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	09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME - A WATERS COMMUNITY	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00333061, IN00328225, and IN00321525. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00321525 - Unsubstantiated due to lack of evidence. Complaint IN00328225 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00333061 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Survey dates: September 15, 16, and 17, 2020. Facility number: 000376 Provider number: 155717 AIM number: 100275510 Census Bed Type: SNF/NF: 39 Total: 39 Census Payor Type: Medicare: 2 Medicaid: 36 Other: 1 Total: 39 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 25, 2020.	F 0000	Please consider this plan of correction as our credible allegation of compliance to the complaint survey ending on 9/17/20. We respectfully request a desktop review	

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

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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 appropriate monitoring, measuring, and treatments for a diabetic ulcer to the left heel which worsened over time before the resident required a below the knee amputation (Resident C); and failed to prevent skin impairment for a resident when a shoe horn was used to apply a tight-fitting shoe to a resident's right foot resulting in an abrasion to the right heel (Resident B), for 2 of 3 residents reviewed for skin impairment. Findings include: 1. During an observation, on 9/17/20 at 12:02 p.m., Resident C was observed in his room. The resident had bilateral (affecting both sides) below the knee amputations. A dressing was observed to the resident's left leg stump. At this time, the resident indicated he had been out to the hospital the day prior and his dressing was changed then. Resident C's record was reviewed on 9/16/20 at 1:58 p.m. A wound progress note from the hospital, dated 1/16/20, and presented to the facility upon admission indicated the resident	F 0684	Please consider this plan of correction as our credible allegation of compliance to the complaint survey ending on 9/17/20. We respectfully request a desktop review. F-684 It is the policy of this facility, in order to promote quality of care, to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, as well of resident choices. Resident C no longer receives monitoring and treatment for a diabetic ulcer. Other treatments remained and are properly completed and monitored. Resident B abrasion to right heel (ankle area) continues to receive treatment of calmoseptin daily as well as calcium alginate daily. Both care plans have been reviewed and updated to reflect changes. And resident at risk for skin	10/09/2020

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	had an arterial, neuropathic wound ulcer to the left heel that measured 5 centimeters (cm) x 5.7 cm and was 100% brown/black in color, with eschar (dry, dark scab or falling away of dead skin), and slightly boggy but dry and intact with no drainage. A podiatry consult indicated osteomyelitis, but not an acute infection. Vascular had been consulted and was considering palliative amputation or to continue with local wound care. A census record indicated the resident admitted to the facility on 1/22/20. Diagnoses on the resident's profile included, but were not limited to, acute osteomyelitis (inflammation of bone caused by infection) to left ankle and foot, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar) with diabetic neuropathy. A Medication Administration Record (MAR), dated January 2020, with a start date of 1/23/20 and discontinued on 2/4/20, indicated betadine solution, apply to left heel topically every day for wound care. The resident's medical record lacked documentation from 1/23/20 through 1/31/20 for measurements of the left heel ulcer. A MAR, dated February 2020, indicated left foot: cleanse with saline/gauze then place silver alginate (antimicrobial wound dressing). Cover with ABD (gauze) pad and secure with kerlix (gauze roll) and tape every shift. The MAR indicated the order was discontinued on 2/18/20.		breakdown has the potential to be negatively impacted by this deficient practice. Licensed nursing was educated on the policy “Preventive Skin Care” and “SWAT Meeting” by the DON on 10/6/20. All employees that fail to comply with the points of the in-service may be further educated. Additionally, a 100% audit of all wounds, skin care plans, interventions, and TAR’s/MAR’s have been reviewed for appropriateness and corrections made as indicated. The DON/and or designee will utilize compliance tool entitled “QI Pressure Ulcers” five times a week for four weeks, then three times a week for four weeks, then monthly for four months. Any concerns noted will be immediately corrected. Additionally, and trends identified will be further discussed in QAPI and another action plan may be developed as needed. 10/9/20	

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	The resident's medical record lacked documentation from 2/1/20 through 2/29/20 for measurements of the left heel ulcer. The record lacked documentation for a treatment order to the left heel from 2/19/20 through 2/23/20. A MAR, dated March 2020, indicated Dakin's (antiseptic) solution, apply to left foot and heel ulcers topically two times a day for wound care. Change dressing twice a day to left foot and heel ulcers with moisten Dakin's gauze, start date 2/24/20 and discontinued 3/27/20. The MAR lacked documentation the treatment had been completed at 9:00 a.m. on 3/24 and 3/26; and at 9:00 p.m. on 3/8, 3/13, 3/18, 3/21, and 3/25/20. The resident's medical record lacked documentation from 3/1/20 through 3/31/20 for measurements of the left heel ulcer. A MAR, dated April 2020, indicated cleanse left heel ulcer with saline, apply Santyl (debriding ointment), cover with gauze and ABD pad and secure with kerlix. The MAR lacked documentation this had been completed on 4/6/20. The resident's medical record lacked documentation from 4/1/20 through 4/9/20 for measurements of the left heel ulcer. A weekly wound evaluation, dated 4/10/20, indicated the resident had a diabetic ulcer to the left heel that measured 9 cm x 8 cm x unknown depth. A pain evaluation indicated pain of 4 on a scale of 1 to 10, and was tender to touch. The resident's medical record lacked			

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	documentation from 4/11/20 through 5/6/20 for measurements of the left heel ulcer. A MAR, dated May 2020 start date 3/28/20 and discontinued on 6/5/20, indicated cleanse left heel ulcer with saline, apply Santyl, cover with gauze and ABD pad and secure with kerlix. The MAR lacked documentation this had been completed on 5/8, 5/15, and 5/20. A weekly wound evaluation, dated 5/7/20, indicated the resident had a diabetic ulcer to the left heel that measured 9 cm x 9 cm x 0.2. A pain evaluation indicated pain of 4 on a scale of 1 to 10, and was tender to touch. The resident's medical record lacked documentation from 5/8/20 through 5/27/20 for measurements of the left heel ulcer. A weekly wound evaluation, dated 5/28/20, indicated the resident had a diabetic ulcer to the left heel that measured 6 cm x 6 cm x 0.1. A pain evaluation indicated pain of 4 on a scale of 1 to 10, and was tender to touch. A MAR, dated June 2020 start date 3/28/20 and discontinued on 6/5/20, indicated cleanse left heel ulcer with saline, apply santyl, cover with gauze and ABD pad and secure with kerlix. Also, cleanse anterior left foot with wound cleanser, pat dry and cover with abd pad and secure with kerlix. A weekly wound evaluation, dated 6/3/20, indicated the resident had a diabetic ulcer to the left heel that measured 6 cm x 5.5 cm x 0.1. A pain evaluation indicated pain of 3 on a scale of 1 to 10, and was tender to touch.			

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	A census record indicated the resident discharged from the facility on 6/4/20 and readmitted to the facility on 7/1/20. The record lacked documentation for a treatment order to the left heel from 7/1/20 through 7/13/20. The resident's medical record lacked documentation from 7/1/20 through 7/8/20 for measurements of the left heel ulcer. A weekly wound evaluation, dated 7/9/20, indicated the resident had a diabetic ulcer to the left heel that measured 9.5 cm x 9 cm x 1.3. A pain evaluation indicated pain of 5 on a scale of 1 to 10, had odor and was tender to touch. A physician's progress note, dated 7/9/20, indicated the resident had a diabetic ulcer to the left heel present on admission to the facility. The wound measured 9.5 cm x 9.0 cm x 1.3 cm. Discontinue santyl, calcium alginate, and ABD and kerlix order to left heel. New order to cleanse with 1/4 strength Dakin's solution, apply gauze moistened with 1/4 strength Dakin's solution. Cover with ABD pads x 2 and secure loosely with kerlix and tape, change dressing twice daily and as needed for soilage. Please refer resident to a vascular surgeon for possible intervention and or amputation recommendation. A MAR, dated July 2020, with a start date of 7/14/20 and discontinued on 7/23/20, indicated Dakin's full strength solution apply to left heel wet to dry topically two times a day. A progress note, dated 7/16/20 at 6:41 p.m., indicated the resident was transferred to the hospital due to left heel infected ulcer.			

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A progress note, dated 7/24/20 at 1:19 a.m., indicated the resident was readmitted to the facility. He had been admitted to the hospital on 7/17/20 for an infection to the left foot. His left foot was amputated as part of the intervention, and was now bilateral below the knee amputee.

During an interview, on 9/16/20 at 1:32 p.m., the Assistant Director of Nursing (ADON) indicated Resident C was admitted to the facility on 1/23/20 with a diabetic ulcer to the left heel. She was unable to find any documentation with measurements until 4/10/20 and there should have been weekly wound assessments completed that included measurements.

During an interview, on 9/17/20, the Director of Nursing (DON) indicated she was unable to find documentation of measurements for the resident's diabetic ulcer to his left heel from 1/23/20 through 4/9/20, and where it had been done weekly after that. She reached out to the prior DON and was told measurements were not recorded on the facilities electronic record, she had kept it on a notebook and took the notebook when she left the DON position at the facility. The current DON indicated she was unable to obtain the documentation from the prior DON. She was unable to find where treatments had been completed on the dates there was no documentation to support the treatment had been completed. Treatments should be completed as ordered and a weekly skin assessment that included measurements of the wound should have also been completed and documented in the resident's electronic record.

2. During an observation, on 9/16/20 at 1:39 p.m., Resident B was observed in a motorized

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	wheelchair. The resident was observed to have a bandage to his right heel and no shoe was observed to the right foot. Resident B's record was reviewed on 9/16/20 at 10:29 a.m. Diagnoses on the resident's profile included, but were not limited to, quadriplegia (paralysis caused by injury that results in the partial or total loss of use of all four limbs and torso). A care plan, initiated 8/10/20, indicated the resident required staff with activities of daily living (ADL's) due to quadriplegia. A physician's progress note, dated 9/10/20 at 10:35 a.m., indicated the resident had an abrasion related wound to the right heel. The wound was a full thickness abrasion related to the use of a shoe horn. The wound measured 1 centimeter (cm) length (l) x 1.4 cm width (w) x 0.2 cm depth (d). The amount of drainage was scant and would be classified as serosanguinous with 100% slough. A care plan, dated 9/10/20, indicated the resident had an abrasion to the right heel. During an interview, on 9/16/20 at 10:59 a.m., the Assistant Director of Nursing (ADON) indicated Resident B developed an abrasion to his right heel due to the staff using a shoe horn to put the resident's shoe on. It was determined the shoe was a tight fit and hard to put on by staff and that was why a shoe horn was used. The family provided better fitting shoes for the resident. The resident or staff had not mentioned the shoes were a tight fit prior to the development of the abrasion.			

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	On 9/16/20 at 12:10 p.m. the ADON provided a document, undated, and titled, "Preventive Skin Care," and indicated it was the policy currently being used by the facility. The policy indicated, "Guideline: It is the intent of the facility that the facility provide preventive skin care through careful washing , rinsing, and drying to keep residents clean, comfortable, well-groomed and free from pressure sores. All residents will be provided a preventative pressure reducing mattress...10. Ensure proper fit of...braces, shoes...." On 9/17/20 at 12:56 p.m. the DON provided a document, undated, and titled, "What to do for.... New Skin Areas," and indicated it was the policy currently being used by the facility. The policy indicated, "Assess the area: Measure wound (length x width x depth), description of the wound bed/tunneling. Undermining, description of the peri-wound, presence of odor, presence of pain...Complete a risk management report: make sure to be descriptive...Complete a new Braden assessment, complete a new skin and wound assessment...apply treatment (must be initialed and dated)...." This Federal tag relates to Complaint IN00333061. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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	§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 interventions were implemented after a fall for 1 of 3 residents reviewed for falls (Resident D). Findings include: A record review was completed for Resident D on 9/17/20. A progress note, dated 7/25/20 at 7:30 a.m., indicated Resident D fell during a self transfer from bed to wheelchair in an attempt to toilet. "Resident was found laying [sic] on right side between bed and wheelchair. Resident has no injuries. Skin intact. VS [vital signs] taken. Grips equal and strong. Resident has weakness from a recent stroke and is a new admit from 7/24/20. PERLA [pupils equal and reactive to light and accommodation]. Neuro [neurological] assessment initiated due to an unwitnessed fall. Resident did not want family notified due to no injuries. Physician and DON [Director of Nursing] notified." A fall risk assessment, completed on 7/25/20 at 6:03 p.m., indicated Resident D was a high risk for falls. This was based on the resident receiving a medication that affected her awareness, judgment and safety, she needed assistance with ambulation (movement), her gait (walking) included balance problems while standing/walking with decreased muscular coordination/jerking movements that required the use of assistive devices, and 1-2 health conditions that predisposed her to be at risk for	F 0689	Please consider this plan of correction as our credible allegation of compliance to the complaint survey ending on 9/17/20. We respectfully request a desktop review. 689 It is the policy of this facility to ensure the residents environment remain free of accident hazards and that each resident receives adequate supervision and assist devices to prevent accidents, including falls. Resident D fall interventions and care plans have been reviewed and updated as needed. All residents have the potential to be negatively impacted by this deficient practice. Licensed nursing was in-serviced by the DON on the policy “Fall Meeting Guidelines” on 10/6/20. Anyone who fails to comply with the points of the in-service may be further educated as needed. Additionally, a 100% audit of all falls that have occurred over the past 30 days has been completed for proper care planning and interventions. The DON and or designee will utilize audit tool entitled “Falls” for 100% of all falls for the next two months, then monthly for four months. And concerns noted will	10/09/2020

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	falls. Resident D's record lacked a care plan or documented interventions related to her high risk for falls. A progress note, dated 8/21/20 at 11:37 a.m., indicated Resident D was walking with her walker during therapy. She attempted to sit in her wheelchair (w/c) and fell forward, onto the floor, landing on her stomach. Vital signs and neuro checks were completed and were within normal limits (wnl). A skin assessment was completed with no open areas or swelling noted. Resident denied pain, dizziness or nausea. The resident was assisted up and into her w/c with the assistance of 2 staff. A fall care plan, initiated on 8/24/20, for Resident D, indicated, "The resident is at risk for falls r/t (related to) gait/balance problems. [Resident D's name] will be free of falls through the review date ...Anticipate and meet the resident's needs, be sure the [sic] [Resident D's name] call light is within reach and encourage the resident to use it for assistance as needed, the resident needs prompt response to all requests for assistance ...follow facility fall protocol." During an interview, on 9/17/20 at 12:30, the Director of Nursing (DON) indicated the expectation was to create a care plan after a first fall. There should have been further progress notes, and 72 hour follow-up. The neuro checks should have been implemented on paper and the care plan was not done. A current policy, titled, "Accident and Incident Guidelines," with no date, was provided by the DON on 9/17/20 at 2:03 p.m. A review of the policy, indicated, "Based on the results of the incident/accident/fall, the resident's care plan		be immediately corrected. Additionally, any trends noted will be further discussed in QAPI and an action plan may be further developed. 10/9/20	

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	will be addressed to ensure that any needed points of focus have measurable goals with appropriate interventions in place." This Federal tag relates to Complaint IN00328225. 3.1-45(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to			

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

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	155717	A. BUILDING 00 B. WING	09/17/2020

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	necessary. Based on observation, interview, and record review, the facility failed to ensure adequate social distancing for two staff members smoking outside and for 2 of 18 memory care residents observed eating breakfast (Residents 39 and 40). The facility failed to ensure a nurse did not touch medication with her bare hands before providing it for 1 of 5 residents reviewed for medication administration (Resident 21). Findings include: 1a. On 9/15/20 at 12:45 p.m., two staff members were observed standing outside smoking. They were standing within six feet of each other, not social distancing. During an interview on 9/15/20 at 1:12 p.m., Housekeeping Aide 7 indicated he and Laundry Assistant 8 were outside smoking with their masks down and they were not social distancing. During an interview on 9/15/290 at 1:41 p.m., Laundry Assistant 8 indicated she was outside with Housekeeping Aide 7, they were not socially distanced because she thought if she was outside it was not necessary. She did not realize when she had her mask off she needed to socially distance. On 9/15/20 at 3:09 p.m., the Administrator provided a document, dated 9/15/10, titled, "To All Employees." A review of this document indicated, "An interesting event happened when the surveyors observed staff going out to smoke. They took down their masks ...BUT DID NOT MAINTAIN SOCIAL DISTANCING! IT IS ABSOLUTELY A REQUIREMENT IF YOU ARE ON OUR PROPERTY YOU MAINTAIN	F 0880	Please consider this plan of correction as our credible allegation of compliance to the complaint survey ending on 9/17/20. We respectfully request a desktop review. 880 It is the policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections, including COVID. This program encompasses the need for residents and staff alike to be socially distanced by six feet, according to CDC guidelines. Resident 39 and 40 have shown no signs and symptoms of infection. Additionally, Resident 21 has shown no ill effects from the medication administration. All dining rooms have been specifically marked to ensure proper distancing in order to prevent transmission of virus. Face coverings have been provided to all residents. If resident cannot tolerate the mask, they will be social distanced, and care planned. A root cause analysis was conducted, and increased supervision and education was deemed primary cause. The ltc self-assessment	10/09/2020

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	SOCAIL [sic] DISTANCING." During an interview, 9/15/20 at 3:09 p.m., the Administrator indicated the facility had no policy for employee social distancing, but we gave them education one a month. She provided the educational in-service document, titled, "Tips for Staying Safe during COVID." A review of this document indicated, " ...Maintain social distancing everywhere!" 1b. On 9/16/20 at 8:45 a.m., during the memory care (MC) breakfast, Resident 39 and Resident 40 were seated at the same table with no social distancing. They were not wearing masks. During an interview, on 9/16/20 at 9:50 a.m., the Director of Nursing (DON) indicated the residents should not be sitting closer that six feet while eating. During an interview, on 9/16/20 at 10:18 a.m., the Administrator indicated the MC residents eat in different stages to keep residents six feet apart during dining. On 9/17/20 at 9:35 a.m., the Administrator indicated there was no specific policy for residents staying 6 feet apart. She believed it was in the general policy and would provide that policy. No resident specific policy about social distancing was provided. The CDC Guidance. - What you need to know about Coronavirus disease 2020 (COVID-19). "Risk of infection with COVID-19 is higher for people who are close contacts with someone known to have COVID-19, for example healthcare workers, or household members...The virus is thought to spread mainly between people		was updated as needed. All residents all the potential to be impacted by this deficient practice. All staff was in-serviced on the policy “Staff responsibilities” and “Infection Prevention” by the DON and or designee on 10/6/20. Additionally, all licensed nursing was educated on the policy “Medication Administration” by the DON and or designee on 10/6/20. Anyone who fails to comply with the points of the in-service will be further educated. To improve social distancing all dining rooms were structure to maintain proper social distancing, including seating six feet apart. Additionally, designated areas for staff to smoke have been established. The DON and or designee will utilize the audit tool entitled “Social Distancing compliance for staff” and “Social Distancing compliance for residents daily for 6 weeks, then once a week for two weeks, then monthly for four months. Additionally, the DON and or designee will utilize audit toll entitled “Medication Infection Control Compliance” five days a week for four weeks, then three days a week for four weeks, then monthly for four months. Any concerns will be immediately corrected. Results on monitoring will be further reviewed in QAPI and if trends are identified then	

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	who are in close contact with one another [within about 6 feet] through respiratory droplets produced when an infected person coughs or sneezes. It may also be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes ...If you have traveled from an affected area, there may be restrictions on your movements for up to 2 weeks ...While sick, avoid contact with people, don't go out and delay any travel to reduce the possibility of spreading illness to others ..." 2. During a medication administration observation, on 9/16/20 at 8:55 a.m., Licensed Practical Nurse (LPN) 9 provided medication for Resident 21 from the 300 cart. She dropped each medication into the medication cup without touched them, as follows: atorvastatin calcium 10 mg (anti-cholesterol), depakote 250 sprinkles (anti-epileptic), buspirone 7.5 mg (anxiolytic), metformin 1000 mg (controls the amount of sugar in the blood), Vitamin c 1000 mg (supplement), and cholecalciferol capsule (Vitamin D3 supplement) 5000 units. When dropping the medication: levocarnitine 990 mg (protein based dietary supplement), a piece of foil backing, dropped in medicine cup with all of the other medications, the nurse pulled the foil out with her artificial nails and gave the medication to Resident 21. On 9/16/20 at 9:08 a.m., LPN 9 indicated she should not have pulled the foil backing out of the medication cup with her artificial nails with Resident 21's medication in it because it contaminated the medication. During an interview, on 9/16/20 at 10:25 a.m., the DON indicated the nurse should not have		another action plan may be developed. 10/9/20	

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	touch the resident's medication at any time, and the nurse should not have touched anything that goes into the resident's mouth. 3.1-18(b)(1) 3.1-18(b)(4)			