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	12/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND ST INDIANAPOLIS, IN 46250

(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
F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00369586. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00369586 - Substantiated. Federal/State deficiencies related to the allegations are cited at F607 and F684. Unrelated deficiencies are cited. Survey dates: December 28-29, 2021 Facility number: 000172 Provider number: 155272 AIM number: 100267130 Census Bed Type: SNF/NF: 135 Total: 135 Census Payor Type: Medicare: 16 Medicaid: 86 Other: 33 Total: 135 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 3, 2022	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.	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.			

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

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	§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation and record review, the facility failed to ensure a residents' right to secure and confidential medical records by having residents' medication stickers, which contained the resident's name and medication name with dose information, stuck to the unattended medication cart on the Brookshire wing 3 hallway for 6 residents during a random observation.	F 0583	A The medication labels for residents H, J, K, E, M, N were secured from view to protect the privacy of those resident. B All residents have the potential to be affected by the deficient	01/24/2022

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	(Residents E, H, J, K, M, and N) Findings include: A random observation of a medication cart, on the Brookshire unit, was made on 12/29/21 at 2 p.m. The medication cart was positioned near the beginning of wing 3. The medication cart had 9 medication labels partially stuck and hanging off the top of the cart. The information on the medication labels included, but not limited to, the resident's name, medication name and medication dose for the following residents: 1. Resident H had medication labels for the following medications: fish oil 100 mg, simvastatin (cholesterol reducer) 40 mg, vitamin d 3 500 units, and; hydocholorthiazide (diuretic) 25 mg 2. Resident J had a medication label for sucralafate (ulcer treatment) 1 gram 3. Resident K had a medication label for aripiprazole (antipsychotic) 5 mg 4. Resident E had a medication label for oxandrolone (steroid) 2.5 mg 5. Resident M had a medication label for lisinopril (blood pressure) 2.5 mg 6. Resident N had a medication label for amlodipine (blood pressure) 10 mg At the time of the observation, the medication cart was left attended and the medication labels were in full view of other residents who were walking past the cart. A clinical documentation standards policy was received on 12/29/21 at 2:45 p.m. from DON (Director of Nursing). It indicated, "Legal Considerations and Maintaining Integrity of documentation a. Each resident will have a medical record maintained in accordance with state and federal guidelines and will be kept		practice. An audit was performed on all medication and treatment carts to ensure that all confidential information was secured. C All licensed nurses and qualified medication aides were educated on facilities "Clinical Documentation Standards" policy with an emphasis on securing residents' private medical information. D Audits of nursing carts will be performed by the DON or designee to ensure documentation is secured in a way to maintain privacy for all residents at the following frequency - 10 x per week x 30 days, then 5 x per week x 30 days, then 3 x per week x 1 month. Results of the audit will be reviewed in the monthly QA meeting or a period of 3 months to ensure compliance is maintained.	

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	secure, will be easily accessible and systematically organized per regulatory requirements..." 3.1-50(d) 3.1-50(e)			
F 0607 SS=D Bldg. 00	483.12(b)(1)-(3) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, Based on interview and record review, the facility failed to implement written policies and procedures to investigate abuse, neglect, and exploitation of residents and misappropriation of resident property by not having witness statements signed by the witness, not obtaining statements from staff related to the incident, and not including in the statements a description of what was witnessed, seen or heard, and not identifying and/or investigating injuries of unknown origin for 2 of 3 residents reviewed for abuse. (Resident B and E) Findings include: 1. An incident report dated 12/3/21 was provided by DON (Director of Nursing) on 12/28/21 at 1:37	F 0607	A Resident B has discharged from the facility. Resident E's skin condition was immediately addressed by the DON, reported to ISDH, and investigated completely. B All residents have the potential to be affected. A 100% audit will be conducted concerning the skin integrity of the residents. Those residents identified with skin conditions will be placed on wound rounds and appropriate treatments reviewed and documented. If any injury of unknow origin is	01/24/2022

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	p.m. The incident report involved Resident B. The brief description of the incident indicated, "Resident's spouse reports that Resident's room mate told her that staff are repeatedly entering the room between 2 to 4 a.m. (sic) and talking loudly to the resident and giving him commands using rough tones of voice. The room mate's account is that he was unable to identify the staff on any occasion because they are behind a curtain while giving (sic, Resident B's name) care and that he is usually asleep when they first enter the room". The immediate action taken was "An investigation was begun". The investigation file for Resident B's incident on 12/3/21 was received on 12/28/21 at 4 p.m. from ED (Executive Director). The investigation file contained two witness statements and several completed resident questionnaires regarding abuse. One witness statement was from Resident B's roommate. Resident B's roommate's statement was not signed by the roommate, but indicated, he woke up on 12/2/21 between 2 a.m. and 4 a.m. because staff came in room talking loudly and yelling at his roommate. The second witness statement was from Resident B's spouse which she indicated, she told ED that her husband's roommate told her that staff came in room and was talking loudly and yelled at her husband. The investigation file did not contain written statements from staff who had worked the day and time in which the incident occurred thus not ensuring the completeness and/or accuracy of the alleged abuse investigation. An interview with ED was conducted on 12/28/21 at 4:15 p.m. ED indicated, he is the person responsible for directing the investigation and ensuring the completeness of the investigations.		identified, it will be reported and investigated. The Regional Director of Operations or Regional Director of Clinical Operations will conduct an audit on all reportables for the last 30 days to ensure a complete investigation was obtained and documented. C All licensed nurses and IDT team were educated on facilities "skin management policy" with an emphasis on ensuring source of skin concern is obtained, physician and family notification, and obtaining treatment orders. Licensed nurses and IDT team were educated on facilities policy “Indiana Abuse & Neglect & Misappropriation of Property” with an emphasis on ensuring source of skin concerns are obtained and injuries of unknown origin are reported and investigated and on ensuring complete investigations with signed and dated statements from residents, witnesses, and staff who worked at time of incidents. D 24-hour report will be utilized 5 days a week to identify residents with compromised skin condition in daily clinical stand-up and in weekly wound rounds and appropriate treatments reviewed and documented. This will be an ongoing facility practice. DON or designee will perform resident	

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	An Indiana Abuse & Neglect & Misappropriation of Property policy was received on 12/28/21 at 1:37 p.m. It indicated, "V. Investigation of Incidents 1. In the event a situation is identified as abuse, neglect or misappropriation, and investigation by the executive leadership will immediately follow up...e. Statements will be obtained from the resident or from the reporter of the incident, in writing whenever possible by the Executive Director or designee...g. Documentation of the facts and findings will be completed in each resident medical record...2. A suspected Abuse...d. Statements will be obtained from staff related to the incident, including victim, person reporting incident, accused perpetrator and witnesses. This statement should in writing, signed, and dated at the time it is written. Supervisors may write the statement for a person giving a statement about the incident to them and the person giving the statement must sign and date it. or a third party may witness the statements. e. Statements should include the following: i. First hand knowledge of the incident ii. A description of what was witnessed, seen or heard...g. By the fifth day, the alleged abuse investigation form is completed and reviewed for completeness and accuracy by the Executive Director or designee and submitted to the state." 2. The clinical record for Resident E was reviewed on 12/29/21 at 11:02 a.m. Resident E's diagnoses included, but not limited to, subdural hemorrhage (brain bleed) and Parkinson's disease. Resident E's care plan dated 10/16/21 indicated, Resident E has impaired skin integrity related to immobility. Interventions included, but not limited to, complete weekly skin checks and to complete skin risk assessment upon admission/ readmission, quarterly, and as needed.		observations each week to identify any unreported injuries at the following frequency – 10 observations per week x 4 weeks, then 5 observations per week x 4 weeks, then 3 observations per week x 1 month. Any injury of unknown origin will be reported and investigated. A check list corresponding to the facility's policy for "Abuse, neglect and exploitation of residents and misappropriation of resident property" will be used to audit investigations for completeness. All new investigation of Abuse, neglect, exploitation or resident and misappropriation of resident property will be reviewed weekly to ensure completeness using the aforementioned check list. This will be an ongoing facility practice. The results of weekly wound rounds will be reviewed in the monthly QA for 6 months. The results of the weekly Abuse, neglect, exploitation or resident and misappropriation of resident property investigations will be reviewed month audits will be reviewed in the monthly QA for 6 months.	

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	A review of Resident E's weekly skin assessment for the time period of 12/15/21 to 12/25/21 indicated, Resident E had no skin conditions, changes, ulcers, or injury. An observation of Resident E was made on 12/29/21 at 11:48 a.m. with DON. Resident E was lying in bed with several towels over and around him. The towels had spots of blood on them. Resident E had several open wounds in the following locations: -Left hand had two wounds - a quarter sized, round, open area with a beefy red wound base and no dressing; and a quarter sized, open area with beefy red wound base on his ring finger without a dressing. - Right arm had several wounds in various stages of healing including, but not limited to, a dried, yellow stained Kerlix wrap around his bicep with noted bruising in shape of finger tips; and many scabbed areas on right hand and arm. The date of application of the Kerlix wrap could not be established. During the observation, DON attempted to remove the Kerlix wrap from Resident E's right upper arm but was unable to completely remove the wrap as it was stuck to the wound underneath it and Resident E cried out in pain when attempting to remove the bandage using saline to wet the dressing. DON indicated, she was unaware of how Resident E received the wounds or when they had occurred but did note Resident E picked at himself on occasion. The wounds in question, did not appear to be a result of him picking at his skin. A review of Resident E's nursing notes from 12/1/21 to 12/29/21 did not indicate when or how			

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	the injuries occurred nor where there any wound care orders. A PCP (primary care provider) progress note dated 12/20/21 at 1:28 p.m. indicated, in regards to skin, "bandages on his right arm and elbow with some bruising seen. An Indiana Abuse & Neglect & Misappropriation policy was received on 12/28/21 at 1:37 p.m. from DON. It indicated, the definition of an injury of unknown origin was "In Indiana, an injury should be classified as an injury of unknown origin when both of the following conditions are met: a) the source of the injury was not observed by any person or the source of injury could not be explained by the resident AND b) the injury is suspicious because of: a. the extent of the injury or the location of the injury; (the injury is located in an area not generally vulnerable to trauma) b. or the number of injuries observed at one particular point in time; or c. the incidence of injuries over time Examples of suspicious injuries: black eye, marks or bruising in the shape of fingers/hand or an object, in the genital or breast area, on back, buttocks or neck." It further stated, "Identification of incidents and allegations 1. The accurate and timely identification of any event which would place our residents at risk is a primary concern of the facility. 2...a. Each occurrence of resident incident, bruise, abrasion, or injury of unknown source; or report of alleged abuse, neglect or misappropriation of funds will be identified and reported to the supervisor and investigated timely." This Federal tag relates to complaint IN00369586.			

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	3.1-28(b) 3.1-28(d)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to ensure a resident received treatment and care for multiple wounds on his hands and bilateral arms related to not identifying how and when the resident got the wounds for 1 of 3 residents reviewed for abuse. (Resident E). Findings include: The clinical record for Resident E was reviewed on 12/29/21 at 11:02 a.m. Resident E's diagnoses included, but not limited to, subdural hemorrhage (brain bleed) and Parkinson's disease. Resident E's care plan dated 10/16/21 indicated, Resident E has impaired skin integrity related to immobility. Interventions included, but not limited to, complete weekly skin checks and to complete skin risk assessment upon admission/ readmission, quarterly, and as needed. A review of Resident E's weekly skin assessment for the time period of 12/15/21 to 12/25/21 indicated, Resident E had no skin conditions,	F 0684	A Resident E skin condition was reported to ISDH and a complete investigation was conducted and documented. B All residents have the potential to be affected. A 100% audit will be conducted concerning the skin integrity of the residents. Those residents identified with skin conditions will be placed on wound rounds and appropriate treatments reviewed and documented. C All licensed nurses and IDT team were educated on facilities "skin care and wound management policy" with an emphasis on ensuring source of skin concern is obtained, physician and family notification, and obtaining treatment orders. D 24-hour report will be utilized 5	01/24/2022

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	changes, ulcers, or injury. An observation of Resident E was made on 12/29/21 at 11:48 a.m. with DON. Resident E was lying in bed with several towels over and around him. The towels had spots of blood on them. Resident E had several open wounds in the following locations: -Left hand had two wounds - a quarter sized, round, open area with a beefy red wound base and no dressing; and a quarter sized, open area with beefy red wound base on his ring finger without a dressing. - Right arm had several wounds in various stages of healing including, but not limited to, a dried, yellow stained, Kerlix wrap around his bicep with noted bruising in shape of finger tips; and many scabbed areas on right hand and arm. The date of application of the Kerlix wrap could not be established. During the observation, DON attempted to remove the Kerlix wrap from Resident E's right upper arm but was unable to completely remove the wrap as it was stuck to the wound underneath it and Resident E cried out in pain when attempting to remove the bandage using saline to wet the dressing. DON indicated, she was unaware of how Resident E received the wounds or when they had occurred, but she did mention Resident E picked at himself on occasion. The wounds in question, did not appear to be a result of him picking at his skin. A review of Resident E's nursing notes from 12/1/21 to 12/29/21 did not indicate when or how the injuries occurred. Resident E did not have any wound care orders. A PCP (primary care provider) progress note		days a week to identify residents with compromised skin condition in daily clinical stand-up and in weekly wound rounds and appropriate treatments reviewed and documented. Any injury of unknown origin will be reported and investigated. This will be an ongoing facility practice. The results of weekly wound rounds will be reviewed in the monthly QA for 6 months.	

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	dated 12/20/21 at 1:28 p.m. indicated, in regards to skin, "bandages on his right arm and elbow with some bruising seen. A Skin Care and Wound Management policy was received on 12/29/21 at 2:14 p.m. from DON (Director of Nursing). It indicated, "The interdisciplinary team works with the resident/patient and/or family/responsible party to identify and implement interventions to prevent and and(sic) treat potential skin integrity issues. The interdisciplinary team evaluates and documents identified skin impairments and pre-existing signs to determine the type of impairment, underlying condition(s) contributing to it and description of impairment to determine appropriate treatment. Each resident/patient is evaluated upon admission and weekly thereafter for changes in skin condition....Skin care and wound management program includes, but is not limited to:...Daily monitoring of existing wounds..." This Federal tag relates to complaint IN00369586. 3.1-37(a) 3.1-17(c)(4) 3.1-17(c)(5)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals			

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	§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, and interview, the facility failed to ensure safe and secure storage of a medication by leaving a medication bottle on top of an unattended medication cart on the Brookshire unit for 79 of 79 residents residing on the Brookshire unit. Findings include: A random observation of a medication cart, on the Brookshire unit, was made on 12/29/21 at 2 p.m. The medication cart was positioned near the beginning of wing 3 and had a bottle of Polyethylene Glycol sitting on top. The medication cart was unattended at the time and residents were observed walking past the medication cart. An interview with DON (Director of Nursing) was conducted on 12/29/21 at 2:17 p.m. DON indicated, medications are to be secured inside the medication cart and not left out when the	F 0761	A The medication bottle was secured within the medication cart. B All residents have the potential to be affected. An audit was performed on all medication carts and treatment carts to ensure medications were secured. C All Licensed Nurses and QMAs were educated on the facilities policy "Medication storage". D Director of Nursing Services or designee will conduct weekly audits to ensure all medications are secured 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance.	01/24/2022

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND ST INDIANAPOLIS, IN 46250

(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
	medication cart is unattended. 3.1-25(m)		The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	