed. An admission minimum data set (MDS) assessment dated 8/24/19 indicated Resident 45 had diagnoses to include but were not limited to: Diabetes Mellitus type II, and morbid obesity. Resident 45 had physician orders to include, but were not limited to: Metformin 500 mg (milligrams) two times a day. On 9/12/19 at 1:30 p.m., the Administrator provided a copy of current, undated, facility policy titled, "Medication Administration Guidelines." The policy indicated, "...The Right Dose: Stay with the resident until oral medications are swallowed...You [facility staff] are held accountable for professional standards of care...." 6. On 9/17/19 at 9:17 a.m., Resident 40 was observed laying in her bed with her eyes open, and her legs propped up but restlessly moved up and down, in a scooting motion. Her bed was elevated, and not lowered to the floor.		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. - by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Corrections will be completed by 10/18/19	

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On 9/17/19 at 9:29 a.m., Certified Nursing Assistant (CNA) 24 observed Resident 40 lying in bed and indicated her bed was not supposed to be that high, because the resident could scoot herself out of bed, and could fall.

During an interview on 9/18/19 at 10:33 a.m., LPN 23 indicated, Resident 40 would scoot. When she gets restless sometimes she will start to scoot and can slip out of her bed or chair, so interventions in place to prevent a fall included but were not limited to, having her bed in its lowest position.

On 9/16/19 at 10:48 a.m., Resident 40's medical record was reviewed.

A nursing progress note dated 5/21/19 at 11:02 a.m., indicated, "... IDT [Interdisciplinary Team] met to review the fall on 5/20/19. Resident was found on the floor in her room beside her bed... when nurse looked at the room it was noticed that the bed was in high position and she is on a low air loss mattress... education was done with this CNA related to bed height and positioning on a low air loss mattress...."

Resident 40 had a comprehensive care plan dated 10/13/15, and revised 9/14/19. The care plan indicated, "...The resident is at risk for falls related to diagnosis of history of CVA [cardiovascular accident, stroke] with left side weakness..." interventions for this care plan included but were not limited to: CNA education related to bed height and positioning on a low air loss mattress, keep resident's bed in lowest position, and anticipate the resident's needs...."

On 9/17/19 at 11:02 a.m., the Administrator provided a copy of current but undated facility

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	policy, titled, "Incident/Accidents/Falls." The policy indicated, "...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 toll out interventions to prevent another similar occurrence...." 3.1-45(a)			
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 memory care residents had assistance or cueing while eating for 2 of 5 residents reviewed for nutrition which resulted in harm when Resident 18 had severe	F 0692	I would like to respectfully purse a reduction in scope and severity for this deficiency What corrective action(s) will be accomplished for those residents	10/18/2019

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	weight loss of 13.4% in 6 months and Resident 1 had severe weight loss of 10.8 % in 6 months (Residents 18 and 1). The facility failed to ensure a resident wore dentures during meals resulting in the potential for harm when the resident had a 3% weight loss in less than 1 month for 1 of 5 residents reviewed for nutrition (Resident 51). Findings include: 1. On 9/16/19, during a continuous lunch observation, from 12:21 p.m., to 12:47 p.m., Resident 18 was observed not eating. No staff member directed, cued, or assisted her with eating. At 12:47 p.m., Licensed Practical Nurse (LPN) 9 took Resident 18's food away, and indicated she never ate. A slice of pumpkin pie was left, but no silverware. Resident 18 asked 2 unidentified staff members for a spoon. No one responded to her request, and no one assisted her with eating. At 12:55 p.m., Resident 18 had eaten about 1/3 of her pumpkin pie, dropped about 1/3 to the floor. She indicated she was through because she had no strength left. No one assisted her with finishing her pie. At 12:58 p.m., LPN 9 took the rest of Resident 18's pumpkin pie and threw it away. No staff member directed, cued, tried to assist her with eating, or offered to bring her another slice of pumpkin pie. On 9/16/19, during a continuous breakfast observation, from 8:37 a.m., to 9:02 a.m., Resident 18 was observed not eating. She was drinking from her milk carton with a straw. No one assisted her with eating. At 9/18/19 at 8:59 a.m., the Minimum Data Set		found to have been affected by the deficient practice; Resident 18 and Resident 1 had their records reviewed by the Corporate Dietitian. Resident 18 was added to the SWAT agenda (Skin-Weight-Assessment-Team) for weekly discussion. She had fortified foods added to her diet (an extra 200 calories; 6 grams of protein per item). The resident received this intervention on 9/03/19. She was to receive one of these items daily. Then, on 9/18/19, she began receiving one of these items with each meal. From 9/03/19 to 9/21/19 this resident gained 8.5 lbs. She continues to eat her meals as served. She will continued to be monitored. Resident 1 was added to SWAT agenda (Skin-Weight-Assessment-Team) for weekly discussion. Resident 1 was found during this review to be stable as far as his weight for the past 4 months. He had in place; fortified cereal for breakfast plus 120 ccs of Med Pass (Dietary Supplement) 4 x daily. He was consuming 75% of meals and 100% of these stated supplements. He will continue to be monitored. Resident 51 has dentures, staff has been educated regarding checking and making sure resident 51 has dentures in at	

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	(MDS) Coordinator provided chocolate ice cream for Resident 18, and she began actively eating it. Resident 18's record was reviewed on 9/16/19 at 1:51 p.m. Resident 18 had diagnoses including, but not limited to, schizophrenia, Alzheimer's disease, dementia, altered mental status, cognitive communication deficit, need for assistance with personal care, dysphagia (difficulty swallowing), and weakness. A quarterly Minimum Data Set (MDS) assessment, dated 7/3/19, indicated she had severe cognitive impairment, and had not had staff assistance with eating and/or swallowing during the assessment. A care plan, dated 3/26/17, indicated the resident required assistance with activities of daily living (ADL), she would have these activities met by staff, and staff assist, as needed, with eating. The Registered Dietician (RD) note indicated on 2/7/19, Resident 18 weighed 173.4 pounds (lbs.), and on 9/3/19, she weighed 152.9 lbs. This was a 6 month weight loss of 13.4 percent (%). The dietary orders, dated 6/2/19, were general diet, mechanical soft texture, thin consistency, and fortified cereal one time a day. A RD note indicated, on 8/19/19 at 8:27 a.m., Resident 18's weight was 163.2 lbs., she was down 18 lbs. in 30 days. A RD note, on 9/3/19 at 1:23 p.m., Resident 18's weight was 158.2 lbs., which was down 20.4 lbs., 11.4% in 90 days. Will suggest fortified food one time a day, will continue to monitor. Facility will monitor in SWAT (skin and weight assessment		meal service time. This resident was already on the SWAT agenda for weekly review. Additionally, the Corporate Dietitian spoke with her daughter related to the resident's supplements. The dietitian and daughter agreed to continue fortified oatmeal and a fried egg for each meal, plus a Magic Cup twice daily. This is in addition to her meals. These residents have had any notifications, care plans, MDSs appropriately addressed. Residents who need cueing as per their plans of care during mealtimes are receiving needed cues. A facility wide audit was conducted to assess for any other significant weight losses. Any that were of any concern were addressed by the Corporate Dietitian. Any needed notifications, care plans, MDSs were appropriately addressed. - 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	

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	team). 2. On 9/16/19 at 1:24 p.m., Certified Nursing Assistant (CNA) 11 indicated Resident 1 ate 50% of his lunch in his room. No one assisted him with eating. On 9/18/19 at 8:36 a.m., Resident 1 was observed eating breakfast in the memory care dining room. No one assisted him with eating. Resident 1's record was reviewed on 9/17/19 at 11:18 a.m. Resident 1 had diagnoses including, but not limited to, dementia with behavioral disturbances, Parkinson's disease, bipolar disorder, schizoaffective disorder, other impulse disorders, cognitive communication deficit, and diabetes mellitus. The dietary orders, dated 3/25/19, were general diet, regular texture, and thin consistency. On 7/22/19, nutritional supplements were ordered 4 times a day. The Registered Dietician (RD) notes and resident weights were reviewed on 9/17/19 at 11:26 a.m. and indicated the following: On 3/21/19, the resident weighed 161.2 lbs., which was a loss of 19.6 lbs. and 10.8% in 6 months. On 4/9/19, the resident weighed 154.6 lbs., which was down another 6.6 lbs. On 5/8/19, the resident weighed 146.6 lbs., down 8 lbs., 5.2% in 30 days. On 6/3/19, the resident weighed 149.6 lbs., was down 17 lbs. and 10.2% in 90 days.		into place and what systemic changes will be made to ensure that the deficient practice does not recur; At an in-service held for all staff on 10/15/19 and 10/16/19, which will be conducted by the Administrator and DON, the following were reviewed: a) The Dining Experience—to include assisting with feeding and cueing residents (by qualified staff) b) SWAT Program c) Obtaining and recording weights—When? Why? By Whom? Where recorded? When to notify nurse? d) What is a significant weigh gain? Loss? e) Why is weight tracking so important? f) Why is chewing important? Why must residents wear dentures during meals? g) Discussion The weights will be reviewed and discussed daily as part of the CQI (Clinical) morning meeting daily. Any concerns will be addressed. The Dietary Manager and DON will meet weekly to discuss any weight concerns. This meeting will continue for a period of 6 months to ensure on going compliance. The Dietitian will meet with the Dietary Manager and DON every 2 weeks to review any weight issues. New residents	

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	On 7/18/19, the resident weighed 144.4 lbs., down 17.4 lbs., 10.8% in 6 months. Staff assisted resident with meals. RD suggested an increase in nutritional supplement to 4 times a day. On 9/3/19, Resident 1 weighed 147. Resident 1's care plans, dated 9/28/18, indicated the resident had late loss ADL's and required staff assist with ADL's due to impaired cognition. The goal was for the resident to maintain the current level of self-care ability, extensive assist. Interventions included but were not limited to staff assist with eating as needed, resident needed cueing and sometimes one assist with eating, and staff to assist as needed. 3. On 9/12/19 at 12:20 p.m., Resident 51 was observed trying to eat lunch without her dentures in her mouth. No one assisted her with eating. During a family interview, on 9/12/19 at 2:49 p.m., Resident 51's daughter indicated her mother was losing weight because the staff did not put her dentures in her mouth before eating. On 9/13/19 at 9:10 a.m., Resident 51 was observed trying to eat breakfast without her dentures in her mouth. No one assisted her with eating. On 9/16/19 at 12:23 p.m., Resident 51 was observed trying to eat lunch without her dentures in her mouth. No one assisted her with eating. On 9/16/19 at 12:41 p.m., LPN 9 gave Resident 51 a, "milkshake." She drank about 1/3 of it. LPN 9 indicated it was 120 mL (4 ounces) of a nutritional supplement. On 9/16/19 at 12:54 p.m., CNA 11 removed		will continue to be weighed weekly x 4 weeks. Any residents with weight concerns will be placed on SWAT for weekly review. - 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 The DON/Designee will monitor 5 meals (various meals) weekly on Memory Springs to ensure that cueing is done and that dentures are in place. This monitoring will continue for 4 weeks. After that, the monitoring will be for 3 meals (various) weekly for 6 months to ensure ongoing compliance. Any concerns will be addressed if found. At the monthly QAPI meetings, the results of the weight monitoring by the DM and DON with input from the Dietician will be reviewed, as well as the meal monitoring on Memory Springs by the DON/Designee. Any concerns will have been addressed. Any patterns will be identified. If needed, an Action Plan will be written by the QAPI **Committee**. Any written Action Plan will be monitored by the Administrator weekly until resolved. Corrections will be completed by 10/18/19	

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Resident 51's lunch tray. She indicated resident 51 ate about 50% of it, and will only eat soft foods like applesauce. No one assisted her with eating the remainder of her food.

On 9/18/19 at 8:38 a.m., LPN 10 indicated Resident 51 used to need assistance with eating, but she could feed herself now.

Resident 51's record was reviewed, on 9/16/19 at 3:35 p.m. Resident 51 had diagnoses including, but not limited to, dementia, cognitive communication deficit, bilateral absolute glaucoma (vision loss with pain), and weakness.

A significant change Minimum Data Set (MDS) assessment, dated 6/7/19, indicated Resident 51 had severe cognitive impairment.

The dietary orders, as of 9/16/19, were general diet, mechanical soft texture, thin consistency, ground meat, fortified oatmeal for breakfast, and nutritional supplements 3 times a day.

The Registered Dietician (RD) notes indicated, on 9/3/19, Resident 51 weighed 105 pounds (lbs.), and, on 8/19/19, she weighed 108.2 lbs. This was a one month weight loss of 3.2 lbs. and 3 percent (%).

A care plan, dated 8/8/19, indicated the resident required assistance with activities of daily living (ADL). She would have these activities met by staff. Staff would assist as needed with eating, oral care, and assist with dentures.

A care plan, dated 8/8/19, indicated the resident had potential for alteration in oral consumption due to upper and lower dentures. The goal was resident would not have significant weight loss.

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On 9/17/19 at 11:56 a.m., the Administrator indicated if a nurse noticed a significant weight change, then she would need to bring it to the Administrative staff, so a plan could have been put into place to stop the weight loss. If the RD noticed the significant weight loss, she should have brought it to the Administrator with a plan for interventions. The expectation for the nursing staff was to follow the resident's care plans with regard to assisting residents with eating. If the resident did not want the food, staff should have offered something else, or assist them with eating. We needed to, at least, try to figure out why the residents were not eating the food.

On 9/18/19 at 8:38 a.m., Licensed Practical Nurse (LPN) 10 indicated Resident 27 was the only resident who needed assistance with eating or cueing to eat. There was no one else currently needing assistance.

On 9/18/19 at 11:53 a.m., the Regional Director of Operations indicated the facility policy was the State Regulations.

A current policy, titled, "Feeding Assistance," was provided by the Administrator on 9/17/19 at 8:50 a.m. A review of the policy indicated, "...Residents will be assessed to determine their ability to feed themselves secondary to decreased ROM (range-of-motion), decreased strength, incoordination/tremors, or sensory impairment. Feeding assistance will be completed according to the individual needs of the resident...."

A current policy, titled, "Indiana State Board of Health, Facility Administrators. Laws and Regulations," dated 2011, was provided by the Director of Nursing on 9/18/19 at 11:36 a.m. A

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	review of the policy indicated, " ...Based on a resident's comprehensive assessment and care plan, but subject to the resident's right to refuse, the facility must ensure the following: That a resident maintain acceptable parameters of nutritional status...." 3.1-46(a)(1)			
F 0741 SS=E Bldg. 00	483.40(a)(1)(2) Sufficient/Competent Staff-Behav Health Needs §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing			

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	non-pharmacological interventions. Based on interview, and record review, the facility failed to ensure the Memory care Director met qualifications for the position. This deficient practice had the potential to effect 23 of 23 residents who resided on the Memory Care Unit. Findings include: On 9/18/19 at 9:21 a.m., during an interview, the Business Office Manager indicated the facility did not have an employee with the job title of Memory Care Director, or facilitator. She believed the Activity Director was appointed to that role, as part of her job duties. On 9/18/19 at 11:00 a.m., the employee record was reviewed for the Activity Director. The Activity Director's employee record did not include a job description for Memory Care Director. On 9/18/19 at 9:58 a.m., during an interview, the Administrator indicated the Social Service Director, had assumed the role of Memory Care Director in April 2019, after her recent hire. Prior to the hiring of the current Social Service Director, the Activity Director filled that role. The Activity Director had done the training, and was the Memory Care Director until the Social Service Director was hired. "They are currently both in the role, right now." The Activity Director did not have any completed secondary education, diplomas. When she (the Activity Director) was hired she took the course, for Memory Care, back then (2016), and was appointed to the role. He did not recall submitting an Alzheimer's and dementia special care unit disclosure form, to the State, identifying the Memory Care Director. The facility followed the State Rules in regard to the Memory	F 0741	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; In accordance with the regulation criteria for sufficient/competent staff- Behavior Health Needs, the Social Services Director meets the qualifications for the position of Memory Care Director and has been in that role since April of 2019. - 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 who reside in the memory care unit 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 that the deficient practice does not recur; An in-service will be held on 10/16/19 and conducted by the Corporate Director of Social Services and Activities, the duties of this role were reviewed with the facility's Memory Care Coordinator. - 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	10/18/2019

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	Care Director. On 9/18/19 at 10:31 a.m., during an interview the Social Service Director (SSD) indicated she had started working at the facility in March 2019, and was the SSD for the whole facility, which included the Memory Care Unit. The Activity Director did a big part, back there (in the Memory Care Unit). She had been here longer, and knew all the families and residents, her office was back there. We worked together. In facilities that are required, under IC 12-10-5.5, to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. 3.1-37(a)		The Corporate Director of Social Services and Activities will follow up and review the programming and required documentation for the Memory Care Coordinator monthly for 6 months to ensure that all aspects of the position are being performed with success. Any concerns will be addressed if found. The Corporate Director of Social Services and Activities will report to the QAPI monthly on the progress and performance of the Memory Care Unit under the direction and supervision of the Memory Care Coordinator. Any concerns will be addressed if found. - by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Corrections will be completed by 10/18/19	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure staff wore hair nets and beard restraints while in the kitchen for 2 of 2 observations, and the facility failed to replace a resident's food after it had become contaminated and to wash hands appropriately during lunch service for 2 of 16 residents eating lunch in the memory care unit dining room. (Resident 2 and 27). Findings include: 1. On 9/12/19 at 9:52 a.m., an observation of the kitchen: Dietary Aide (DA) 12 walked through the kitchen while food was being prepared with a long beard uncovered. The Dietary Manager (DM) indicated his beard should have been covered while in the kitchen.	F 0812	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; It is the expectation of this facility that all facility staff follow the policy and procedure requirements for food procurement, store/prepare/serve-sanitary. Staff who work in the Dietary Department have their head hair as well as their facial hair restrained with nets. Further, any food that becomes contaminated for any reason is replaced. Additionally, Staff wash their hands appropriately during meal service. - how other residents having the potential to be affected by the	10/18/2019

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	On 9/12/19 at 12:40 p.m., DA 12 was working the lunch food serving line, and the back half of his hair was exposed. On 9/12/19 at 12:46 p.m., the Registered Dietician (RD) indicated all of DA 12's hair should have been covered. On 9/17/19 at 11:37 a.m., the Administrator indicated his expectation was the staff would wear hair nets and beard net while in the kitchen. A current policy, titled, "Hair Restraints," dated 2017, was provided by the Administrator on 9/13/19 at 10:35 a.m. A review of the policy indicated, "...Hair restraints shall be worn by all Dining Services staff ...Staff shall wear hair restraints in all food preparation, dishwashing and servings areas ..beard guards shall be used to prevent hair from contacting exposed food. Facial hair is discouraged. Any facial hair that is longer than a 1/4 inch shall require coverage with a beard guard...." 2. On 9/16/19 at 12:24 p.m., during an observation of the memory care lunch: Resident 2 was eating with a purple plastic square toy in his food. Certified Nurse Assistant (CNA) 15 reached into his food with her bare hands, and removed the toy. She did not offer to replace Resident 2's lunch meal. He just continued to eat. Resident 2 had severe cognitive impairment. On 9/16/19 at 12:32 p.m., CNA 15 moved Resident 18's wheelchair with her bare hands on the wheelchair handles. Then, she pushed a chair across the room, next to Resident 27. Without washing her hands, she sat down and assisted Resident 27 with eating. Resident 27 had severe cognitive impairment.		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 that the deficient practice does not recur; At an in-service for dietary staff conducted on 9/25/19 by the DON requirement/policy of covering head and facial hair in the kitchen was reviewed. A second in-service for dietary staff will be held on 10/11/19 and conducted by the registered dietitian to ensure 100% attendance of dietary staff. Any staff who fail to comply with this requirement will be further educated and/or progressively disciplined. At an in-service held for all staff on 9/25/19 conducted by the DON the following was reviewed: a) Food that becomes contaminated for any reason must be replaced. This includes food where a foreign object has been dropped into the food. b) Never is it allowed for a staff member to touch food that is to be consumed by a resident with their bare hands. c) Hand-washing requirements during meal service Any staff who fail to comply will be	

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	On 9/17/19 at 11:34 a.m., the Administrator indicated Resident 2 should have been offered another plate of food. Staff should have washed her hands prior to removing the toy, or put gloves on. It was his expectation for the staff to follow the hand washing policy. A current policy, titled, "Policy and Procedure, Meal Service," was provided by the Administrator, on 9/17/19 at 9:50 a.m. A review of the policy indicated, " ...conditions and cognitive status that put them at risk ... will wash their hands ...assisting another resident with their meal ...there is no bare hand contact with ready to eat foods...." 3.1-21(i)(2)		further educated and/or progressively disciplined. A second and third in-service will be held on 10/15/2019 and 10/16/19 for facility staff and be conducted by the Administrator and DON to ensure 100% attendance of all facility staff. - 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 The Dietary Manager will monitor hair covering 5 days weekly x 4 weeks then 3 days weekly x 6 months. Any concerns will be addressed if found. The DON/ Designee will monitor meal service in the Memory Springs unit for contaminated food being replaced, as well as staff refraining from touching food that is to be consumed with their bare hands. Additionally, hand-washing during meal service will be monitored. This monitoring will be for 5 meals weekly x 4 weeks, the 3 meals weekly x 6 months. Any concerns will have been addressed as found. If any patterns are identified. If needed, an Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored weekly by the Administrator until resolved. - by what date the systemic changes for each deficiency will	

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			be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Corrections will be completed by 10/18/19	
F 0883 SS=E Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side			

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	effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on interview, and record review, the facility failed to provide pneumonia immunizations to residents, for 5 of 7 residents reviewed for immunizations. (Residents 54, 25, 40, 38, and 5) Findings include: 1.On 9/13/19 at 2:35 p.m., Resident 54's medical	F 0883	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; In accordance with the regulation criteria for influenza and Pneumococcal immunizations, the facility must ensure that residents	10/18/2019

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	record was reviewed. Resident 54 was admitted to the facility on 5/10/19. There was no documentation of any pneumonia immunizations, or refusals, for the resident. 2. On 9/13/19 at 2:52 p.m., Resident 25's medical record was reviewed. Resident 25 was admitted to the facility on 9/29/18. There was no documentation of any pneumonia immunizations, or refusals, for the resident. 3. On 9/16/19 at 10:48 a.m., Resident 40's medical record was reviewed. Resident 40 was admitted to the facility on 10/8/15. There was no documentation of any pneumonia immunizations, or refusals, for the resident. 4. On 9/16/19 at 10:53 a.m., Resident 38's medical record was reviewed. Resident 38 was admitted to the facility on 11/7/16. There was no documentation of any pneumonia immunizations, or refusals, for the resident. 5. On 9/16/19 at 3:10 p.m., Resident 5's medical record was reviewed. Resident 5 was admitted to the facility on 11/1/18. There was no documentation of any pneumonia immunizations, or refusals, for the resident. On 9/17/19 at 12:45 p.m., during the Infection Control interview, with the Director of Nursing (DON), she indicated she was new to the facility, but she had identified pneumonia immunizations, for the residents, as a problem area. They had not been offering them routinely. She had a discussion with the Nurse Practitioner (NP), related to pneumonia vaccines, and which immunizations the residents should have been offered. The NP indicated Pneumovax 23, or Prevnar 13, but the DON had not yet done an		receive the pneumococcal immunization or do not receive the pneumococcal immunization due to medical contraindication or refusal. Residents 54, 25, 40, 38 and 5 have been approached and their responsible parties have indicated their desire (or not) for pneumonia immunizations. Corresponding orders were obtained, as well as any other needed documents, and immunizations were given as indicated. - 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 that the deficient practice does not recur; Designated staff will obtain consents from residents or family designee for flu and pneumonia vaccines. The auditing has begun and will be completed prior to flu season 10/19. Charts, resident, and families will be used to determine the residents that need a pneumovac, or a Prevnar 13 or 23. The IDT team will review and discuss all new admissions during stand up meeting, and verify that all vaccinations have been	

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	audit to determine which residents needed immunizations. On 9/18/19 at 12:03 p.m., the Director of Nursing provided copies of immunization records for Residents 54, 25, 40, 38, and 5. She indicated these residents had not been offered a pneumonia immunization, if a refusal, or immunization was not documented. The residents should have been offered the immunization, and they were working to get better at this. At the entrance conference, on 9/12/19, the Administrator provided a copy of the current Influenza and Pneumococcal Immunization Policy, dated 7/1/11. This policy indicated "...It is the intent of this facility to minimize the risk of residents acquiring, transmitting, or experiencing complications from Influenza and Pneumococcal pneumonia. This policy will ensure that each resident is informed about the benefits and risks of immunizations and has the opportunity to receive, unless medically contraindicated or refused or already immunized, the Influenza and Pneumococcal vaccine; assure documentation in the residents' medical record of the information/education provided regarding the benefits and risks of immunization and the administration of the refusal of, or medical contraindications to the vaccine(s) ...Pneumococcal vaccine upon admission to the facility unless it has already been received ...For residents currently residing in the facility, that are not new admissions, the following will be completed: The CDC (Center for Disease Control) Vaccine Information related to the Influenza and Pneumococcal Vaccines will be given to the resident and/or responsible party ...It is the practice of this facility to offer and administer the Pneumococcal vaccine upon admission and		completed. All nursing staff will be in-serviced on how to utilize the immunization tab in PCC by 10/18/2019, this will be conducted by the DON. - 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 The Director of Nursing/designee will monitor influenza and Pneumococcal immunizations at the daily CQI meetings along with new admission orders. A QA tool titled, “Resident Influenza and Pneumococcal immunizations will be used and reviewed daily at the CQI meetings as part of the agenda going forward. the results will be presented at the monthly QAPI meetings. Any concerns will have been addressed. If any patterns are identified. If needed, an Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored weekly by the Administrator until resolution. - by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of	

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ALPHA HOME - A WATERS COMMUNITY	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	throughout the entire year unless the immunization is medically contraindicated or the resident has already been immunized...." 3.1-13(a)		correction date. Corrections will be completed by 10/18/19	
F 0908 SS=F Bldg. 00	483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview, and record review, the facility failed to ensure the dishwashwer reached minimal temperatures for the kitchen dishwasher rinse cycle. This deficiency had the potential to effect 57 of 57 residents who ate from the kitchen. Findings include: On 9/12/19 at 9:40 a.m., after ten observations of the dishwasher washing cycle, it failed to reach the minimum temperature of 180 degrees Fahrenheit (F). The Dietary Manager (DM) indicated she would contact the maintenance man. On 9/12/19 at 9:52 a.m., Dietary Aide (DA) 12 indicated the dishwasher was an old machine, getting the machine to the minimum of 180 degrees F had been on and off. On 9/12/19 at 12:20 p.m., disposable Styrofoam multiple compartment containers were used for the resident's lunch meal. Desserts were served on small Styrofoam plates. On 9/12/19 at 12:44 p.m., the DM indicated the dishwasher would not get up to the minimum	F 0908	The dishwasher has been replaced. All residents and all staff and visitors have the potential to be affected by this deficient practice. The Dietary Staff have been in-serviced on 9/19/19 by the Maintenance Supervisor as to the following: How to use the newly installed dishwasher How to identify a problem with the newly installed dishwasher Documentation required related to the newly installed dishwasher Discussion Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. The Dietary Manager will monitor temps related to the newly installed dishwasher 5 meals a week for 4 weeks to ensure proper	10/18/2019

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	temperatures of 180 degrees F. The staff had hand washed the cups and silverware and sanitized them. On 9/12/19 at 12:59 p.m., the Regional Director of Operations indicated the facility was replacing the dishwasher and provided a bid from (name of) company. On 9/12/19 at 3:23 p.m., the Regional Director of Operations indicated the (name of) company was replacing the booster heater on the dishwasher. On 9/13/19 at 9:00 a.m., (name of company) came into the facility to replace the dishwasher's heat booster. The DM indicated the dietary staff were hand washing all the pots and pans, steam trays, utensils, cups, and silverware until the heat booster was installed. On 9/13/19 at 1:10 p.m., the Administrator provided a copy of their dishwasher instruction manual. A review of the manual indicated the minimum wash cycle was 150 degrees Fahrenheit (F), and the minimum rinse cycle was 180 degrees F. On 9/13/19 at 3:46 p.m., the Administrator indicated the dishwasher had been repaired. On 9/16/19 at 10:39 a.m., the dishwasher did not reach the minimum temperature of 180 degrees F. The DM indicated the dishwasher achieved 183 degrees this morning before breakfast, but the facility would use Styrofoam multiple compartment containers to serve food. On 9/16/19 at 11:05 a.m., the MM indicated he turned the dishwasher's heat booster up to a hotter temperature.		sanitation of dish/glass/flat wear is occurring (and a temp of 180 degrees is being reached). This monitoring will continue after this time period to coincide with the dietary schedule/policy. Any concerns will be addressed if found. The results of the monitoring will be presented to the QAPI committee at the monthly QAPI meeting. Any concerns will have been addressed. If any patterns are identified. If needed, an Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	On 9/16/19 at 3:10 p.m., after (name of company) serviced the dishwasher, four dishwasher cycles were observed to run with all temperatures achieving more than 180 degrees F. On 9/18/19 at 10:45 a.m., the MM indicated the new dishwasher had arrived, and they are getting ready to install it. On 9/17/19 at 11:33 a.m., the Administrator indicated his expectation would have been for the dishwasher to function appropriately. A current policy, titled, "Dishwashing Machine," dated 2017, was provided by the facility. A review of the policy indicated, " ...All dishwashing machines should be operated according to the manufacturer recommendations ...." 3.1-21(i)(2)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure the memory care area was free of potential accidents. An electrical hazard and peeled paint were present in a resident room (Resident 1), a toilet overflowed with feces and water on the floor (Resident 23, and 9) for 2 of 2 random observations. Findings include: 1. On 9/12/19 at 10:23 a.m., an electrical hazard was	F 0921	On 9/12/19 the Maintenance Supervisor/designee repaired and painted the damaged drywall area, repaired the electrical plate pulled away from the wall, and cleaned the drywall debris from behind the head of the bed and repainted the wall next to the bed in Resident #1's room to meet set standards. The Administrator verified the work on 9/12/19. On 9/12/19 Housekeeping	10/18/2019

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	observed in Resident 1's room. The head of the bed was away from the wall, it exposed the electrical hazard. The electrical plate was pulled away from the wall, the dry wall was exposed, and debris from the dry wall was on the floor. It appeared some of the dry wall had been intentional pulled away from the wall. Resident 1 was in his room, sitting up in a wheelchair. There was paint peeled away from the wall next to where Resident 1 slept at night. On 9/12/19 at 10:36 a.m., the Maintenance Director (MM) indicated he was very busy, did not know how it happened, but it was a hazard for the residents. On 9/12/19 at 10:46 a.m., Certified Nursing Aide (CNA) 11 indicated the electrical hazard had been there more than a day, and she had notified the MM when she discovered it. On 9/12/19 at 11:36 a.m., the Administrator indicated he was made aware of the electrical hazard. The plate cover and electrical outlet should not have been in that condition because it was a shocking hazard to the residents. When the staff reported it to the MM, he should have taken care of it right away. On 9/12/19 at 2:31 p.m., an observation of the dry wall debris still on the floor of Resident 1's room. On 9/17/18 at 11:43 p.m., the Administrator indicated who ever noticed the electric hazard first, should have filled out paper work first, so it could have been addressed and fixed. 2. On 9/12/19 at 10:28 a.m., Resident 23 and Resident 9 were in their room. There was a brown		Supervisor/designee/nursing staff cleaned the feces from the side of the toilet and the floor and removed the wet bedsheet from around the toilet in the room of Resident #23 and Resident #9. On 9/12/19 the Maintenance Supervisor/designee repaired and re-set the toilet to prevent it leaking to meet set standards. The Administrator verified the cleaning and repairs on 9/12/19. All residents and all staff and visitors have the potential to be affected but none were. On 9/12/19 the Maintenance Supervisor/designee inspected all electrical outlets, drywall areas, and walls for damage or potential safety hazards and inspected all toilets for leaks throughout the facility and found no other negative findings. On 9/12/19 the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that electrical outlets must be installed properly, all drywall areas and walls must be in good condition, and all toilets must be in good repair to meet set standards. Maintenance Supervisor/designee will inspect all electrical outlets, drywall areas, and walls for damage or potential safety hazards and inspect all toilets throughout the facility for leaks as a part of the facility's Preventive	

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	substance on the side of the toilet, and on the floor, the toilet had water around it. A bed sheet had been placed on the floor to sop up the water. At 10:39, the MM indicated the toilet had overflowed, had been knocked off its foundation, and because the toilet was loose, it was leaking. He used his shoe to move the bed sheet closer to the toilet to sop up more of the water. He left the bed sheet on the floor when he left the room. On 9/17/18 at 11:47 a.m., the Administrator indicated if the toilet overflowed, the nurses would have dealt with the feces on the side of the toilet and floor. The MM should have been contacted directly, or with a work order, so this issue could have been addressed immediately. On 9/13/19 at 10:08 a.m., the Administrator indicated Resident 15 wandered in the memory care area. A current policy, titled, "Homelike Environment," dated August 17, was provided by the Administrator on 9/18/19 at 9:05 a.m. A review of the policy indicated, " ...It is the policy of the facility to ensure that the environment provided by the facility is safe, sanitary, functional and comfortable." 3.1-19(a)(1)		Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. Corrections will be completed by 10/18/19	