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	03/18/2022

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00374443, IN00374918, IN00375155, and IN00375460. Complaint IN00374443- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00374918- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00375155 Substantiated. Deficiencies related to the allegations are cite at F0637 and F0656. Complaint IN00375460- Substantiated. No deficiencies related to the allegations are cited. Survey dates: March 16, 17, and 18, 2022. Facility number: 000172 Provider number: 155272 AIM number: 100267130 Census bed type: SNF/NF: 135 Total: 135 Census payor type: Medicare: 34 Medicaid: 100 Other: 1 Total: 135 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 31, 2022	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint (IN00374443, IN00374918, IN000375155, IN00375460) on 3/18/2022. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

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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F 0637 SS=D Bldg. 00	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)			
	Based on record review and interview, the facility failed to ensure a significant change Minimum Data Set assessment was done within 14 days of a resident exhibiting signs of a significant change in medical condition, including decreased appetite, refusal of hydration, onset of nausea and weakness, urinary incontinence, a new requirement for intravenous fluids, a change in responsiveness, and a new onset of dysphagia and nausea. Findings include: The record of Resident B was reviewed on 03/16/22 at 11:00 A.M. Diagnoses included, but were not limited to, congenital hydrocephalus, malnutrition, symptoms involving cognitive functions and awareness, irritable bowel syndrome, gastro-esophageal reflux disease, and hypertension. A review of progress notes for Resident D indicated:	F 0637	**F 637** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident B has been discharged. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: MDS Coordinator or designee will audit current residents for a significant change in status, per the RAI Manual, to ensure a significant change Minimum Data Set assessment was done within 14 days of the identified significant change. **Measures put in place and**	04/25/2022

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	A note dated 1/15/22 indicated the resident was seen for decreased appetite and fluid intake. The family requested (IV)intravenous fluids be started. A note dated 1/19/22 indicated the resident had been out to the hospital and returned. A note dated 1/20/22 indicated the resident was seen for a change in condition-Urinary incontinence. IV fluids were started and labs were ordered. A note dated 1/21/22 indicated the resident demonstrated a slowed responsiveness, decreased mobility, tachycardia, was not drinking water, and eating little of offered food. A note dated 1/25/22 indicated the resident was experiencing low blood pressure, and an alteration in mental status. A note dated 1/27/22 indicated the resident refused to get out of bed to her wheelchair. A note dated 1/31/22 indicated the resident had a urinary tract infection and was started on an antibiotic. A note dated 2/10/22 indicated the resident was seen for a new onset of dysphagia and nausea. The resident was gagging on pills and was nauseated, both new onset. The dysphagia was noted as acute, sudden in onset, and ongoing. A note dated 2/11/22 indicated the resident could not swallow medication even if crushed. A Care Conference note dated 2/17/22 indicated		**systemic changes made to ensure the alleged deficient practice does not recur:** Regional MDS Coordinator or designee will re-educate the MDS Lead and MDS Assistant on the guidelines, per the RAI manual, on identifying a significant change in condition and completing the MDS timely. The MDS Coordinator will attend clinical meeting 5 days per week to review the resident's clinical documentation to identify an significant change in status and schedule the MDS. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the MDS Coordinator or designee 2 times per week times 8 weeks then monthly x 4 months to ensure compliance: audit residents for a significant change in status, per the RAI Manual, to ensure a significant change Minimum Data Set assessment was done within 14 days of the identified significant change The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality	

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	the resident the resident had lost weight, declined supplements, ate very little, had trouble swallowing medications, and lacked participation in her care. Hospice and a change of code status were discussed. A note dated 2/21/22 indicated the resident was sent to the hospital. The Executive Director, Director of Nursing, and Social Worker were interviewed on 3/18/21. The Director of Nursing indicated the facility did not have a policy related to Minimum Data Set assessments, but followed the regulations and guidelines. This Federal tag relates to Complaint IN00375155. 3.1-31(d)(1)		Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be			

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	required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on record review and interview, the facility failed to ensure a resident who had repeated refusals of nutrition, hydration, and medications, had care plans that addressed these issues, with appropriate focus, goals, interventions, and measurable outcomes for 1 resident of 4 reviewed for care plans. (Resident D.) Findings include: The record of Resident B was reviewed on 03/16/22 at 11:00 A.M. Diagnoses included, but were not limited to, congenital hydrocephalus, malnutrition, symptoms involving cognitive functions and awareness, irritable bowel	F 0656	**F 656** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident D has been discharged. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: MDS Coordinator or designee will audit current residents for	04/25/2022

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	syndrome, gastro-esophageal reflux disease, and hypertension. A review of progress notes for Resident D indicated: A noted dated 1/20/22 indicated the resident was not drinking fluids, even with encouragement. A noted dated 1/21/22 indicated the resident was provided water continuously but would not drink, was eating 20% (percent) of her meals or less, and the family had been made aware. A noted dated 1/25/22 indicated the resident refused to be weighed. A noted dated 1/27/22 indicated the resident refused to get up in her wheelchair, choosing to lay in bed. A noted dated 2/10/22 indicated the resident was seen for loss of appetite and not drinking enough fluids. A noted dated 2/11/22 indicated the resident was consuming only 5% of her meals with very little fluid intake. A noted dated 2/13/22 indicated the resident refused medications. A noted dated 2/14/22 indicated the resident refused medications. A noted dated 2/15/22 indicated the resident refused medications. A noted dated 2/16/22 indicated the resident refused medications at two separate times.		repeated refusals of care to ensure a care plan is in place with an appropriate focus, goal, interventions and measurable outcomes. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Regional Director of Clinical or designee will re-educate the MDS Lead, MDS Assistant and DON on the facility policy for Plan of Care. The MDS Coordinator, DON and designee will attend clinical meeting 5 days per week to review the resident's clinical documentation to identify any refusals of care to ensure a care plan is in place with an appropriate focus, goal, interventions and measurable outcomes. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the MDS Coordinator or designee 2 times per week times 8 weeks then monthly x 4 months to ensure compliance: audit residents for repeated refusals of care to ensure a care plan is in place with an appropriate focus, goal, interventions and measurable	

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	Resident D's care plans, which have a final revision date of 3/13/2022, contain no focus or identified problem related to Resident D's behavior of refusing medications, hydration, nutrition, and positioning, including appropriate goals and interventions, with measurable objectives and time frames. The Executive Director, Director of Nursing, and Social Worker were interviewed on 3/18/21 and the issue of Resident D's care plans was addressed. None had any further information to provide. A policy titled "Care Plan Overview" dated 7/26/18 was received from the Director of Nursing on 3/18/22 at 11:00 A.M. It indicated: "Definitions: for the purpose of this policy the Plan of Care, also Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care. Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents.... Procedure: d. The facility will:..Review care plans...with significant changes in care." This Federal tag relates to Complaint IN00375155. 3.1-35(a)		outcomes. 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.	