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	09/20/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00440656, IN00441557, and IN00442137. Complaint IN00440656 - Federal/State deficiencies related to the allegations are cited at F0684 and F0690. Complaint IN00441557 - No deficiencies related to the allegations are cited. Complaint IN00442137 - No deficiencies related to the allegations are cited. Survey dates: September 20, 2024 Facility number: 000172 Provider number: 155272 AIM number: 100267130 Census Bed Type: SNF/NF: 113 Total: 113 Census Payor Type: Medicare: 4 Medicaid: 84 Other: 25 Total: 113 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 24, 2024.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider for any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey.	
F 0684 SS=D	483.25 Quality of Care			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Victoria Gunter	RN	10/04/2024

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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Bldg. 00	Based on interview and record review, the facility failed to ensure monitoring was completed of a resident on anticoagulant medications for 1 of 3 residents reviewed for medications. (Resident B) Findings include: The clinical record for Resident B was reviewed on 9/20/24 at 1:00 p.m. The diagnoses included, but was not limited to, lung cancer and pulmonary embolism (blood clot in the lungs). The resident was admitted to the facility on 9/13/24. A hospital discharge medication list, dated 9/13/24, indicated Resident B was to receive 0.7 milliliters (ml) enoxaparin injection medication (anticoagulant medication) twice a day while receiving 5 milligrams (mg) of warfarin (anticoagulant medication) daily. The staff was to obtain daily international normalized ratio (INR) test (blood test measures how long it takes the blood to clot) until he becomes therapeutic with INR levels within a 2-3 range; then discontinue the enoxaparin and continue with the daily warfarin. A physician order, dated 9/13/24, indicated the resident was to receive 0.7 ml of enoxaparin injection twice a day. "Continue while giving warfarin with daily INR until INR becomes within 2-3 range, d/c [discontinue] enoxaparin." A physician order, dated 9/13/24, indicated the resident was to receive 5 mg of warfarin daily. A physician order, dated 9/19/24, indicated the staff was to obtain PT/INR (Prothrombin Time Test and INR) daily. The order was discontinued	F 0684	Resident B was not harmed by the alleged deficient practice. Resident B had a PT/INR drawn stat on 9/20/24. All Residents on warfarin have the ability to be affected. An audit was completed to ensure all residents have an order for PT/INR to be drawn and has been drawn and is current. Education was completed to all nurses using policy titled “Warfarin Monitoring”. An audit will be completed 3 times a week times 4 weeks then 2 times a week times 4 weeks then weekly times 4 weeks on all residents on Warfarin to validate that PT/INR labs are completed. The results of the audits will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months, then randomly, thereafter for further recommendation.	10/07/2024

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	on 9/20/24. A physician order, dated 9/20/24, indicated the staff was to obtain a PT/INR STAT (immediately). A September 2024 medication administration record indicated Resident B received the anticoagulant medications, 0.7 ml of enoxaparin injection twice a day and 5 mg of warfarin once a day from 9/14/24 through the morning of 9/20/24 as ordered. Resident B's medical record did not include a developed care plan for anticoagulant usage nor INR test results that had been obtained as ordered. An interview was conducted with the Assistant Director of Nursing (ADON) and the Nurse Consultant (NC) on 9/20/24 at 4:32 p.m. The ADON and the NC indicated the Nurse Practitioner (NP) wanted the resident to receive dosages of the warfarin and enoxaparin for at least a week before obtaining INR test results. They were unable to provide documentation that indicated the NP wanted to delay in obtaining INR results. The NC indicated she had developed the resident's care plan for anticoagulant usage that day. There was an order, on 9/19/24, to obtain the INR test, but the lab technician had missed it, and it was not obtained. An order was placed, on 9/20/24, for a STAT INR test to be conducted. A warfarin monitoring policy was provided by the NC on 9/20/24 at 4:48 p.m. It indicated, "...Procedure: A. The prescriber/physician will provide an order for INR monitoring for warfarin use. B. The frequency of the monitoring is specific to each resident based upon their medical history, reason for anticoagulation therapy, and medical			

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	condition. II. Communication Method. A. The facility will have an established communication method between the facility and the prescriber/physician for monitoring residents on the drug warfarin. B. The communication for documenting the INR labs by resident is in the form of a log...V. Assessments. A. The nurse will monitor the resident for signs/symptoms that may include but are not limited to... i. Unusual or excessive bleeding...ii. Unusual or excessive bruising of the skin. VI. Care plan. A. Information regarding anticoagulant therapy is placed on the care plan for the purpose of monitoring excessive bruising, or bleeding in the event of a fall, head injury or other injury. B. The reason for the anticoagulation therapy and the INR therapeutic range, if known...." This citation is related to Complaint IN00440656. 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on interview and record review, the facility failed to record urine outputs for residents utilizing a urinary catheter for 2 of 3 residents reviewed for urinary catheters. (Resident F and Resident G) Findings include: 1. The clinical record for Resident G was reviewed on 9/20/24 at 1:30 p.m. The diagnoses included, but was not limited to, paraplegia and neuromuscular dysfunction of bladder (bladder problems due to nerve/spinal cord damage).	F 0690	Resident F and Resident G were not harmed by the alleged deficient practice. Resident G and B were assessed with no issues noted. All Residents utilizing a urinary catheter have the ability to be affected. An audit was completed to ensure urinary output is being recorded any issues identified were corrected and the family and MD were notified. Education was completed to all nurses, QMAs and CNAs using policy titled “Intake and Output	10/07/2024

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	A care plan, dated 8/16/24, indicated Resident G had an indwelling and suprapubic (tube that drains urine from the bladder through a small incision in the lower abdomen) urinary catheters. A physician order, dated 8/15/24, indicated the resident had an 18 French (size of catheter) Foley Catheter (type of urinary catheter) to be changed every 30 days. A physician order, dated 8/15/24, indicated the staff was to measure and record the urine output every shift. A physician order, dated 8/15/24, indicated the staff was to empty the urostomy bag (an opening in the abdominal wall to redirect urine away from the bladder) every shift. The September 2024 Medication and Treatment Administration Records (MAR/TAR) indicated the following days the staff had not recorded any urine outputs for Resident G: Foley catheter: 9/1/24 - evening shift, 9/5/24 - evening and night shift, 9/14/24 - day shift, 9/16/24 - evening and night shift, and 9/18/24 - night shift. Urostomy bag: 9/1/24 - evening and night shift, 9/2/24 - evening shift - documented as NA (not applicable), 9/5/24 - evening shift - documented as NA, 9/13/24 - night shift - documented as NA, 9/14/24 - day shift,		Measurement". An audit will be completed 3 times a week times 4 weeks to ensure urine output is being recorded for residents utilizing a urinary catheter then 2 times a week times 4 weeks then weekly times 4 weeks. The results of the audits will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months, then randomly, thereafter for further recommendation.	

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	9/16/24 - evening and night shift, and 9/18/24 - night shift. 2. The clinical record for Resident F was reviewed on 9/20/24 at 1:30 p.m. The diagnoses included, but were not limited to, neurogenic bladder. A care plan, last revised on 3/5/24, indicated Resident E had a suprapubic catheter. The goal was for him to be free from catheter-related trauma. The interventions included, but were not limited to, provide catheter care every shift and as needed and notify medical provider if urine was of abnormal color, consistency, or odor. A physician's order, dated 5/7/24, indicated to measure and record output from urinary catheter every shift. A Quarterly Minimum Data Set assessment, dated 6/10/24, indicated he had an indwelling urinary catheter, and continence was not rated due to him having an indwelling catheter. The September 2024 TAR did not contain the amount of urine emptied from the urinary catheter on the following days and shifts: 9/6/24 - evening shift, 9/7/24 - evening shift documented as N/A, 9/9/24 - night shift documented as N/A, 9/10/24 - night shift, 9/11/24 - night shift, 9/14/24 - night shift documented as N/A, 9/15/24 - night shift, and 9/19/24- evening and night shift documented as N/A. An interview was conducted with the Assistant Director of Nursing on 9/20/24 at 3:13 p.m. She indicated the staff should be documenting urine			

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	output on the TAR for Resident F and Resident G every shift. This citation is related to Complaint IN00440656. 3.1-41(a)(2)			