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	08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00301445. Complaint IN00301445 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600. Survey dates: August 1, and 2, 2019. Facility number: 000376 Provider number: 155717 AIM number: 100275510 Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type: Medicare: 2 Medicaid: 36 Other: 14 Total: 52 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 8, 2019.	F 0000	**The facility would like to respectively request a desk review for this plan of correction to attain compliance**	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment,			

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.

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	08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
	involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview, and record review, the facility failed to protect 1 of 3 residents reviewed for abuse from physical abuse, when Resident C hit Resident B on the head, and neck, with a walking cane resulting in Resident B sustaining a laceration (open cut), and a contusion (bruising). Findings include: On 8/1/19 at 2:45 p.m., during an observation, and interview, Resident B was observed as he rested on his bed. A small scabbed area was noted on his right forehead. The area above the scab was pink in color. The total area was approximately 1 inch in length, and 1/8 inch wide. Resident B indicated Resident C used to be his roommate. They were "OK", as roommates. They never had any problems, "until that one day, I guess he just snapped or something. I was sitting up there in the hall, by the nurses' desk. He just came up and hit me right there (touched scabbed area on forehead), with his cane. It really hurt too. It hurt really bad. They sent me to the hospital. They did all kinds of tests and stuff." On 8/1/19 at 11:00 a.m., Resident B's medical record was reviewed. His diagnoses included, but were not limited to, end stage renal disease, anemia, and heart failure.	F 0600	-What corrective actions will be put in place for the residents affected by this delinquent practice? 1. Resident C no longer resides in the facility. - How other residents having the potential to be affected by same delinquent practice will be identified and the corrective actions taken. 2. A 30 day “look back” audit was conducted by the appropriate IDT (Interdisciplinary Team) members at which time the following were reviewed for all residents who exhibit behaviors per observation, review and/or assessment: a) Progress notes related to behaviors for each individual resident b) Tracking results of behaviors c) Any medication changes or GDRs related to behavior management for each specific resident d) Any concerns with side	09/01/2019

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	08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
	On 7/19/2019 at 9:05 a.m., a Nursing Progress Note indicated, "Resident was involved in altercation with another resident ....Sustained laceration to forehead, and bruise to neck. Incident reported to emergency contact [Name of Contact] at 10:31[a.m.]. Neuro [neurological] checks WNL [with in normal limits], and wound notes updated for head and neck. Incident reported to [Name of Nurse Practitioner] NP for [Name of Medical Group] group. States, 'I am alright', but sending to [Name of Hospital] for evaluation." On 7/19/2019 at 2:29 p.m., a Social Service Note indicated, "Today resident had an argument with his roommate which resulted in resident injury, after incident this writer met with resident and he reported to be doing well. He will go to the ER [Emergency Room] to be evaluated, nursing put a bandage on his head, and his mood appeared stable." On 7/19/2019 at 10:40 p.m., a Nursing Progress Note indicated, "Resident returned from ED [Emergency Department] evaluation. Noted with laceration to right side of forehead, intact and open to air at this time. V/SS [vital signs stable], low grade fever noted, and medicated as ordered. Also noted bruising to left side of neck, red in color. No complaints voiced/noted. No diff [difference] with medication administration. No acute distress noted." A wound/skin evaluation assessment, dated 7/19/19 at 9:56 a.m., indicated Resident B had a bruise, on his left neck, 11 cm (centimeters) by 4 cm. The bruise was purple in color, and there was erythema (redness) present. The facility's hospital transfer form, dated 7/19/19, indicated Resident B was involved in an		effects of behavior related medications e) Any behavior related physician progress notes f) Any behavior related assessments g) Care Plans Any concerns were reviewed and addressed as found. -What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not reoccur? Note: Resident B stated during the interview with the surveyor that he had ben roommates with Resident C with no issues up until the incident named in the survey. It would have been difficult for anyone to have anticipated and then prevented the behavior of Resident C 3. The DON/ADON/SSD will monitor the progress notes daily as well as the Behavior Tracking Sheets to ensure that all behaviors were addressed and managed timely and appropriately and per care plan and policy. This will be part of the daily CQI meeting agenda going forward. On weekends and holidays, a nurse manager will conduct the review. Any concerns will be addressed as found.	

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	08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
	altercation with another resident. Resident B was struck on the head with a cane. He had a laceration. On 8/2/19 at 11:27 a.m., the Director of Nursing (DON) provided a copy of Resident B's Emergency Room Discharge Record. The record indicated, on 7/19/19 Resident B was seen in the (Name of Hospital) Emergency Room for a closed head injury. He received a CT (computerized x-ray) scan, a tetanus injection (prevents infection), and the laceration to his head was repaired. On 8/2/19 at 10:55 a.m., during an interview, Registered Nurse (RN) 8 indicated, she was working on the day Resident B and Resident C had an altercation. She was on the 100 Hall and heard someone yelling "Stop! Stop!" She ran to the common area, by the nurse's desk. Two other staff members, who were there first, separated the residents. Resident B was seated in a chair, and Resident C was in his wheelchair, holding his cane. Resident C had just hit Resident B in the head with his cane. Resident B's head was bleeding. She put a bandage, and ice, on Resident B's head and called 911 (for an ambulance). On 8/2/19 at 9:12 a.m., the DON provided a current, undated policy, titled "Abuse Prevention Program." This policy indicated, "...It is the policy of this facility to prevent resident abuse, neglect, mistreatment and misappropriation of resident property. Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings...The facility desires to prevent abuse, neglect, and theft by establishing a sensitive and resident-secure environment...." On 8/2/19 at 12:09 p.m., the Administrator		The DON/ADON and the SSD will monitor to assure this is happening 3 days weekly x 4 weeks. Then monitoring will occur 2 days weekly for a period of not less than 6 months to ensure ongoing compliance. Any concerns will be addressed as found. The facility will continue to have a monthly Behavior Management Meeting attended by the appropriate Department Heads (usually the Administrator/ (DON/ADON/SSD/Activities Director/Dietary Mgr./MDS Coordinator/Therapy Representative/Charge Nurse/) well as a member of the psych provider team. At an in-service held for all staff on 8/21/19, and conducted by the DON, the following was reviewed: a) Behavior Management Program—over view of the program b) What should you do in your role as a staff member if you see or hear a resident say or do something that indicates that the resident may be having a "behavior" to include becoming upset or agitated? c) To whom should this be reported? When? d) Who would document	

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	08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
	provided a current, undated policy, titled, "Resident Rights." This policy indicated, "...You have the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion...." 3.1-27(a)(1)		behaviors? When? Where? e) Care Plans—related to behavior and appropriate interventions for various behaviors f) Guardian Angel Rounds—related to behaviors g) CNA Assignment Sheets h) Discussion—Questions and Answers Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. -How will corrective action be monitored to ensure the deficient practice will not reoccur? 4. At the monthly QAPI meetings, the results of the monitoring of follow up on behaviors done by the DON/ADON and SSD will be reviewed. Any patterns will be 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. Further, minutes of the Behavior Management meetings will be reviewed at the monthly QAPI meetings. Any concerns will be reviewed and discussed. If needed, the QAPI Committee will write an Action Plan. Any written Action Plan will be monitored by	

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	08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
			the Administrator weekly until resolved. -By what date will the systemic changes for the deficiency be completed? 5. **September 1, 2019**	