DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	04/13/2022

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 a Recertification and State Licensure Survey. This visit included Investigations of Complaints IN00373923, IN00376769, IN00376905 and IN00377535. This visit resulted in an Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00373923 - Unsubstantiated due to lack of evidence. Complaint IN00376769 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00376905 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00377535 - Unsubstantiated due to lack of evidence. Survey dates: April 4, 5, 6, 7, 8, 11, 12 and 13, 2022. Facility number: 000376 Provider number: 155717 AIM number: 100275510 Census Bed Type: SNF/NF: 57 Total: 57 Census Payor Type: Medicare: 6 Medicaid: 39 Other: 12 Total:	F 0000	Preparation or 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. The Plan of Correction is prepared and executed solely because it is required by Federal and State law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during survey event ID V9S711. Please accept this plan of correction as the provider's credible allegation of compliance We respectfully request a desk review for 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.

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	04/13/2022

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
	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 26, 2022.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination,			

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	04/13/2022

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
	or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to maintain the dignity of residents by not cleaning up urine in a timely manner, and not cleaning up a resident with food spilled on her who required assistance to eat for 2 of 3 residents reviewed for dignity (Residents 30 and 36). Findings include: 1. During a random observation on 4/4/22 at 9:56 a.m., Resident 30 was observed sitting up on the edge of her bed with her bedside table in front of her with a breakfast tray. She wore a hospital gown and there was a pile soiled linen at her bare feet. There was a puddle of fluid that soaked out from under the linen and Resident 30's bare feet sat in the fluid. At this time Resident 30 at first indicated she spilled water on the floor, but the room and air directly around her was pungent with the smell of urine. When asked if she had an accident, Resident 30 indicated she did, she was just embarrassed to say that at first. She indicated Sometimes she can get to the bathroom on her own, sometimes she needed help, but that morning she didn't make it. Resident 30 indicated she did not know how long ago it had been, but when she told the staff about it, they just brought her towels and put them on the floor and said they would get to it after breakfast.	F 0550	F550-Resident Rights 1. Resident #30 and resident #36 had no adverse outcomes related to the deficient practices. Resident #30's plan of care was updated to include a toileting program. QMA #14 and CNA #26 were educated on resident rights to include dignity. 2. Any resident who needs assistance with incontinence care or eating has the potential to be affected by the alleged deficient practice. 3. DON/designee will educate all staff on residents rights to include dignity. DON/designee will conduct dignity rounds to ensure residents are assisted with toileting/incontinence care, clothing is clean and dry, and residents are assisted with eating as per plan of care. 4. Audits will be completed by DON/designee 5 x week x 4 weeks, 4 x week x 4 weeks, 3 x week x 4 weeks, 2 x week x 4 weeks, weekly x 4 weeks, then monthly for 2 months. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and	05/12/2022

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	04/13/2022

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 4/4/22 at 10:45 a.m., Resident 30 was observed. The urine-soaked towels remained on the floor. During an interview on 4/4/22 at 10:46 a.m., Certified Nursing Aid (CNA) 28 indicated he was not aware that Resident 30 had an accident, but it was probably not cleaned up yet since there was no housekeeping staff that morning. They had just gotten to the building, and he would let someone know to help get it cleaned up. During a second random observation on 4/5/22 at 10:55 a.m., Resident 30 called from her room. At this time, she was observed as she sat in a WC in her room, but there was a large puddle of fluid directly under her and surrounded the area in front of bed and where she sat in the wheelchair. Resident 30 indicated she accidently spilled her water cup, but no one had come and cleaned it up yet. During an interview on 4/6/22 at 10:57 a.m., an agency CNA (CNA 29) indicated she was aware Resident 30 has spilled her water, and indicated, she probably did it for attention. CNA 29 indicated she was an agency CNA, so she did not know where a mop was. During an interview on 4/6/22 at 11:00 a.m., CNA 28 indicated if a resident had an accident, like went to the bathroom on the floor or spilled water it should be cleaned up immediately to prevent a fall, and also for the resident's dignity. On 4/13/22 at 9:00 a.m., the Administrator provided a copy of current, but undated facility policy titled, "Resident Rights." The policy indicated, "As a resident of this facility, you have the right to a dignified existence... the facility will treat you with dignity and respect in full		submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. 5. DOC 5/12/22.	

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	04/13/2022

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

recognition of your individuality... the facility must provide a safe, clean, comfortable, home-like environment...."2. On 4/08/22 at 9:25 a.m., Resident 36 was observed as the last person eating in the Well Springs (memory care) dining room. The remaining trays, dishes, and food had been removed and the tables cleaned up. She was trying to eat cereal in milk. The cereal and milk were observed spilled down the front of her shirt, in her lap, and on the thigh and calf of her pants. Cereal and milk were observed in a puddle of the floor. No staff members were present in the memory care dining room.

On 4/08/22 at 9:31 a.m., Resident 36 was observed to move herself, with her legs only, in her wheelchair near the doorway of another resident room. She made a slight arm gesture to go in by raising her arm toward the room. Qualified Medical Aide (QMA) 14 was working with medications at the medication cart near her. Resident 36 was slightly slumped in her chair with her head down.

During a continuous observation from 9:31 to 10:34 a.m., several unidentified Certified Nursing Aides (CNA) walked past the resident several times. QMA 14 walked past her twice. CNA 26 walked past the resident 4 times.

On 4/08/22 at 11:30 a.m., Resident 36's record was reviewed. Her diagnoses included, but were not limited to, schizoaffective disorder bipolar type (mental illness that can affect your thoughts, mood and behavior with mania, depression and psychosis), protein-calorie malnutrition, muscle wasting and atrophy (loss of muscle tissue, thinning) to right and left upper arm, Alzheimer's disease (progressive mental deterioration), and muscle weakness, lack of coordination. Her Brief Interview for Mental Status (BIMS) indicated she

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	04/13/2022

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
	had severe cognition impairment. A care plan, dated 1/22/21, indicated Resident 36 had limited physical mobility related to muscle wasting and atrophy. A care plan, dated 1/5/21, indicated Resident 36 required assistance with activities of daily living (ADLs) related to cognition and debility. Interventions included, but were not limited to, staff assist as needed with eating and assist as needed so resident is clean and dry. A care plan, dated 2/6/21, indicated Resident 36 had a history of weight loss and received an appetite stimulant. On 4/12/22 at 4:49 p.m., the Administrator indicated the staff should have helped her with eating and should have cleaned her up immediately after. A current policy, titled, "Resident Rights," with no date, was provided by the Administrator, on 4/13/22 at 10:20 a.m. A review of this policy indicated, " ...As a resident of this facility, you have the right to a dignified existence...The facility must care for you in a manner and environment that enhances or promotes your quality of life...." 3.1-3(a)			
F 0558 SS=E Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident			

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	04/13/2022

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
	or other residents. Based on observation, interview, and record review, the facility failed to ensure call lights were in reach for 5 of 20 residents reviewed for call lights in reach (Resident 12, 17, 33, 34, and 35). Findings include: On 4/04/22 at 3:28 p.m., Resident 35 was in his room. His call light was clipped to the call light cord as close to the wall as possible. It was not in his reach. On 4/07/22 at 9:07 a.m., Resident 35 was in bed, his call light was on the floor, out of his reach. On 4/08/22 at 10:18 a.m., Resident 34's call light was clipped near her pillow. She was in her wheelchair on the other side of the bed. Her call light was not within reach. On 4/08/22 at 10:20 a.m., Resident 17 was laying in her bed, with her head at the foot of the bed. Her call light was at the head of the bed, on the floor. The call light was not in reach. On 4/08/22 at 10:29 a.m., Resident 12 was in bed with her eyes closed. Her call light was at the head of the bed, on the floor. It was not within reach. On 4/08/22 at 10:30 a.m., Resident 33 was partially sitting up in bed, holding a pink bin to her chest. She indicated she was sick to her stomach and felt like vomiting. Her call light was at the head of the bed, on the floor, against the wall. During a continuous tour with Maintenance, on 4/11/22 from 10:23 to 11:30 a.m., the findings were observed by as follows:	F 0558	F558-Reasonable Accommodations/Preferences 1. The identified residents had no adverse outcomes related to the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. DON/designee will educate nursing staff on the policy “Call Lights”. The education was completed on or before 5/11/22. DON/designee will complete audits to ensure call lights are within reach of resident when in their room. 4. Audits will be completed by DON/designee 5 x week x 4 weeks, 4 x week x 4 weeks, 3 x week x 4 weeks, 2 x week x 4 weeks, weekly x 4 weeks, then monthly for 2 months. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. 5. DOC 5/12/22.	05/12/2022

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	04/13/2022

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
	Resident 34's call light was observed to be clipped under the blanket and sheet of her made bed. She was in her wheelchair on the other side of the bed. It was not in reach. On 4/11/22 at 11:54 a.m., the Director of Nursing (DON) indicated if the resident was in bed the call light should be clipped near them, if the resident was out of bed, the call light should be clipped to them. On 4/11/22 at 11:58 a.m., the Administrator indicated the staff should answer the call light in 5-10 minutes and be in reach of the resident. A current policy, titled, "Call Lights," with no date, was provided by the Administrator, on 4/11/22 at 9:15 a.m. A review of the policy indicated, " ...Always place the call light in an accessible location to where the resident is located in their room ...." 3.1-3(v)(1)			
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident			

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	04/13/2022

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
	or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.			
	Based on observation, interview and record review, the facility failed to ensure grievances and concerns presented by the Resident Council were responded to for 6 of 6 regularly participating Resident Council members (Residents 9, 15, 19, 29, 39 and 44). Findings include: During an interview on 4/4/22 at 11:15 a.m., the Resident 15 indicated it would be a great idea to have a Resident Council meeting during the survey because the residents had a lot of issues they would like to talk about.	F 0565	F 565 Resident/Family Group and Response 1. A concern form for Resident Council meeting was given to the Activity Director on May 5, 2022; it is to be used to address concerns brought up in resident council. 2. All residents have the potential to be affected by this deficient practice. 3. Administrator reviewed “Resident Council Guide” along with concern form to be used. This education was completed on	05/12/2022

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	04/13/2022

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 4/12/22 at 10:13 a.m. the Resident Council minutes were reviewed. From January 2021 to February 2022, the Resident Council met 12 times on the following dates: 1/7/21, 2/18/21, 3/10/21, 4/10/21, 5/21/21, 7/21/21, 8/23/21, 9/21/21, 10/21/21, 11/21/21, 1/21/22, and 2/16/22. For all 12 meetings, there were no Resident Council Response forms on file. There were several reoccurring concerns discussed by the Resident Council over these 12 meetings which included but were not limited to: a. Request for additional smoke breaks (more than the allotted 3 times a day) b. Call light response time c. More/alternative activity choices d. Honoring shower/bathing preferences e. Environment/gnats An ad-hock Resident Council Meeting was held on 4/12/22 at 2:0 p.m., with Residents 9, 15, 19, 29, 39 and 44 present. When the residents were asked if the facility responded to the group's concerns, they all answered "no." The following concerns were shared as "on-going" issues that the residents wanted addressed. The Resident 15 indicated her biggest request was to increase the amount of smoke breaks that were allowed. She indicated, she was of sound mind, and had been smoking since she was 9, she wanted more than 3 quick smoke breaks where she was supervised like a baby. She indicated the group has complained over and over about the amount of smoke breaks and the facility just said, "those are the rules, and if you don't like it, then you can find somewhere else," but then they don't help you look for another place. All the residents in attendance conquered with this concern. Resident 39 indicated he used to be the Resident Council president and one of the reasons he quit		May 5, 2022. 4. Social Services/designee will audit resident council minutes to ensure concerns are addressed timely. Audits will be done monthly for 6 months. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. 5. DOC 5/12/22.	

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	04/13/2022

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

was because the meetings seemed pointless because they all kept complaining about the same things and nothing ever got done about it. All the residents in attendance agreed with this concern.

Resident 19 indicated it would be nice to be able to go outside when she wanted. Staff treated the building like it was a prison, and the residents who were "mentally ok" were not allowed to sign LOA (leave of absence) or go outside when they wanted. "It feels like a prison." All the residents agreed it would be nice to go outside when they wanted, but if it was bad weather, at least have activities available inside.

All the residents in attendance indicated the only activity they had was Bingo twice a week. Activities on the calendar did not happen as scheduled. They agreed it would be nice to have activities to keep them occupied and have something meaningful to do.

Resident 44 indicated when she had questions about her medication scheduling or dosage, the nurses or Qualified Medication Aides (QMA) on the cart looked at her like she had no business asking about it. Resident 44 indicated she never saw a doctor, instead the staff would just bring around a phone with a video chat that would barely last a minute. All the residents during the meeting agreed, the Tele-health phone/video doctors were not good enough and wanted to see a doctor in person.

During an interview with the Activities Director (AD), on 4/12/22 at 2:45 p.m., she indicated she was new to the position and had just finished her Activity Director 90-hour training course. The AD indicated she brought the Resident Council Grievance procedure to the Quality Assurance

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	04/13/2022

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
	Program (QAPI), but nothing had been done about it yet and was not sure who the appointed grievance response person was. During an interview about the facilities' QAPI program, on 4/13/22 at 12:40 p.m., the Administrator and Regional Director of Operations were present. The Administrator indicated the purpose of QAPI was to give the facility the opportunity to identify concerns about itself and address those concerns for quality assurance and customer service for residents and staff. Although there were a set of scheduled topics addressed throughout the year, the ADM indicated, some of the top identified concerns at that time included but were not limited to: nursing admission assessments, nursing documentation, and staffing. The Administrator did not indicate Resident Council Grievance procedures and a recent concern. On 4/13/22 at 9:00 a.m., the Administrator provided a copy of current, but undated facility policy titled, "Resident Council Guide." The policy indicated, "...The Resident Council is an independent, organized group of residents who meet on a regular basis to create change, address quality and dignity of care provided in the facility, plan activities and discuss other matters brought before the council. The role of the Resident Council is to improve the quality of life of the residents who reside in the facility and to take part in actions to maintain a positive living environment... the Resident Council offers an avenue by which residents can have an active role in influencing decision which will affect them. Participation and involvement in the Resident Council gives the resident a sense of being in control which results in a positive impact on their physical and mental health. Some objectives of			

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	04/13/2022

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 council are as follows: A. Improves communication between staff and residents... C. Helps identify quality of life issues... E. Identify issues early when they may be easier to correct; before becoming larger scale. F. Provide input on the planning of activities and events... H. Encourage a person-centered philosophy of care through recommendations... Group Concerns and Follow-Up: It is vital to establish an atmosphere of trust and responsibility for concerns to be voiced. This encouraged members to openly discuss issues that impact them and/or other residents... the council group members who voice a concern usually except a timely response about the resolution to their concern. this must happen. The Administrator monitors this process... Effective Council Requirements: Concerns- when concerns are voiced show serious interest and approach follow up on all concerns and GET BACK WITH RESOLUTIONS/Document demonstrate that all concerns/requests brought up by the council either individually or by the group are very important...." On 4/13/22 at 9:00 a.m., the Administrator provided a copy of current, but undated facility policy titled, "Resident Rights." The policy indicated, "...you may expect prompt efforts for the resolution of grievances... the facility will provide a staff person to assist and follow up with the group's written requests..." 3.1-3(k)			
F 0575 SS=C Bldg. 00	483.10(g)(5)(i)(ii) Required Postings §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and			

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	04/13/2022

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
	email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.			
	Based on observation, interview and record review, the facility failed to post contact information for the State Ombudsman. This deficient practice had the potential to effect 57 of 57 Residents who resided at the facility. Findings include: On 4/4/20/22 at 1:13 p.m., during a random observation of the facility, the posting for the State Ombudsman contact information was not seen in the facility. On 4/4/22 at 2:41 p.m., during a walking tour observation and interview, the Administrator indicated the Ombudsman information should have been posted and available to all residents. A wall across from the Nurses' Station, was	F 0575	F 575 – Required Posting 1. The required contact information for the Ombudsman was immediately posted. 2. All residents have the potential to be affected by the deficient practice. 3. Administrator/designee will educate resident council on the location of contact information for the ombudsman. This education was completed on or before 5/11/22. Administrator/designee will audit the location to ensure the contact information remains posted. 4. Audits will be completed by Administrator/designee weekly for	05/12/2022

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	04/13/2022

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
	observed with Residents' Rights and Elder Justice Act posted in frames. The Administrator indicated it should have been posted on that wall, but it was not there. She pointed out a nail on the wall where it should have been. An Easter basket decoration was hung on that nail. On 4/6/22 at 11:48 a.m., the Administrator indicated there was no policy for posting of the Ombudsman's contact information. The facility followed all State regulations. A current policy, titled, "Resident Rights," with no date, was provided by the Administrator, on 4/13/22 at 10:20 a.m. A review of the policy indicated, " ...The facility must post the names, addresses and telephone numbers of all pertinent state client advocacy groups ...." 3.1-4(j)(3)(C)		4 weeks; then monthly for 5 months. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. 5. DOC 5/12/22.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to			

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	04/13/2022

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
	inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.			
	Based on interview and record review, the facility failed to ensure residents had a code status and had the correct code status according to the wishes of the resident and legal guardian for 2 of 24 residents reviewed for code status (Resident D and B). Findings include: 1. On 4/6/22 at 3:56 p.m., a nursing progress note, dated 1/24/22 at 3:36 p.m., indicated Resident D had returned from the hospital. While in the hospital, she became a do not resuscitate (DNR). "...Will have mother check with social worker to	F 0578	F578-Request/Refuse/Discontinue TX/Advance Directives 1. Resident D's code status was changed to DNR on 4/12/2022 and care plan updated to reflect change. An order was obtained for Resident B's code status on 4/5/22. A care plan was updated on 4/6/22 to reflect residents code status. 2. All residents have the potential to be affected by the deficient practice. A full house audit of resident code statuses	05/12/2022

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	04/13/2022

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
	get status changed." On 4/7/22 at 9:48 a.m., Resident D's record was reviewed. A facility physician's order indicated Resident D was a full code. The facility's POST (physician's orders for score of treatment) form, dated 6/9/21, was reviewed. It indicated, to provide CPR (cardiopulmonary resuscitation: external cardiac massage and breathing). A care plan, dated 6/9/21, indicated Resident D had a full code status. A review of the care plan indicated; the resident requested CPR measures be attempted when needed. Communicate resident's choice to necessary healthcare providers as needed. If cardiac arrest or no respirations occurred, do initiate resuscitation/CPR, Call 911. Transfer to the hospital or Intensive Care Unit if indicated to meet medical needs. Hospital/EMTs (emergency medical technician) to initiate interventions including life support measures such as intubation (place breathing tube of throat and provided artificial breathing), mechanical ventilation, IV (intravenous) fluids/medications, treatment to stabilize medical condition and comfort needs. On 4/7/22 at 1:17 p.m., the Director of Nursing (DON) provided Resident D's discharge summary from her 1/19/22 to 1/24/22 hospital stay. The hospital discharge summary indicated the resident's code status was discussed with the patient's family, " ...we have decided that the patient will not receive resuscitative efforts ...." During an interview on 4/10/22 at 7:27 p.m., the legal guardian for Resident D indicated she		was completed and verified with resident/legal guardian. Any discrepancies were immediately corrected. Care plans were updated as needed to reflect correct code status. 3. DON/designee will educate nursing staff/social services on the policy “Advance Directives Policy and Procedure” and the policy for initiating a baseline care plan for code status. This education was completed on or before 5/11/22. DON/designee will complete audits on new admissions to ensure a code status is present and a baseline care plan has been initiated for code status. 4. Audits will be completed by DON/designee 5 x week x 4 weeks, 4 x week x 4 weeks, 3 x week x 4 weeks, 2 x week x 4 weeks, weekly x 4 weeks, then monthly for 2 months. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. 5. DOC 5/12/22.	

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	04/13/2022

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

wanted Resident D as a no code at the hospital and at the facility. Before Resident D had a traumatic brain injury, Resident D had voiced she did not want to be put on a machine to survive. She did not want CPR (cardiopulmonary resuscitation: external heart massage).

A Job Description document, titled, "Director of Social Services," with no date, was provided by the Administrator, on 4/11/22 at 9:15 a.m. A review of the job description indicated, " ...Obtains updated information over the telephone from Hospital Discharge Planner to prepare various departments of incoming resident's needs...Updates any new assessment information on resident's chart ...."

On 4/11/22 at 12:13 p.m., the DON indicated the facility did not know the legal guardian had spoken to the doctors at the hospital and determined together that Resident D would be a no code. The legal guardian nor the hospital had provided the no code documents from the hospital. Everything had to be signed in the facility, not just a "say so" from the hospital medical doctor.

On 4/11/22 at 12:15 p.m., the Administrator indicated to the DON, if the legal guardian had a witness, the facility could make the code change over the telephone.

On 4/12/22 at 11:36 a.m., the Regional Director of Operations indicated the facility would adopt whatever the hospital indicated. The facility Social Services Designee (SSD) should have followed up.

On 4/12/22 at 1:37 p.m., the Administrator provided a new POST form for Resident D. It was

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	04/13/2022

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

dated 4/11/22, and indicated do not attempt resuscitation, comfort measure to allow a natural death.2. On 4/5/22 at 10:05 a.m., during an observation and interview, Resident B was lying in bed watching television. Both of his legs were wrapped in gauze, from his knees to his ankles. The resident indicated the wounds were from his diabetes and he was unable to wear shoes comfortably. He had stopped taking his diabetic pills at home because he thought he didn't need them. That was what caused his problems and landed him in the hospital. He had "a lot of pain" in his legs, "they hurt all the time." He rated his pain as 6 out of 10. They gave him some Advil or "something like that." It helped "a little bit."

On 4/5/22 at 3:15 p.m., the electronic and paper medical records were reviewed for Resident B. The diagnoses included but were not limited to diabetes with neuropathy (nerve pain), cellulitis (skin infection) right lower limb (leg), and congestive heart failure.

On 3/18/22 at 7:14 p.m., in a progress note Licensed Practical Nurse (LPN) 11 indicated Resident B had arrived to the facility by stretcher. He was alert and oriented and a full code.

A hospital physician summary notation, dated 3/17/22 at 12:39 p.m., indicated, " ...He had initially declined to consider SNF [skilled nursing facility], but after I spoke with him today about whether he thinks he can take care of his wounds himself. He agreed that he cannot and that it would be better if he had assistance with wound care. He also agreed that he needs to have better nutrition and get stronger prior to returning home. In view of all this he is now agreeable to short-term SNF after discharge, but 'I don't want to die there'."

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	04/13/2022

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

A review of the resident's current physician orders did not include a code status.

The resident's code status was blank on the Face Sheet and electronic record information bar.

A review of Resident B's Baseline Care Plan Code Status section was blank, advanced directive indicated "n/a" (not applicable).

The resident did not have a comprehensive care plan for code status or advanced directive.

The resident's paper record did not contain any advance directive written or signed documents.

During an interview, on 4/4/22 at 4:00 p.m., the Director of Nursing (DON) indicated Resident B was admitted on 3/18/22. Only the Director of Nursing (herself) or the Assistant Director of Nursing (ADON) did all the resident admissions. She had done Resident B's admission herself.

During an interview, on 4/5/22 at 8:40 a.m., the DON indicated usually her and the ADON did do all the facility admissions but recently they had been having new hire nurses do the admissions and that was what happened with Resident B's admission. It was completed by one of the other nurses. They were training them to do admissions during orientation.

During an interview, on 4/5/22 at 10:54 a.m., the DON indicated she contacted the physician yesterday and the Nurse Practitioner (NP) would see Resident B today. The physician and NP only did telehealth (video) visits, they wouldn't come into the facility. The physician had done a telehealth visit with the resident after admission.

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	04/13/2022

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
	He had access to the hospital discharge papers and did not order anything additionally. Standards of practice did not trigger them to contact the physician for additional orders. On 4/7/22 at 3:26 p.m., the Administrator provided a current, undated policy, titled "Advance Directives Policy and Procedure." This policy indicated "The facility provides to all residents the right to accept or refuse medical and surgical treatment, and at the resident's option, formulate an advance directive...determine upon admission...review the resident's condition and existing choices and modify approaches as necessary. Establish mechanisms for documenting and communicating resident choices to the IDT [intradisciplinary care team]...Upon admission the facility will provide written information to resident/legal representative concerning the resident's rights to make decisions...If the resident/legal representative has executed one or more advance directives (or executes on admission, copies will be obtained and incorporated in the resident medical record...The resident's desires will be reevaluated on an annual basis or upon a change in condition..." 3.1-4(f)(4)(A)(ii) 3.1-4(f)(4)(B)			
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-			

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	04/13/2022

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
	§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.			
	Based on observation, interview, and record review, the facility failed to maintain the memory care (MC) residents' rooms in a safe, repaired and home-like condition for 15 of 20 residents residing on the memory care unit (Resident 2, 7, 8, 11, 13, 17, 28, 36, 34, 35, 46, 48, 49, 54, and D).	F 0584	F 584 – Safe/Clean/Comfortable/Homelike Environment 1. The identified areas on Memory Care that were in need of	05/12/2022

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	04/13/2022

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
	Findings include: On 4/04/22 at 3:16 p.m., Resident 35 indicated he wanted pictures on the walls of his room. He had no TV but did have a TV mount on the wall in his room. There was no dresser for his clothes, only a dresser drawer front against the PTAC. A metal bracket was mounted to the bathroom door, it did not have a towel hanger attached. On 4/04/22 at 3:44 p.m., Resident 46 had a dime size hole in the wall by her bed. On 4/08/22 at 9:33 a.m., Resident 49's room was observed without a doorknob. The aide was providing care for the resident and needed to open the bathroom door to create privacy for the resident since the entrance door would not stay closed. On 4/04/22 at 10:51 a.m. and on 4/8/22 at 9:43 p.m., the entry/exit area of the dining/activity room was missing door frame trim. The wall board paper peeled off at the top of the doorway. The wall board was broken at bottom and part of the baseboard unattached. There was plaster powder on the floor. Paint was missing. On 4/04/22 at 12:35 p.m., and 4/8/22 at 10:03 a.m., Resident 54 had a large section of the wall board near her bed peeled off. On 4/10/22 at 7:27 p.m., the legal guardian for Resident D indicated her room was not home like. She indicated she offered to bring a recliner to Resident D, but the facility refused because it would bring other residents into her room to sit in it.		repair were completed by maintenance on or before 5/11/22. 2. All residents on the Memory Care unit have the potential to be affected by the deficient practice. 3. Administrator/designee will educate maintenance on the importance of completing repairs asap and tour the facility with maintenance to ensure no other areas are in need of repair. This education was completed on 5/6/22. 4. Audits will be completed by the Administrator/designee of 2 rooms on memory care 5 days a week for 4 weeks; 4 days a week for 4 weeks; 3 days a week for 4 weeks; 2 days a week for 4 weeks; weekly for 4 weeks; then monthly for 2 months. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. 5. DOC 5/12/22.	

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	04/13/2022

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
	A continuous tour with the Maintenance Employee on 4/11/22 from 10:23 to 11:30 a.m. in the memory care found: For Resident 36's room, the Maintenance Employee indicated the wall at the head of the bed needed paint. For Resident 28's room, the Maintenance Employee indicated the corner of the drywall was peeling and needed repaired. Resident 17 indicated her room was not home like. There were no pictures on the walls. For Resident 17 and 34's room, the Maintenance Employee indicated the exterior bathroom door frame had peeling paint and need to be repainted. For Resident 2 and 8's room, the Maintenance Employee indicated the PTAC (packaged terminal air conditioner) caulking was cracked and needed repaired. He observed spider webs beside the PTAC. He indicated there was peeling paint on the exterior of the bathroom door frame, it needed to be repainted. For Resident 49 and 11's room, the door to the entrance of their room did not have a doorknob. The Maintenance Employee indicated the latch was still there, but he needed to replace the doorknob. Resident D indicated her was not home like because there was no TV in her room or a clock. For Resident 35's room, the Maintenance Employee indicated there should not have been 6 unused nails in the wall, an empty TV mount with four pencil-width sized holes in the wall. The nails			

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	04/13/2022

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

and TV mount needed to be removed and the holes in the wall repaired and painted. He indicated the bathroom door frame needed paint. The bracket on the bathroom needed it be removed or the towel appliance put back on.

For Resident 13's room, the Maintenance Employee indicated there was a small gouge in the wall behind her bed that needed fixed. The wall mount for a TV needed to be removed and the exterior bathroom door frame needed painted.

In Resident 7's room, a bed foot board with two heavy metal bed attachments were found in his room. The PTAC caulking was cracked and needed repair. He observed a spider web next to the PTAC.

Resident 46 indicated her room was not home like. She would like some pictures on the walls.

For Resident 46's room, the Maintenance Employee indicated the large, peeled wallboard by the resident's bed needed to be repaired and painted.

For Resident 48's room, the Maintenance Employee observed the window blind laying on the windowsill and indicated he needed to put the window blind back up. He indicated the PTAC caulking was badly cracked and needed repaired.

On 4/11/22 at 11:31 a.m., the Maintenance Employee indicated he was new to this work and needed to get to work on the MC rooms. He indicated he did not go room to room, but only saw a scattered number of rooms as repairs became necessary. He did not check for issues with missing paint or paint peeling, gouges or holes in the walls, or nails left in walls in the MC

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	04/13/2022

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

area rooms. He indicated the facility did not do work requisitions and could not provide them for work that had been requested. Everything that needed repaired was a verbal request.

On 4/11/22 at 11:55 a.m., the DON indicated the MC rooms should be repaired, but it was the resident family's responsibility to make the rooms home like.

On 4/11/22 at 12:01 p.m., the Administrator indicated the MC resident's rooms should have been maintained and would be repaired now. It was the family's responsibility to bring in TVs for the MC residents. The resident's family was encouraged to bring in items to make the resident's room home like.

A current policy, titled, "Resident Rights," with no date, was provided by the Administrator, on 4/13/22 10:20 a.m. A review of the policy indicated, " ...The facility must provide a safe, clean home-like environment ...The facility will provide housekeeping and maintenance services ...."

A current policy, titled, "Physical Plant - Daily Inspection," with no date, was provided by the Administrator, on 4/12/22 at 1:37 p.m. A review of the policy indicated, " ...Building and grounds are to be inspected daily ...As areas needing repair or attention are identified, they should be dealt with immediately. If that is not possible, the issue and the area and/or resident room number should be recorded for proper follow up...Inspect and touch up all resident room and hallway walls including all doors and door frames. If nay wall damage is found, schedule for repairs ...."

3.1-19(a)(4)
3.1-19(f)(5)

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	04/13/2022

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 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to ensure an allegation of resident abuse was reported for 1 of 1 resident reviewed for reporting allegations of abuse (Resident D). Findings include:	F 0609	F 609 – Reporting of Alleged Violations 1. The resident’s incident was immediately reported to IDOH. Resident D had no adverse outcomes related to the deficient	05/12/2022

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	04/13/2022

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 4/04/22 at 7:24 p.m., the legal guardian indicated the last time they went to see Resident D there was a lot of dried blood in her hair. No one had cleaned up her head when her head wound was seeping blood. The facility indicated she possibly had a fight with another resident. This was about 2 to 3 months ago. On 4/06/22 at 10:11 a.m., Resident D's record was reviewed. Resident D's diagnoses included but were not limited to schizoaffective disorder (disorder of mood, hallucinations and delusions), dementia (chronic disorder of mental processes), epilepsy (sudden recurrent episode of sensory disturbance with loss of consciousness), and anoxic (lack of oxygen) brain damage. A nursing progress note indicated, on 1/19/22 at 1:30 a.m., written by Licensed Practical Nurse (LPN) 11 indicated Resident D was observed sitting in an upright position on the floor in her room. She stated her and her boyfriend had gotten into a fight, and he hit her, and she hit him. She had a minimal amount of dried blood on her neck and to the back of the left head area. Resident D was hard to understand due to confusion and slurred speech. She denied pain. Emergency Medical Technicians (EMT) notified to send Resident D to the hospital for further evaluation. A nursing progress note, on 1/19/2022 at 2:00 a.m., indicated she called Resident D's legal guardian about the fall with injury. The legal guardian was concerned because Resident D had 2 falls in the last 2 days and requested the resident be sent to the hospital. A nursing progress note, on 1/19/2022 at 2:02 a.m., indicated the Director of Nursing (DON) was notified and updated on Resident D's fall with		practice 2. All residents have the potential to be affected by the deficient practice. 3. Administrator/DON/ Designee will educate staff on the Abuse Prevention Program including when and who to report abuse to. This education was completed on or before 5/11/22. 4. At the daily CQI morning meeting, the progress notes written since the previous daily CQI morning meeting will be reviewed to ensure that any event that meets reportable criteria was initially reported, investigated and had all appropriate protocol followed as per policy and regulation. On week-ends and holidays, the supervisor on each shift will ensure that incidents of abuse or potential abuse as well as grievances, are addressed per policy and regulation. Any concerns will be addressed if found. The Administrator and /or designee will conduct random ongoing audits of the Grievances and daily reports to ensure they are documented, investigated, followed up, and reported to ISDH if required. Audits will be completed by the Administrator/designee 5 days a week for 4 weeks; 4 days a week for 4 weeks; 3 days a week for 4 weeks; 2 days a week for 4 weeks; weekly for 4 weeks; then monthly for 2 months. The results	

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	04/13/2022

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
	injury. On 1/19/22 at 2:29 p.m., the hospital called to inquire concerning the events that led to Resident D being sent over to the hospital. No answers were indicated per nursing progress notes or hospital notes provided from the facility. The hospital notes indicated, " ...after a fall at her facility that led to a significant occipital [back of the head] laceration [deep cut]...she was not initially responsive or conversational for many hours ...overnight, she gradually became more responsive...the facility reported a total of 4 falls over the last two days ...." An IDT (interdisciplinary team) note, dated 1/20/22 at 12:28 p.m., indicated Resident D had a fall on 1/19/22. The immediate intervention was to send to hospital emergency room (ER) for evaluation of increased falls. There was no mention of the laceration to the back of her head that needed 6 staples. On 4/6/22 at 12:48 p.m., the self-reported facility document of the incident to the Indiana Department of Health (IDOH), dated 1/25/22 at 11:30 a.m., indicated Resident D had a fall on 1/19/22 and was sent to the emergency room for evaluation and treatment. She was admitted with the diagnosis of multiple sub-segmental pulmonary emboli (blood clots in the lungs). She returned on 1/25/22, after she received staples to the back of her head. IDT completed an investigation to determine the cause of the fall. The report did not document an allegation of abuse. On 4/11/22 at 3:07 p.m., LPN 11 indicated Resident D indicated her back of the head laceration was done by her boyfriend, another resident, who hit		of the audits done by the administrator/designee, will be presented to the QAPI committee at the monthly meetings. Any concerns will be addressed if found. Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Acton Plan will be monitored by the administrator weekly until resolved. 5. DOC 5/12/22.	

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	04/13/2022

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

her. LPN 11 was called to the MC area to do an assessment on Resident D by Qualified Medication Aide (QMA) 23. QMA 23 had indicated to LPN 11 that Resident D did have a boyfriend in the memory care area and it was not the first time the 2 residents had altercations. QMA 23 knew more about the other times it happened. LPN 11 only reported the incident to the DON, then DON was to call the doctor.

On 4/12/22 at 11:40 a.m., the Regional Director of Operations (RDO) indicated the event with Resident D should have been reported. After a thorough investigation it then should have been reported as abuse to the state department of health with a follow up report.

On 4/12/22 at 1:50 p.m., Certified Nurse Aide (CNA) 27 indicated Resident D used to hang-out with Resident 113, but he was not there anymore, and with Resident 7. A couple of months ago, Resident 7 was "cussing her out" and they stopped spending time together.
There was no documentation that the verbal abuse between Resident 7and Resident D was reported to the state department of health or management.

On 4/12/22 at 1:52 p.m., the RDO indicated the facility was going to self-report the incident with Resident D's abuse. The facility had initial discussion with nursing staff and determined Resident D spent time around Resident 113. He discharged 2 days after this incident. She had a history with an abusive boyfriend before she was admitted to the facility. Resident D had an in-patient psychological visit before she admitted to this facility. She had experienced delusion and had statements about her abusive boyfriend. He indicated there was a lack of thorough

(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
	documentation at that time.			
	On 4/12/22 at 4:50 p.m., the DON indicated the progress note in Resident D's chart was not a fact. It indicated the resident claimed she was abused by another resident. There was no one in the hall and she was in a room by herself when she was found.			
	On 4/13/22 at 12:09 p.m., Qualified Medication Aide (QMA) 23 indicated she was not working at the facility at the time of the incident. Later, Resident D had told her it happened and indicated she did say she had a boyfriend at that time, but QMA 23 did not know who it was.			
	On 4/13/22 at 1:07 p.m., the Director of Nursing indicated QMA 23 went to get LPN 11, who was on 200 and 300 halls, to assess Resident D.			
	On 4/13/22 at 1:09 p.m., LPN 11 indicated she was sure QMA 23 was working because she talked to her.			
	A current policy, titled, "Resident Rights," with no date, was provided by the Administrator, on 4/13/22 at 10:20 a.m. A review of the policy indicated, " ...The facility must care for you in a manner and environment that enhances or promotes your quality of life ...You have the right to be free from verbal, sexual, physical or mental abuse ...."			
	3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:			

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	04/13/2022

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
	§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to ensure an allegation of resident abuse was investigated for 1 of 1 resident reviewed for investigating abuse allegations (Resident D). Findings include: On 4/04/22 at 7:24 p.m., the legal guardian indicated the last time she went to see Resident D there was a lot of dried blood in her hair. No one had cleaned up her head when her head wound was seeping blood. The facility indicated she possibly had a fight with another resident. This was about 2-3 months ago. On 4/06/22 at 10:11 a.m., Resident D's record was reviewed. Resident D's diagnoses included, but were not limited to, schizoaffective disorder (disorder of mood, hallucinations and delusions), dementia (chronic disorder of mental processes), epilepsy (sudden recurrent episode of sensory disturbance with loss of consciousness), and anoxic (lack of oxygen) brain damage.	F 0610	F 610 – Investigate/Prevent/Correct Alleged Violation 1. The resident's incident was immediately reported to IDOH. Resident D had no adverse outcomes related to the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. Administrator/DON/ Designee will educate staff on the Abuse Prevention Program including when and who to report abuse to. This education was completed on or before 5/11/22. 4. At the daily CQI morning meeting, the progress notes written since the previous daily CQI morning meeting will be reviewed to ensure that any event that meets reportable criteria was	05/12/2022

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	04/13/2022

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
	A nursing progress note indicated, on 1/19/22 at 1:30 a.m., written by Licensed Practical Nurse (LPN) 11 indicated Resident D was observed sitting in an upright position on the floor in her room. She stated, her and her boyfriend had gotten into a fight, and he hit her, and she hit him. She has a minimal amount of dried blood on her neck and to the back of the left head area. Resident D was hard to understand due to confusion and slurred speech. She denied pain. Emergency Medical Technicians (EMT) notified to send Resident D to the hospital for further evaluation. A nursing progress note, on 1/19/2022 at 2:00 a.m., indicated she called Resident D's legal guardian about the fall with injury. The legal guardian was concerned because Resident D had 2 falls in the last 2 days and requested the resident be sent to the hospital. A nursing progress note, on 1/19/2022 at 2:02 a.m., indicated the Director of Nursing (DON) was notified and updated on Resident D's fall with injury. On 1/19/22 at 2:29 p.m., the hospital called to inquire concerning the events that led to Resident D being sent over to the hospital. No answers were indicated per nursing progress notes or hospital notes provided from the facility. The hospital notes indicated, "after a fall at her facility that led to a significant occipital (back of the head) laceration (deep cut) ...she was not initially responsive or conversational for many hours ...overnight, she gradually became more responsive ...the facility reported a total of 4 falls over the last two days ...." An IDT note, dated 1/20/22 at 12:28 p.m., indicated		initially reported, investigated and had all appropriate protocol followed as per policy and regulation. On week-ends and holidays, the supervisor on each shift will ensure that incidents of abuse or potential abuse as well as grievances, are addressed per policy and regulation. Any concerns will be addressed if found. The Administrator and /or designee will conduct random ongoing audits of the Grievances and daily reports to ensure they are documented, investigated, followed up, and reported to ISDH if required. Audits will be completed by the Administrator/designee 5 days a week for 4 weeks; 4 days a week for 4 weeks; 3 days a week for 4 weeks; 2 days a week for 4 weeks; weekly for 4 weeks; then monthly for 2 months. The results of the audits done by the administrator/designee, will be presented to the QAPI committee at the monthly meetings. Any concerns will be addressed if found. Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Acton Plan will be monitored by the administrator weekly until resolved. 5. DOC 5/12/22.	

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	04/13/2022

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
	Resident D had a fall on 1/19/22. The immediate intervention was to send to hospital emergency room (ER) for evaluation of increased falls. There was no mention of the laceration to the back of her head that needed 6 staples. On 4/7/22 at 1:17 p.m., the DON provided the 1/19/22 incident investigations. It consisted of a line drawing where the resident was located, a post-Fall 72-Hour Monitoring Report with one set of vital signs on it, and a checklist with, "decrease falls with major injury ...Other: ER evaluation ...." checked on it. There were no staff interviews, no interview with Resident D, nor an interview with her boyfriend. On 4/11/22 at 3:07 p.m., LPN 11 indicated Resident D indicated her back of the head laceration was done by her boyfriend, another resident, who hit her. LPN 11 was called to the MC area to do an assessment on Resident D by Qualified Medication Aide (QMA) 23. QMA 23 had indicated to LPN 11 that Resident D did have a boyfriend in the memory care area and it was not the first time the 2 residents had altercations. QMA 23 knew more about the other times it happened. LPN 11 only reported the incident to the DON, then DON was to call the doctor. On 4/12/22 at 11:40 a.m., the Regional Director of Operations (RDO) indicated the event with Resident D should have had a thorough investigation. Then it should have been reported as abuse with a follow up report. The chain of events should have been outlined in the file that would have painted the picture of what happened with evidence to support it. A more thorough investigation should have been done. On 4/12/22 at 11:50 a.m., the RDO indicated the facility had an inadequate follow up and failed to investigate an abuse allegation.			

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	04/13/2022

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 4/12/22 at 1:52 p.m., the RDO indicated the facility was going to self-report the incident with Resident D's abuse. The facility had initial discussion with nursing staff and determined Resident D spent time around Resident 113. He discharged 2 days after this incident. She had a history with an abusive boyfriend before she was admitted to the facility. Resident D had an in-patient psychological visit before she admitted to this facility. She had experienced delusion and had statements about her abusive boyfriend. He indicated there was a lack of thorough documentation at that time.

On 4/12/22 at 3:49 p.m., the RDO provided LPN 11's interview and included LPN 11's timecard to prove she was in the facility on 1/19/22. The interview, with no title or date, indicated on 1/19/22 approximately 1:30 a.m., LPN 11 went to the dementia unit, 200 Hall, to do an assessment on Resident D. There were no residents in the hall at this time nor when the EMTs arrived. When she did a walk-thru at 4:00 a.m., there were still no residents in the hallway.

On 4/12/22 at 4:50 p.m., the DON indicated the progress note in Resident D's chart was not a fact. It indicated the resident claimed she was abused by another resident. There was no one in the hall and she was in a room by herself when she was found.

On 4/13/22 at 12:09 p.m., Qualified Medication Assistant (QMA) 23 indicated she was not working at the facility at the time of the incident. Later, Resident D had told her it happened and indicated she did say she had a boyfriend at that time, but QMA 23 did not know who it was.

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	04/13/2022

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 4/13/22 at 1:07 p.m., the Director of Nursing indicated QMA 23 went to get LPN 11, who was on 200 and 300 halls, to assess Resident D.

On 4/13/22 at 1:09 p.m., LPN 11 indicated she was sure QMA 23 was working because she talked to her.

On 4/13/22 at 3:11 a.m., the RDO indicated the management interview provided indicated the statement Resident D provided to the nurses was delusional because no one was up, out of bed, at the time. Resident D was not a valid historian.

A current policy, titled, "Resident Rights," with no date, was provided by the Administrator, on 4/13/22 at 10:20 a.m. A review of the policy indicated, " ...The facility must care for you in a manner and environment that enhances or promotes your quality of life ...You have the right to be free from verbal, sexual, physical or mental abuse ...."

A current policy, titled, "Abuse Prevention Program," with no date, was provided by the Administrator, on 4/4/22 at 11:00 a.m. A review of the policy indicated, " ...All personnel must promptly report any incident or suspected incident of resident abuse, mistreatment or neglect, including injuries of unknown origin.(an injury should be classified as an "injury of unknown origin" when the source of the injury was not observed or know by any person ...Any alleged violation involving mistreatment, abuse, neglect, misappropriation of resident property and any injuries of an unknown origin MUST be reported to the Administrator and Director of Nursing. The Administrator is the Abuse Coordinator of the facility ...A completed copy of the Incident report and written statements from

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	04/13/2022

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 witnesses, if any, will be provided to the Administrator or individual in charge of the facility within twenty-four (24) hours of the occurrence of such incident ...After notification of alleged abuse or neglect, the Administrator or person in charge of the facility shall immediately commence an investigation of the incident reported ...Abuse involving one resident upon another resident will be reported to Department of Health ...." 3.1-28(d) 3.1-28(e)			
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 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			

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	04/13/2022

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
	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 observation, interview, and record review, the facility failed to develop comprehensive care plans for wound care/skin integrity, diabetes, or advanced directive/ code status choices (Resident B) and failed to develop comprehensive care plans for IV therapy/antibiotic treatment related to sepsis or diabetic care in the medical record (Resident E) for 2 of 17 residents reviewed for care plans. Findings include: 1. On 4/5/22 at 10:05 a.m., during an observation and interview, Resident B was lying in bed watching television. Both of his legs were wrapped in gauze, from his knees to his ankles. There was no date or time on the bandages. His toes were blackened with dark crusty patches and his right great toe appeared to be partially missing. Both feet appeared swollen. The right foot was swollen, much larger than the left. The	F 0656	F656-Develop/Implement comprehensive care plan- 1.) Resident D has been assessed and the care plan has been updated related to her delusions, report has been sent to the ISDH and no findings were found for this resident. Resident B and Resident E no longer reside at this facility. Neither Resident B or Resident E had been her for 7 days past the completion of the comprehensive assessment, (21) which is the guidelines. The baseline careplans had been started within 48 hours of admission. 2.) All residents have the potential to be affected by the deficient practice. 3.) DON/designee conducted an	05/12/2022

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	04/13/2022

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
	right foot was ashen gray, and the left foot was bright red and shiny. The toenails were long and yellow brown in color. The resident indicated the wounds were from his diabetes and he was unable to wear shoes comfortably. He had stopped taking his diabetic pills at home because he thought he did not need them That was what caused his problems and landed him in the hospital. The facility had wrapped gauze on his legs a couple times. They did not do any kind of daily treatments like he had in the hospital. He had "a lot of pain" in his legs, "they hurt all the time." He rated his pain as 6 out of 10. They gave him some Advil or "something like that." It helped "a little bit." On 4/5/22 at 3:15 p.m., the medical record was reviewed for Resident B. The diagnoses included but were not limited to diabetes with neuropathy (nerve pain), cellulitis (skin infection) right lower limb (leg), and congestive heart failure. On 3/18/22 at 7:14 p.m., in a progress note Licensed Practical Nurse (LPN) 11 indicated Resident B had arrived to the facility by stretcher. He was alert and oriented and a full code. He was a fall risk, needed assistance of one, and used a walker to ambulate. The resident was continent of bowel and bladder and used a urinal. The medical history included diabetes, hypertension (high blood pressure) and coronary artery (heart disease) with surgery in 2001. Diet was no more than 3,000 milligrams (mg) salt per day and no more than 75 grams (gm) of carbohydrates per meal, regular consistency, thin liquids. He had 2 plus (+) edema (swelling) to bilateral lower extremities. Resident B had ulcers on both lower legs and vascular disease. His right buttocks had an open area with instructions to cleanse with soap and water, pat dry, apply sensicare ointment,		in-service for all nurses regarding care planning on or before 5/11/22. 4.) Audits of the baseline careplan will be completed within 72 hours of admission. The comprehensive careplan will be reviewed by DON or designee within 30 days of the admission. Audit will be completed at this time and documented. Audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident that the deficiency is resolved. 5.) DOC 5/12/22.	

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	04/13/2022

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

and cover with methiplex border (type of bandage). His right lower extremity had an area with instructions to cleanse with mild soap and water, apply medihoney alginate, abd (padded dressing), and secure with kerlix (gauze wrap) and stretch net. His toes had wounds with instructions to apply betadine to all toes. His left dorsal foot had a blister with instructions to allow betadine to dry, secure with kerlix and stretch net. The dressings should be changed every other (qod) day and as needed (prn). Resident positive for MRSA (infection in wounds). Resident B's last blood sugar was 152. Resident had no complaint of pain or discomfort.

The Admission Assessment form completed by LPN 11, on 3/18/22 at 6:30 p.m., included but was not limited to:
Diet was no more than 75 gm of carbs per meal, regular consistency, and thin liquids. Skin had LLE (left lower extremity) vascular ulcers, right buttock OA [open area], RLE [right lower extremity] vascular ulcers. Resident had ulcers of vascular disease to the bilateral lower extremity (BLE), the right buttocks, has an OA, RLE had a wound, treatment was in place.

The resident had a telehealth progress note for Admission, on 3/23/22 at 1:28 p.m., entered by the facility physician. The note indicated the resident was seen for chief complaint of cellulitis right lower limb, congestive heart failure, diabetes II with neuropathy and alcoholic liver disease. Resident B was seen and examined for new admission.

A review of Resident B's Baseline Care Plan Code Status section was blank, advanced directive indicated "n/a" (not applicable). Section 3A Special Treatment/ Health conditions indicated

"receives a treatment to his legs."
Section 3H Safety Risks indicated "receives a treatment to legs daily." Section 4A Dietary indicated Diet order: General.

There were no physician's orders in place for any treatments to the resident's legs.

The resident did not have comprehensive care plans for wound care/skin integrity, diabetes or advanced directive/ code status choices.

During an interview, on 4/5/22 at 8:40 a.m., the DON indicated usually her and the ADON did do all the facility admissions but recently they had been having new hire nurses do the admissions and that was what happened with Resident B's admission. It was completed by one of the other nurses. They were training them to do admissions during orientation.

2. On 4/4/22 at 10:31 a.m., during an observation and interview, Resident E was watching television seated in a recliner in her room. An IV (intravenous) pole was on her right. A completed bag of IV antibiotic medication hung on the pole. There was no date or time on the tubing or hang time on the bag. A PICC (peripherally inserted central catheter) was visible in the resident's upper right arm. The dressing was dated 3/22/22. Her left foot was wrapped in an ACE bandage (compression bandage). A tubing connected the bandage to a wound vac (vacuum) machine to the resident's left. There was no date or initials visible on the dressing. The Resident indicated she had come to the facility for rehab and IV antibiotics. She had surgery on her foot because of an infection and sore from her diabetes. She was supposed to go home soon, maybe a week or so, because her two or three weeks of antibiotics

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	04/13/2022

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

would be finished. Her PICC line dressing had not been changed since she came to the facility. That dressing was done at the hospital. The wound vac dressing was supposed to be changed on Monday, Wednesday, and Friday. It had not been done yet that day. They had told her the Director of Nursing (DON) was supposed to do it.

On 4/7/22 at 8:46 a.m., the medical record was reviewed for Resident E. The diagnoses included, but were not limited to diabetes, sepsis, and hypertension (high blood pressure).

A progress notes, on 4/6/22 at 9:43 p.m., indicated Resident remained on IV antibiotic for an infection in left foot. No adverse reaction to antibiotic therapy was noted. Midline (IV) to right upper arm flushed well with normal saline and was patent (working).

A review of Resident E's physician orders included, but were not limited to:
"Cefepime HCl Solution 1 GM/50ML (antibiotic) Use 1 gram intravenously every 8 hours for Infection related to OTHER SPECIFIED SEPSIS until 04/12/2022 10:00 p.m."
"Flush PICC line before and after IV antibiotic infusion every 8 hours, every 8 hours for Infection left foot." Active order dated 3/25/2022 at 6:00 a.m.

There were no physician orders for PICC line dressing changes.

There were no comprehensive care plans for IV therapy/antibiotic treatment or diabetic care in the medical record.

On 4/7/22 at 2:36 p.m., the Administrator (ADM) provided a current, undated policy titled "Baseline

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	04/13/2022

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
	Care Plans/ Comprehensive Care Plans." This policy indicated "...The Comprehensive Care Plan will be finalized within 7 days of completion of the full Comprehensive MDS [minimum data set] assessments and corresponding CAAs [care area assessment]...." 3.1-35(a) 3.1-35(c)(1)			
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.			

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	04/13/2022

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
	(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis			

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	04/13/2022

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
	based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.			
	Based on interview and record review, the facility failed to ensure a resident was assisted with a referral to another facility as requested by the legal guardian for 1 of 1 resident reviewed for transfer and discharge (Resident D). Findings include: On 4/08/22 at 9:25 a.m., Resident D indicated she want to move closer to her mother (legal guardian). During an interview, on 4/10/22 at 7:27 p.m., Resident D's legal guardian had asked for Resident D to be referred to another facility three times. She wanted Resident D closer to home for her happiness and contentment. If Resident D lived closer to home the family could visit and talk with her. Resident D had told her she did not have any friends at the facility, and she was not happy. She indicated the Social Service Designee (SSD) told her she wanted to keep Resident D in the facility so she could maintain her usual routine. On 4/11/22 at 2:01 p.m., the Social Services Designee (SSD) indicated Resident D had come a long way since she came here. She was so out of sorts. When her parent/legal guardian wanted to visit, the Aunt needed to bring her and the Aunt had been sick recently. Regarding previous	F 0660	F 660 – Discharge Planning Process 1. Social Services contacted Resident D's family and sent referrals out to requested facilities on 5/6/22. Social Services updated Resident D's care plan to include discharge planning. 2. Any resident wanting to transfer or discharge have the potential to be affected. 3. Administrator/designee educated Social Services on discharge planning on 5/6/22. 4. Audit of all new admissions to ensure that discharge planning care of plan is completed upon admission 5 days a week for 4 weeks; 4 days a week for 4 weeks; 3 days a week for 4 weeks; 2 days a week for 4 weeks; weekly for 4 weeks; then monthly for 2 months. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action.	05/12/2022

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	04/13/2022

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
	facility referrals and transfers, the SSD indicated she did not always chart information regarding conversation with the parent/legal guardian but believed she had changed her mind about a referral. She indicated the only notes she charted regarding Resident D's parent/legal guardian requests for referrals to other facilities was, the mother stated she was touring other facilities near (town of family's residence) and she expected the mother to call her with the name of the facility to send the referral. The SSD indicated this facility had sister facilities in the area the family was interested in. On 4/11/22 at 2:49 p.m., the SSD indicated there was nothing else she could have done to help the resident in August 2021 to find another facility. On 4/12/22 at 10:27 a.m., the Regional Director of Operations (RDO) indicated regarding resident referrals to another skilled facility, my expectation would be the social services department to reasonably assist the resident and family with a referral for transfer. On 4/12/22 at 4:06 p.m., RDO indicated there was no discharge planning care plan. On 4/12/22 at 4:54 p.m., the Administrator indicated the SSD should have followed up with what the family wanted. On 4/12/22 at 12:41 p.m., the Administrator indicated the facility did not have a policy regarding resident referrals to other facilities. A Job Description document, titled, "Director of Social Services," with no date, was provided by the Administrator, on 4/11/22 at 9:15 a.m. A review of the job description indicated, " ...Demonstrates		The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. 5. DOC 5/12/22.	

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	04/13/2022

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
	responsibility for resident transfers to the following: ...Discharge to the Community ...Obtains current release of information ...Conducts a discharge planning conference at the discretion of the planner, and assists resident and family members/responsible party in preparation of discharge ...Roles Responsibilities - Documentation...Completes the Discharge Planning Review within 14 days...Maintain significant social service progress notes on the resident's medical chart on a timely basis and, at least quarterly, completes a progressive assessment...Maintain a current social serve plans and discharge statement...Active involvement in care planning, discharge plans and resident rights...." A current policy titled, "Resident Rights," with no date, was provided by the Administrator on 4/13/22 at 10:20 a.m. A review of the policy indicated, " ...The facility must consult with you and notify your physician and interested family member of any significant change in the condition or treatment, or of any decision to transfer or discharge ...." 3.1-12(a)(18)			
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident,			

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	04/13/2022

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
	encouraging both independence and interaction in the community. Based on observation, interview and record review, the facility failed to ensure the activity program organized and implemented meaningful activities as scheduled on the activity calendar for both the general facility population as well as provide a specialized, structured activity program for residents who resided on the secured memory care unit. These concern was directly expressed by 6 regularly participating Resident Council members (Residents 9, 15, 19, 29, 39 and 44) and had the potential to effect 57 of 57 residents who resided in the facility. Findings include: 1. On 4/4/22 the following activities were scheduled: Coffee & News at 9:00 a.m. Morning Stretch at 11:00 a.m. Music at 1:00 p.m. Bingo at 2:30 p.m. Bingo was the only activity observed throughout the day. On 4/5/22 the following activities were scheduled: Coffee & News at 9:00 a.m. Easy Fit at 11:00 a.m. Music at 1:00 p.m. Monopoly at 2:30 p.m. No organized activities were observed throughout the day. On 4/6/22 the following activities were scheduled: Coffee & News at 9:00 a.m. Easy Exercise at 11:00 a.m. Music at 1:00 p.m. Nail care at 2:30 p.m. No organized activities were observed throughout the day.	F 0679	F 679 Activities Meet Interest/Needs Each Resident 1. Activities Director recreated the May calendar to include an outdoor activity weekly, special events for the month and an offsite trip. Activity Director/designee held a meeting with residents to gather ideas for monthly activities they would like to see on or before 5/11/22. 2. All residents have the potential to be affected by this deficient practice. 3. Administrator educated the Activity Director on the Activity Policy and the importance of following the activity calendar. AD also educated on the importance of including residents to see what is of interest to the residents. This education was completed on 5/6/22. 4. Social Services/designee will audit activities to ensure activities are occurring as scheduled designee 5 days a week for 4 weeks; 4 days a week for 4 weeks; 3 days a week for 4 weeks; 2 days a week for 4 weeks; weekly for 4 weeks; then monthly for 2 months. Social Services/ designee will review monthly calendar before it is posted for the next 6 months. Any deficiencies will be corrected immediately, and the findings of	05/12/2022

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	04/13/2022

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 4/7/22 the following activities were scheduled: Coffee & News at 9:00 a.m. Book Club at 11:00 a.m. Music at 1:00 p.m. Uno at 2:30 p.m. No organized activities were observed throughout the day. On 4/8/22 the following activities were scheduled: Coffee & News at 9:00 a.m. Light Exercise at 11:00 a.m. Music at 1:00 p.m. Bingo at 2:30 p.m. Bingo was the only activity observed throughout the day. On 4/11/22 the following activities were scheduled: Coffee & News at 9:00 a.m. East Fit at 11:00 a.m. Music at 1:00 p.m. Bingo at 2:30 p.m. Bingo was the only activity observed throughout the day. On 4/12/22 the following activities were scheduled: Coffee & News at 9:00 a.m. Craft Time at 11:00 a.m. Music at 1:00 p.m. Yahtzee at 2:3 p.m. No organized activities were observed throughout the day. On 4/13/22 the following activities were scheduled: Coffee & News at 9:00 a.m. Cards at 11:00 a.m. Music at 1:00 p.m. Sorry at 2:30 p.m. No organized activities were observed throughout		the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. 5. DOC 5/12/22.	

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	04/13/2022

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 day.

The Activity Calendar for the month of April was reviewed. There were no scheduled outdoor activities (weather permitting), there were no special events realted to Easter and there were no off-site scheudled activities.

During an interview on 4/4/22 at 11:15 a.m., the Resident Council President, (Resident 15) indicated, it would be a great idea to have a Resident Council meeting during the survey because the residents had a lot of issues they would like to talk about. At this time, Resident 15 gave permission to review the Resident Council minutes to prepare for the meeting.

On 4/12/22 at 10:13 a.m. the Resident Council minutes were reviewed. From January 2021-February 2022, the Resident Council met 12 times on the following dates: 1/7/21, 2/18/21, 3/10/21, 4/10/21, 5/21/21, 7/21/21, 8/23/21, 9/21/21, 10/21/21, 11/21/21, 1/21/22 and 2/16/22. For all 12 meetings, there were no Resident Council Response forms on file. There were several reoccurring concerns discussed by the Resident Council over these 12 meetings which included but was not limited to the request for "more choices of things that happen."

An ad-hock Resident Council Meeting was held on 4/12/22 at 2:0 p.m., with Residents 9, 15, 19, 29, 39 and 44 were present. The following concerns were shared as "on-going" issues that the residents wanted addressed.

The Resident Council President indicated; her biggest request was to increase the amount of smoke breaks that were allowed. She indicated, she was of sound mind, and had been smoking

since she was 9, she wanted more than 3 quick smoke breaks where she was supervised like a baby. She indicated the group has complained over and over about the amount of smoke breaks and the facility just says, "those are the rules, and if you don't like it, then you can find somewhere else," but then they don't help you look for another place. All the residents in attendance conquered with this concern.

Resident 19 indicated it would be nice to be able to go outside when she wanted. Staff treated the building like it is a prison, and the residents who were "mentally ok" were not allowed to sign LOA (leave of absence) or go outside when they wanted. "It feels like a prison." All the residents agreed it would be nice to go outside when they wanted, but if it was bad weather, at least have activities available inside.

All the residents in attendance indicated the only activities they have was Bingo twice a week. Activities on the calendar did no happen as scheduled. They agreed it would be nice to have activities to keep them occupied and have something meaningful to do.

During an interview with the Activities Director, (AD) on 4/12/22 at 2:45 p.m., she indicated she was new to the position and had just finished her Activity Director 90-hour training course. She had really enjoyed the class beucase it helped her understand how important activies were for the resident's quality of life. The AD indicated she brought the Resident Council Grievance procedure to QAPI, (a quality assurance program) but nothing had been done about it yet and was not sure who the appointed grievance response person was. Additionally, the AD indicated the Activities department was short at least one

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	04/13/2022

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

full-time staff person which would be helpful to help make sure activities got done on time. Since she had been away for training, and there were only two other part time activity assistants, activities were not able to be completed as scheduled. Also, because the AD was new to a management position, she did not know who was in charge of activities if she was gone or unavailable. The AD indicated, along with her new administrative responsibilities she still had to ensure many other things were completed such as: supply shopping, creating activity calendars, implementing activities, one-on-one program, decorations, special events ... it was hard to find the time to facilitate the activities as planned. The AD indicated she had been told she could not use volunteers to help with the activity program because they needed to be up to date on the COVID-19 vaccination and needed to complete TB (tuberculosis testing) and there was no one to coordinate that effort. Additionally, because of COVID-19 activities needed to be socially distanced, and the facility bus only held one wheelchair (WC) at a time, so even if she wanted to do an off-campus activity, there were not enough staff to supervise the outing, and only one resident in a WC would be allowed to go (and the majority of residents used WCs).

The Minimum Data Set (MDS) Indicator Facility Rate Report dated 4/8/22 indicated, there were 27 residents with depression, which made it the highest rated indictor at 50% of the population.

On 4/13/22 at 9:00 a.m., the Administrator provided a copy of current, but undated facility policy titled, "Activities Program." The policy indicated, "It is the policy of the facility to provide an ongoing program of Activities designed to meet, in accordance with the comprehensive

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	04/13/2022

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
	assessment, the interests and the physical, mental an psychological well-being of the residents... facility will offer activities both individual and group to enhance the physical, mental and psychosocial well-being of residents, taking into consideration any limitations that the resident's might have individually or as a group... facility will provide activities that promote self-esteem, pleasure, comfort, educations, creativity, success and independence... The Activity Director will work with other staff and the community to secure planned Field Trips as well as outside agencies and individuals with a "specialized" talent to be part of the Activity Program. Note: Adequate staff will be available to provide care and assistance as needed...." On 4/13/22 at 9:00 a.m., the Administrator provided a copy of current, but undated facility policy titled, "Resident Rights." The policy indicated, "...you have the right to participate in activities of choice that do not interfere with the rights of other residents... the facility must provide a program of activities designed to meet your needs and interests...." 2. On 4/4/22 at 9:07 a.m., the Memory Care (MC) area was observed, no activities were in progress. The MC activity calendar indicated at 9:00 a.m., Coffee and News should have occurred. On 4/4/22 at 9:53 a.m., an unidentified Certified Nursing Aide (CNA) provided snacks to 4 residents in the dining/activity room. She continued to pass snacks until 11:30 a.m. to the residents in their rooms. Lunch was scheduled to arrive at 12:30 p.m. On 4/4/22 at 11:08 a.m., the MC area was observed, no activities were in progress. The MC activity calendar indicate at 11:00 a.m., Morning			

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	04/13/2022

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
	Stretch should have occurred. On 4/4/22 at 3:13 p.m., the MC area was observed, no activities were in progress. The MC calendar indicated at 2:30 p.m., Sensory Time should have occurred. No events were scheduled after 2:30 p.m. On 4/5/22 at 9:47 a.m., the MC area was observed, no activities were in progress. The MC calendar indicated at 9:00 a.m., Coffee and News should have occurred. On 4/7/22 at 9:05 a.m., the MC area was observed, no activities were in progress. The MC calendar indicated at 9:00 a.m., Coffee and News should have occurred. On 4/7/22 at 2:02 p.m., the MC area was observed, no activities were in progress. The MC calendar indicated at 1:00 p.m., Music should have occurred. On 4/8/22 at 9:30 a.m., the MC area was observed, no activities were in progress. The MC calendar indicated at 9:00 a.m., Coffee and News should have occurred. On 4/11/22 at 11:00 a.m., the MC area was observed, no activities were in progress. The MC calendar indicated at 11:00 a.m., Easy Fit should have occurred. On 4/12/22 at 2:32 p.m., the MC area was observed, no activities were in progress. The MC calendar indicated at 2:30 p.m., Finger Painting should have occurred. During an interview, on 4/12/22 at 12:19 p.m.,			

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	04/13/2022

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
	Resident 7 indicated there were no activities in the MC area. He indicated any activity would be good. During an interview, on 4/12/22 at 12:19 p.m., Resident 35 indicated there were no activities in the MC area and he would like to have activities to do. During an interview, on 4/12/22 at 12:23 p.m., Resident 11 indicated there were no activities in the MC area. When asked if there were any crafts, games, or puzzles, he indicated none. During an interview, on 4/12/22 at 12:26 p.m., Resident 48 indicated there were no activities in the MC area. During an interview, on 4/12/22 at 9:59 a.m., the DON indicated the Activity Director (AD) took her test to become a State approved Activity Director. During an interview, on 4/12/22 at 4:56 p.m., the Administrator indicated the AD was not here all last week, 4/4 to 4/8/22, because she was in class to become a State approved Activity Director. The Activities Assistant (AA) should have completed the MC area activities. She did not know why the MC activities were not occurring for the MC residents. During an interview, on 4/13/22 at 12:29 p.m., the AA indicated she was also a Certified Nursing Aide (CNA). She worked at whatever the facility needed. The facility management told her she needed to take charge of activities last week when the Activity Director was off. She indicated the Social Services Designee (SSD) helped and they did some events. On Monday, she indicated they			

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	04/13/2022

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
	had Bingo. The activity calendar changed according to the number of staff available to complete it. She usually worked with the MC residents. Some residents did not want to participate. The main building residents liked outings. Coffee and News was scheduled during breakfast. The sensory care was for 1:1 resident activity for residents who did not like to come out of their rooms. The activities can be driven by the residents' choices, if she took music to MC, she would ask if they wanted music or TV. They usually picked TV. On Friday, she was off, but the Activity Director was back. A current policy, titled, "Resident Rights," with no date, was provided by the Administrator, on 4/13/22 at 10:20 a.m. A review of the policy indicated, " ...The facility must provide a program of activities designed to meet your needs and interests...." 3.1-33(a) 3.1-33(b)(2) 3.1-33(b)(3)			
F 0684 SS=J 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 treat a resident with Diabetes Meletus as ordered by the hospital	F 0684	F 684 Quality of Care - DISCLAIMER STATEMENT: The	05/12/2022

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	04/13/2022

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
	discharge instructions for diabetic medication and diabetic wound care resulting in Resident B having significant risk of hypo/hyperglycemia and wound deterioration or infection and the facility also failed to ensure care was given for diabetic wound care, IV antibiotics (Resident E), and non-pressure wound care (Resident C and D) for 4 of 9 residents reviewed for quality of care. The Immediate Jeopardy began on 3/18/22 at 7:14 p.m. when Resident B was admitted to the facility from the local hospital. The resident's hospital discharge paperwork indicated the resident was receiving Accuchecks and insulin on a sliding scale at the hospital and received treatment for multiple wounds on the legs, feet and toes. The hospital discharge notes indicated the Accuchecks, insulin, and wound treatments should have been continued at the facility. The facility failed to continue to assess and document the resident's wounds after admission. The nurses did not receive orders for wound treatments or document any treatments to the wounds. There were no orders for Accuchecks (rapid blood sugar testing) or diabetic medication since admission, and the facility failed to assess the residents blood sugar since admission. The physician was not notified of the missing diabetic care orders or the wounds. A medication for edema in the lower extremities was ordered but needed clarification for the missing dosage. The facility failed to obtain the clarification and the medication was not administered. The Administrator, Director of Nursing, and the Regional Nurse Consultants were notified of the immediate jeopardy at 3:20 p.m. on 4/5/22. The immediate jeopardy was removed, but noncompliance remained at a lower scope and severity of isolated no actual harm with potential for more than minimal harm that is not immediate jeopardy, on 4/7/22 when the facility		completion and submission of this credible allegation of compliance does not constitute an admission that the facility agrees with the allegation in the notification of Immediate Jeopardy. The facility is completing the allegation of compliance because it is required by state and federal law. The facility disagrees with and disputes the alleged deficiency as stated in the notification of Immediate Jeopardy at the scope and severity at which they are cited. Further, the facility disputes and disagrees with the accuracy of statements and other information relied upon in the support of the alleged deficiencies. This includes, but is not limited to, the alleged content/summary of interviews, the chronological timing of sequences of events and contact with healthcare professionals, and the description of the care and supervision provided to residents. The facility reserves the right to continue Disputing, appealing and contesting these alleged deficiencies and any action related to and arising therefrom in any forum as needed. **Allegation—F-684—Quality of Care** The facility failed to assess and treat a diabetic resident's blood sugar and provide diabetic	

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	04/13/2022

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
	audited all the diabetic residents and residents with new admissions for medication, diet, and wound care orders and completed nursing staff education for the new admission process. Findings include: 1. On 4/5/22 at 10:05 a.m., during an observation and interview, Resident B was lying in bed watching television. Both of his legs were wrapped in gauze, from his knees to his ankles. There was no date or time on the bandages. His toes were blackened with dark crusty patches and his right great toe appeared to be partially missing. Both feet appeared swollen. The right foot was swollen, much larger than the left. The right foot was ashen gray, and the left foot was bright red and shiny. The toenails were long and yellow brown in color. The resident indicated the wounds were from his diabetes and he was unable to wear shoes comfortably. He had stopped taking his diabetic pills at home because he thought he didn't need them That was what caused his problems and landed him in the hospital. The facility had wrapped gauze on his legs a couple times. They did not do any kind of daily treatments like he had in the hospital. He had "a lot of pain" in his legs, "they hurt all the time." He rated his pain as 6 out of 10. They gave him some Advil or "something like that." It helped "a little bit." On 4/5/22 at 3:15 p.m., the medical record was reviewed for Resident B. The diagnoses included but were not limited to diabetes with neuropathy (nerve pain), cellulitis (skin infection) right lower limb (leg), and congestive heart failure. On 3/18/22 at 7:14 p.m., in a progress note Licensed Practical Nurse (LPN) 11 indicated		medications as ordered on the hospital discharge documentation; and failed to assess and treat the diabetic resident's multiple wounds on the bilateral extremities for 1 of 9 residents reviewed for diabetic care. A diabetic resident with multiple wounds on bilateral legs was admitted to the facility on March 18, 2022. The resident's hospital discharge paperwork indicated the resident was receiving accuchecks and insulin on a sliding scale at the hospital and received treatment for the multiple wounds on the legs, feet and toes. The hospital discharge notes indicated the accuchecks, insulin and wound treatments should be continued at the facility. The facility failed to assess and document the resident's wounds on admission. The nurses do not have orders for wound treatments or documentation for treatments on the wounds. The resident has not received orders for accuchecks or diabetic medication since admission, and the facility has failed to assess the resident's blood sugar since admission. The physician was not notified of the missing diabetic care orders or the wounds. A medication for edema in the lower extremities was ordered but needed clarification for the missing dose. The facility failed to get clarification or notify	

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	04/13/2022

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
	Resident B had arrived to the facility by stretcher. He was alert and oriented and a full code. He was a fall risk, needed assistance of one, and used a walker to ambulate. The resident was continent of bowel and bladder and used a urinal. The medical history included diabetes, hypertension (high blood pressure) and coronary artery (heart disease) with surgery in 2001. Diet was no more than 3,000 milligrams (mg) salt per day and no more than 75 grams (gm) of carbohydrates per meal, regular consistency, and thin liquids. He had 2 plus (+) edema (swelling) to bilateral lower extremities. Resident B had ulcers on both lower legs and vascular disease. His right buttocks had an open area with instructions to cleanse with soap and water, pat dry, apply sensicare ointment, and cover with methiplex border (type of bandage). His right lower extremity had an area with instructions to cleanse with mild soap and water, apply medihoney alginate, abd (padded dressing), and secure with kerlix (gauze wrap) and stretch net. His toes had wounds with instructions to apply betadine to all toes. His left dorsal foot had a blister with instructions to allow betadine to dry, secure with kerlix and stretch net. The dressings should be changed every other (qod) day and as needed (prn). Resident positive for MRSA (infection in wounds). Resident B's last blood sugar was 152. Resident had no complaint of pain or discomfort. A review of Resident B's hospital transfer documents, dated 3/18/22, indicated the following: Future clinic visits were scheduled on 3/25/22 at 12:00 p.m. for a Lab Blood Draw, on 3/25/22 at 12:30 p.m. to check-in for the appointment, and on 3/25/22 1:00 p.m. for the Geriatrics Practitioner appointment. On 3/28/22 at 11:45 a.m. for a Lab Blood Draw, on 3/28/22 at 12:45 p.m. for the appointment check in,		the physician, and the medication has not been administered. The facility needs to ensure that residents with diabetes receive immediate assessment, have orders for accuchecks and medications as appropriate. The facility needs to ensure that all residents with wounds, are assessed for appropriate orders and treatment. Staff needs to be in-serviced on admission procedure, assessing for wounds, following physician orders and notifying the physician of missing orders. **What corrective actions will be accomplished for those residents found to be affected by the deficient practice--** The resident of focus has been assessed and the following have been accomplished: a) Head to toe skin assessment to include assessment of all skin wounds with measurements has been done and documented b) Appropriate treatment orders for each skin wound have been obtained and the medications have been ordered and treatments are being done and documented c) Orders for scheduled blood sugars (accuchecks), with reporting parameters have been obtained and are	

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	04/13/2022

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
	and on 3/28/22 at 1:00 p.m. for the Geriatrics Practitioner appointment. An appointment for Vascular surgery was to be scheduled in 1 to 2 weeks. The reasons the patient was admitted to the hospital were skin infection and ulcers on his legs due to vascular disease. He was diagnosed with cellulitis which improved with antibiotics (vancomycin and unasyn). The MRSA (methicillin resistant staph aureous) screening was positive. The hospital transfer documents, dated 3/18/22, indicated Resident B was to continue taking these medications: acetaminophen (Tylenol) 650 milligrams (mg) by mouth every 6 hours aspirin enteric coated 325 mg by mouth once a day atorvastatin (blood pressure medicine) 40 mg by mouth every p.m. cholecalciferol (vitamin D3) 50 mg by mouth every day clopidogrel (blood thinner) 75 mg by mouth daily melatonin (sleep aid) 6 mg by mouth every p.m., as needed multivitamin with minerals, prenatal cap one by mouth daily polyethylene glycol (laxative) 3350 powder one packet by mouth daily sacubitril/Valsartan (reduces blood pressure and improves circulation) one tablet twice a day sennosides (stool softener) tab give 8.6 mg by mouth twice a day spironolactone (blood pressure and fluid retention) 12.5 mg by mouth daily The hospital transfer documents, dated 3/18/22, indicated Resident B was on a modified diet of low salt with no more than 3,000 mg of salt per day,		being done and documented and reported as indicated d) Orders for insulin administration to include coverage insulin based on sliding scale results have been obtained and are being done and documented e) Clarification for medication to address edema in lower extremities has been done and the medication has been ordered for administration as indicated and will be documented as administered f) The resident of focus has been added to the list of residents who are reviewed and discussed at the weekly SWAT (Skin/Weight/Assessment/Team) meetings related to his wounds. **How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective actions will be taken-** All residents had a head to toe skin assessment to ensure that any skin alterations have: a) Appropriate documentation to include measurements b) An appropriate treatment in place to address the skin alteration c) Documentation of these skin alterations and their treatments d) Resident added to list of	

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	04/13/2022

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
	and limited carbohydrates with no more than 75 gram (g) per meal The hospital transfer documents, dated 3/18/22, indicated Resident B's Hgb A1C (indicates high blood sugar over a 3 month period, diabetes) was 7.7 % with a diabetic range of 6.5% or higher and a normal range of below 5.7%. Resident B indicated he was prescribed metformin (diabetic pill) but had not taken it for several weeks. "Will restart metformin on discharge. QID [four times a day] glucose checks, sliding scale insulin correction 1:60 and PCP [primary care physician] follow-up." A hospital physician summary notation, dated 3/17/22 at 12:39 p.m., indicated, " ...States he can't tell much difference in his right leg after stenting yesterday. He had initially declined to consider SNF [skilled nursing facility], but after I spoke with him today about whether he thinks he can take care of his wounds himself. He agreed that he cannot and that it would be better if he had assistance with wound care. He also agreed that he needs to have better nutrition and get stronger prior to returning home. In view of all this he is now agreeable to short-term SNF after discharge, but 'I don't want to die there'." The hospital medication list from the hospital transfer paperwork had ink check marks beside each medication. A handwritten notation beside the Valsartan order indicated, "Need clarification on strength." The Admission Assessment form completed by LPN 11, on 3/18/22 at 6:30 p.m., included but was not limited to: Diet was no more than 75 gm of carbs per meal, regular consistency, and thin liquids. Skin had LLE (left lower extremity) vascular ulcers,		residents reviewed and discussed at the weekly SWAT meetings e) Care plans of residents with skin alterations were revised as indicated related to any skin issue Note: Any new areas found would have been reported to the physician and to the resident's responsible party. All residents had their medical records reviewed to ensure that any diagnosis related to diabetes was identified and that there were orders in place to address monitoring of blood sugars and administration of appropriate medication, to include insulin to manage the presence of diabetes. Any concerns would have been addressed as found. All residents had their medical records reviewed to ensure that no clarification of any medication was outstanding. Further, any medication ordered for management of edema was reviewed to ensure that when and why the medication was to be administered was clearly evident. Further, that if and when given, the medication was documented to include effectiveness. Any concerns would have been addressed as found. Additionally, a 30 day "look back" audit was done to ensure that residents admitted over the last 30	

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	04/13/2022

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
	right buttock OA [open area], RLE [right lower extremity] vascular ulcers. Resident had ulcers of vascular disease to the bilateral lower extremity (BLE), the right buttocks, has an OA, RLE had a wound, treatment was in place. The resident had a telehealth progress note for Admission, on 3/23/22 at 1:28 p.m., entered by the facility physician. The note indicated the resident was seen for chief complaint of cellulitis right lower limb, congestive heart failure, diabetes II with neuropathy and alcoholic liver disease. Resident B was seen and examined for new admission. The current medications were listed. There was no descriptions of the resident's wounds and no treatment orders listed. No orders for diabetic medication, labs or blood sugars were ordered. There were no new orders. Weekly skin check documentation, dated 3/25/22 and 4/1/22, indicated the resident had existing areas of loss of skin integrity and no new loss of skin integrity. The form indicated the existing areas were to be updated on the Weekly Wound Evaluation for each existing area of loss. There were no Weekly Wound Evaluations in the medical record. There was no wound description or measurements. There was no record of treatments. A review of the resident's current physician orders did not include any dressing change orders or treatment orders for the resident's wounds on the bilateral legs or buttocks. There was no order for Valsartan. The resident did not have orders for blood glucose testing, Accuchecks or any diabetic medication. There were no orders for the resident to return to the hospital clinic on 3/25/22 and 3/28/22, or to schedule an appointment in 1-2 weeks with the vascular surgery clinic.		days (who may have been discharged) and who were diabetic---had orders in place to monitor their blood sugar levels as well as appropriate orders to manage their diabetes with either oral preparations or insulin. Care plans were reviewed related to diabetes. Further, during this “look back,” residents’ medical records were reviewed to ensure that any skin issues were addressed per policy and regulation to include: a) Identification of any skin alteration b) Measurements taken and documented c) Appropriate treatment in place d) Resident reviewed and discussed at the weekly SWAT meetings e) Care plans addressed related to any skin issues f) Notifications made timely to the physician and resident’s responsible party related to the skin alteration Going forward, the DON/ADON will review all new admits or re-admits to ensure that any orders on the order sheet, or the Discharge Summary are implemented for the facility stay. Any order that is not on the order sheet, but appears on	

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	04/13/2022

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

There was no documentation in the record that indicated the resident had returned to the hospital clinic since his admission to the facility.

A review of the medication administration record (MAR) and treatment administration record (TAR) since admission did not include any blood sugar testing/Accuchecks, diabetic medication, or wound care. The resident's diet order was "General diet, regular texture, thin liquid consistency." There was no code status order. The resident had not received any Valsartan and it was not listed as a medication order.

The resident's code status was blank on the Face Sheet and electronic record information bar.

A review of Resident B's Baseline Care Plan Code Status section was blank, advanced directive indicated "n/a" (not applicable). Section 3A Special Treatment/ Health conditions indicated "receives a treatment to his legs."
Section 3H Safety Risks indicated "receives a treatment to legs daily." Section 4A Dietary indicated Diet order: General.

The resident did not have a comprehensive care plan for wound care/skin integrity or diabetes.

On 4/4/22 the Minimum Data Set (MDS) Coordinator entered a new Care Plan for Resident B on 4/4/22. The focus was "Diabetes with risk for hypo/hyperglycemia" and the goal was "Will have no s/sx of hypo/hyperglycemia daily." The interventions were to provide antidiabetic medicines per order; check blood sugars per order; perform labs per order; monitor for signs and symptoms (s/sx) of hyperglycemia such as, but not limited to be flushed, fruity breath, thirst,

the Discharge Summary will be clarified as to whether or not it is to be implemented for the facility stay. Further, any diagnosis on the History and Physical that does not appear on the current list of diagnoses for the facility stay will also be clarified. This will be an ongoing practice as part of the CQI morning meeting agenda. This review will take place at the subsequent morning CQI (Clinical Quality Indicator) meeting after the admission or re-admission. Any concerns will be addressed as found.

The Nurse Consultant for the facility will monitor any newly admitted or re-admitted residents to ensure that this review is being done. This corporate oversight will continue for 4 weeks. After that, the Nurse Consultant will review 5 newly admitted or re-admitted resident records for a period of not less than 6 months to ensure ongoing compliance. Any concerns will be addressed if found.

Training
What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur—

All nurses were in-serviced on or before 5/11/22 conducted 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	04/13/2022

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
	and/or diaphoretic; monitor for s/sx of hypoglycemia such as pale, clammy, cool, thready pulse, lethargy; Notify MD and family as needed; and observe and report any signs of skin breakdown for example the feet and lower extremities. During an interview, on 4/4/22 at 4:00 p.m., the Director of Nursing (DON) indicated Resident B was admitted on 3/18/22. Only the Director of Nursing (herself) or the Assistant Director of Nursing (ADON) did all the resident admissions. She had done Resident B's admission herself. He did not need blood sugars or diabetic medication according to his hospital discharge. There was a list of medications to continue. Those were the ones entered for his orders. The Valsartan was not ordered because there was no strength given. She was unsure if anyone followed up on the missing strength. He did not receive any blood sugars or diabetic medication. They had not ordered any treatments for his legs. He had gauze on them because he liked for them to be wrapped and would ask the nurses to do it. There was no order for it. The dressing was not documented. He did not have orders to see wound care or be treated by them. They had never seen him. He had not had any labs done that she knew of. He did not get blood sugar checks/Accuchecks, and none had been done. He was diabetic but wasn't getting any treatment for it (insulin or oral medication). He did receive insulin and Accuchecks in the hospital, but it had not been ordered at the facility. On 4/4/22 at 4:20 p.m., during an observation and interview, Resident B was lying on his bed, an unidentified staff member was removing the gauze dressing from his left leg. The right leg bandage was still intact. The resident's calf had 4 quarter		DON/designee. The following was reviewed/discussed: 1) Admission process for newly admitted and re-admitted residents to include review of the Discharge Summary for any possible orders and History and Physical for any diagnosis that may need to be carried forward for facility visit---clarifications to be made 2) Admission Assessments—What are they? Who does them? When are they done? 3) When a Skin Alteration is found—what is done?---Notifications? Treatment? Care Plan? SWAT? 4) If a resident is diabetic—what needs addressed? ---Blood Sugar Checks? Meds? Diet? 5) What are the possible outcomes of untreated skin alterations? 6) What are the possible outcomes of untreated diabetes? 7) Questions/Answers Knowledge of the in-serviced text was measured by a POST TEST that required 100% of accuracy in the answers to pass. No nurse will work without the education after 5/11/22. This incudes staff who are prn, on any type of vacation or leave, agency staff or newly hired staff.	

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	04/13/2022

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
	sized blackened areas with inflammation (bright red tissue) around the perimeter of the blackened tissue. He was able to wiggle his toes and lift his legs to command to help with visualization. There was swelling noted to the left calf and foot. The foot was bright red and shiny. He indicated his pain was a 6/10 all the time. During the observation he was eating a one pound canned ham, directly from the can. During an interview, on 4/5/22 at 8:40 a.m., the DON indicated her and the ADON did do all the facility admissions but recently they had been having new hire nurses do the admissions and that was what happened with Resident B's admission. It was completed by one of the other nurses. They were training them to do admissions during orientation. She did not know if Resident B had been out to any clinic appointments since admission. During an interview, on 4/5/22 at 8:58 a.m., Qualified Medication Aid (QMA) 8 indicated she normally worked a different hall. She had worked the other hall yesterday and it was her first time working with Resident B. He was pretty quick and easy as far as medication pass. She had remembered him talking about going home. She did not know if he was confused. They found physician orders and what treatments to give during medication pass from the MAR, she could only remember 4 residents with Accuchecks yesterday. Resident B was not one of them. "It would surprise me to know that he was a diabetic, because he did not have any orders for Accuchecks or insulin." She indicated she was unaware he had cellulitis. It was important to have full accurate order sets in the MAR since she was an agency nurse and she worked with different residents "a lot of the time."		The RNC/RDO had input on the education related to the AOC. **Monitoring** **How the corrective actions will be monitored to ensure the deficient practice does not recur (i.e.,** **what quality assurance program will be put into place and by what date the systemic changes for each deficiency will be completed=** The results of the monitoring by the DON/ADON and RNC (Regional Nurse Consultant) will be presented to the QAPI committee weekly until the facility is put into substantial compliance by the state. After that, they will presented to the QAPI committee at the monthly meetings. Any concerns will have been addressed. However, any patterns will be identified. If needed, an Action plan will be written by the committee. Any written Action Plan will be monitored by the Administrated until resolved. A member of the Regional Team will attend the facility QAP meetings for at least 3 months to ensure on-going compliance and to offer input as indicated. The facility held an Ad Hoc QAPI meeting 4/4/22 for the IDT	

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	04/13/2022

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
	During an interview, on 4/5/22 at 9:09 a.m., Licensed Practical Nurse (LPN) 9 and QMA 10 indicated they were the care givers for another hall. They both indicated they had never cared for Resident B before. Together they checked his orders and indicated he had never had an Accuchecks done in the facility since admission. He did not receive Accuchecks or receive any diabetic medication. During an interview, on 4/5/22 at 10:54 a.m., the DON indicated she contacted the physician on 4/4/22 and the Nurse Practitioner (NP) would see Resident B on 4/5/22. The physician and NP only did telehealth (video) visits, they wouldn't come into the facility. The physician had done a telehealth visit with the resident after admission. He had access to the hospital discharge papers and did not order anything additionally. Standards of practice did not trigger them to contact the physician for additional orders for wound care or diabetic medications or blood sugars. His cellulitis was healed. They only put dressings on because he wanted them to. He had stopped his own diabetic medication at home before he went to the hospital. During an interview, on 4/5/22 at 11:45 a.m., the DON indicated she had no answer to whether the resident had gone to appointments at the clinic or not. She was trying to get in touch with transportation to see if they took him anywhere. He did refuse some things. "There is no documentation of the resident going out for any appointments or returning with any physician notes. If it happened there should be notes." On 4/5/22 at 12:53 p.m., the DON provided a		(Interdisciplinary Team), led by the Administrator/RDO at which time this AOC was reviewed and discussed. The members of the QAPI committee are: (with respect to HIPAA) Administrator DON Director of Nursing ADON Assistant Director of Nursing Business Office Manager MDS Coordinator Social Service Designee Activities Director Housekeeping /Laundry Supervisor Maintenance Director Rehab Director RVP/RDO/RND/MDS Consultant (may attend if present) Pharmacy Consultant/Dietician (may attend if present) Medical Director/Nurse Practitioner	

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	04/13/2022

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
	written statement she indicated was from the facility transporter. The transporter had not taken Resident B to any appointments. She indicated the hospital picked up the residents themselves. They had not come to take him. The appointments were canceled. He had another appointment for 4/22/22, to go to the vascular clinic. She indicated the admission note, in the resident record, entered by LPN 11 was based on the report she had gotten from the hospital when Resident B was being transferred to the facility. The DON had not done that admission, she was mistaken. LPN 11 had done it. She did not know why the admission note wasn't consistent with the resident's physician orders. On 4/5/22 at 2:46 p.m., the Administrator provided a current, undated policy, titled "Admission Guidelines." This policy indicated "...All applicants for admission will be individually assessed for reasonable accommodation, ensuring that no barriers to admission of whole diagnostic groups or conditions occurs. The pre-admission evaluation of each prospective resident must ensure that only those individuals are admitted whose medical/psychosocial needs can be met by the facility. The facility must have an order for immediate care written by a currently licensed physician for admission of an individual to the facility. An evaluation of each resident shall be made, prior to admission, which shall include personal or telephone interviews with the resident, the resident's physician, or the representative of the facility from which the resident is being transferred, if applicable. At the time each individual is admitted, the facility must have physician's orders for immediate care that are based on a physical examination performed by a currently licensed attending physician or his /her designee, written on the day of admission or			

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	04/13/2022

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

within 30 days prior to admission...."

On 4/5/22 at 2:46 p.m., the Administrator provided a current, undated policy, titled "Physician's Orders- (Following Physician Orders)." This policy indicated "It is the policy of the facility to follow the orders of the physician. At the time of admission, the facility must have physician orders for the resident's immediate care. The facility will have orders to provide essential care to the resident, consistent with the resident's mental and physical status upon admission. The facility must have orders upon admission from the physician for: dietary, drugs (if necessary), routine care to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan. AS assessments are completed, orders will be received from the physician to address significant findings of the assessments. Orders that accompany the resident on admission will be clarified by the physician through action of the nurse who will contact the physician for clarification upon the resident's admission ...."

According an article from the American Diabetes Association, titled, "Glycemic Targets: Standards of Medical Care in Diabetes-2022," dated 12/16/21and retrieved on 4/5/22 at https://doi.org/10.2337/dc22-S006, indicated, "The American Diabetes Association (ADA) 'Standards of Medical Care in Diabetes' includes the ADA's current clinical practice recommendations and is intended to provide the components of diabetes care, general treatment goals and guidelines, and tools to evaluate quality of care ...Glycemic control is assessed by the A1C measurement, continuous glucose monitoring (CGM) using either time in range (TIR) and/or glucose management indicator (GMI), and blood glucose

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	04/13/2022

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

monitoring (BGM). A1C is the metric used to date in clinical trials demonstrating the benefits of improved glycemic control. Individual glucose monitoring is a useful tool for diabetes self-management, which includes meals, exercise, and medication adjustment, particularly in individuals taking insulin. CGM serves an increasingly important role in the management of the effectiveness and safety of treatment in many patients with type 1 diabetes and in selected patients with type 2 diabetes. Individuals on a variety of insulin regimens can benefit from CGM with improved glucose control, decreased hypoglycemia, and enhanced self-efficacy...."

The immediate jeopardy that began on 3/18/22 was removed on 4/7/22 when the facility audited all the diabetic residents and residents with new admissions for medication, diet, and wound care orders and completed nursing staff education for the new admission process. The noncompliance remained at the lower scope and severity level of isolated no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring.

2. On 4/4/22 at 10:31 a.m., during an observation and interview, Resident E was watching television seated in a recliner in her room. An intravenous (IV) pole was on her right. A completed bag of IV antibiotic medication hung on the pole. There was no date or time on the tubing or hang time on the bag. A PICC (peripherally inserted central catheter) was visible in the resident's upper right arm. The dressing was dated 3/22/22. Her left foot was wrapped in an ACE bandage (compression bandage). A tubing connected the bandage to a wound vacuum (vac) machine to the resident's left. There was no date or initials visible on the

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	04/13/2022

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
	dressing. The Resident indicated she had come to the facility for rehab and IV antibiotics. She had surgery on her foot because of an infection and sore from her diabetes. She was supposed to go home soon, maybe a week or so, because her two or three weeks of antibiotics would be finished. Her PICC line dressing had not been changed since she came to the facility. That dressing she had on was done at the hospital. The wound vacuum (vac) dressing was supposed to be changed on Monday, Wednesday, and Friday. It had not been done yet that day. They had told her the Director of Nursing (DON) was supposed to do the dressing change. On 4/7/22 at 9:00 a.m., during an observation and interview, Resident E was observed up in the recliner having breakfast. She indicated the wound vac dressing was changed on Monday and was supposed to be changed on Wednesday (4/6/22) but it was not done. The resident's left foot was wrapped in ace wrap and had visible drainage on it. There was no date on the bandage. The wound vac was not turned on. The resident indicated they had turned off the wound vac yesterday because it was beeping. The nurse did not know how to fix it. The PICC line dressing had been changed on Monday, that was the only time it was changed at the facility since her admission. The clear plastic dressing covering the IV catheter had a gauze pad over the insertion site and it was not possible to assess the site. There was no date on the dressing. The IV pump was beeping, and the message bar indicated "infusion complete." There was still approximately one fourth of the fluid still in the bag. The tubing was not connected to the resident's arm. There was no date or time on the tubing or start time on the bag. The resident indicated the nurse had disconnected her from the pump so she could go			

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	04/13/2022

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

to the bathroom.

On 4/7/22 at 8:46 a.m., the medical record was reviewed for Resident E. The diagnoses included, but were not limited to diabetes, sepsis, and hypertension (high blood pressure).

A care plan, dated 3/23/22 with a target date of 6/20/22, indicated Resident E had a surgical wound on admission and a pressure ulcer on the bottom of her left foot related to disease process, diabetes and non-compliance with treatment regimen, history of ulcers. The goal indicated the resident's pressure ulcer would show signs of healing and remain free from infection through the review date.

The weekly Wound evaluations indicated:
On admission, 3/22/22 the left foot, surgical wound measurements were 4 cm (centimeters) by 4.5 cm by 0 (depth) cm.
On 3/26/22 the left foot, surgical wound measurements were 8.8 cm by 3.28 cm by 1.40 cm.
On 3/28/22 the left foot, surgical wound measurements were 8.8 cm by 3.28 cm by 1.40 cm.

A review of Resident E's physician orders included, but were not limited to:
-Cefepime HCl Solution (antibiotic) 1 gram (gm)/50 milliliters (ml) intravenously every 8 hours for Infection related to sepsis until 04/12/2022 at 10:00 p.m.
-Dakins (1/2 strength) Solution 0.25 % (an antibacterial bleach solution) Apply to left bottom foot topically one time a day every Monday, Wednesday, Friday related to Diabetes Mellitus foot ulcer ordered 4/8/2022 at 9:00 a.m.
-May use normal saline (salt water) wet to dry as needed (PRN) due wound vacuum (vac) malfunction, vac removal every 8 hours as needed

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	04/13/2022

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
	for Wound Care Management, active order date 3/22/2022 at 6:30 p.m. -Negative pressure therapy (wound vac) to left foot. Ordered to change on Monday, Wednesday, and Friday and PRN due to dislodgement, Active order date 3/22/2022 at 6:30 p.m. -Flush PICC line before and after IV antibiotic infusion every 8 hours for Infection left foot, active order date 3/25/2022 at 6:00 a.m. There were no physician orders for PICC line dressing changes. There were no care plans for IV therapy/antibiotic treatment or diabetic care in the medical record. Progress notes, dated 4/6/22 at 9:43 p.m., indicated Resident E remained on IV antibiotic for infection in left foot. No adverse reaction to antibiotic therapy noted. Midline to right upper arm flushed well with normal saline and was patent. On 4/7/22 at 10:33 a.m., the resident was observed still seated in the recliner. Resident E's left foot rested on the lower bar of the overbed table. A pool of serosanguinous (blood) fluid, approximately half the size of the resident's foot was on the floor, under her foot. On 4/7/22 at 10:45 a.m., during an observation and interview the DON talked to the resident about when her wound was last cared for. The DON indicated wound care "should have been done yesterday. If it was documented as having been done yesterday, she would be having disciplinary action with the nurse." The PICC line dressing should have been changed every 7 days and not be occlusive (unable to see the insertion site). It should have only had gauze from the packet used for the initial (first) dressing. There should have			

been an order for the PICC line dressing and IV tubing change. Tubing should have been dated when hung. She would have Licensed Practical Nurse (LPN) 9 change the dressing.

On 4/7/22 at 10:00 a.m. Resident E's Treatment Administration Record (TAR) was reviewed. The Record was initialed by the DON for Wednesday 4/6/22 at 9:00 a.m., which indicated the DON had changed Resident E's wound vac dressing.

On 4/7/22 at 11:26 a.m., LPN 9 indicated she would be changing Resident E's wound vac dressing about 12:30 or 1:00 p.m., since she was busy.

On 4/7/22 at 1:13 p.m., during an observation with LPN 9, Resident E was seated in the recliner in a laid-back position with the footrest up. The left foot dressing had been removed and was in a small trash can under the resident's foot. Bloody drainage dripped from the foot into the can. A washcloth covered the top of the resident's foot. There was still a puddle of red drainage on the floor, about the size of an orange. The wound on left outer aspect of foot was gapping open approximately 2 inches wide and 5 inches long. It appeared around a half an inch deep. LPN 9 did not take any measurements during the dressing application.

On 4/11/22 at 2:35 p.m., Resident E was observed from the doorway as she slept in the recliner. The IV pole had 2 small IV bags hanging on the pump. The pole was pushed away from the resident. The infusion was complete. There was no date or time on the tubing.

During an observation and interview, on 4/12/22 at 2:27 p.m., Resident E's IV pump hung on the pole with a completed IV bag and tubing in place.

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	04/13/2022

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
	There was no date or time on the IV tubing. The wound vac was not connected to the resident's foot. The resident indicated it was beeping the evening before and the nurse could not fix it. She thought there was an air leak in the tubing or something. The nurse took the wound vac off and put on a wet to dry dressing. No one had come back to put the wound vac back on. On 4/5/22 at 2:46 p.m., the Administrator provided a current, undated policy titled, "Admission Guidelines." This policy indicated, "...All applicants for admission will be individually assessed for reasonable accommodation, ensuring that no barriers to admission of whole diagnostic groups or conditions occurs. The pre-admission evaluation of each prospective resident must ensure that only those individuals are admitted whose medical/psychosocial needs can be met by the facility. The facility must have an order for immediate care written by a currently licensed physician for admission of an individual to the facility. An evaluation of each resident shall be made, prior to admission, which shall include personal or telephone interviews with the resident, the resident's physician, or the representative of the facility from which the resident is being transferred, if applicable. At the time each individual is admitted, the facility must have physician's orders for immediate care that are based on a physical examination performed by a currently licensed attending physician or his /her designee, written on the day of admission or within 30 days prior to admission...." On 4/5/22 at 2:46 p.m., the Administrator provided a current, undated policy titled, "Physician's Orders- (Following Physician Orders)." This policy indicated, " ...It is the policy of the facility to follow the orders of the physician. At the time			

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	04/13/2022

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
	of admission, the facility must have physician orders for the resident's immediate care. The facility will have orders to provide essential care to the resident, consistent with the resident's mental and physical status upon admission. The facility must have orders upon admission from the physician for: dietary, drugs (if necessary), routine care to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan. AS assessments are completed, orders will be received from the physician to address significant findings of the assessments. Orders that accompany the resident on admission will be clarified by the physician through action of the nurse who will contact the physician for clarification upon the resident's admission ...."3. During a confidential interview it was indicated, the biggest concern related to Resident C's care at the facility, was how bad her foot and legs got. They weren't "that bad" in the hospital, then all of the sudden she got sent back to the hospital with black feet. She did originally have an ulcer on the bottom of her foot, but when she got back to the hospital, they were gangrene and black and looked like they were "rotted off." Resident C was supposed to have a follow up doctor's appointment on 3/28/22 but the DON didn't "do anything about it." On 4/13/22 at 3:5 8 p.m., Resident C's medical record was reviewed. She was admitted to the facility on 2/28/22 after a 4 day hospital stay where she was treated primarily for a foot fracture sustained during a fall at home and received secondary treatment for burns sustained in a previous smoking accident. A hospital			

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	04/13/2022

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
	discharge summary for the hospitalization prior to admission was dated 2/28/22. The discharge summary included an updated medication and treatment regime that did not indicate any treatments to her feet. The discharge summary indicated Resident C had a pre-scheduled orthopedic follow up appointment for 3/28/22. The discharge summary indicated Resident C had sustained a closed, nondisplaced fracture of the 5th metatarsal bone of the left foot with delayed healing. Multiple skin burns, skin tears, and skin wounds were noted with instructions to clean the wounds two times a day and apply santyl. As for the left foot fracture instructions were given to administer gabapentin 100 mg at bedtime and wear a surgical shoe when out of bed. A physical exam was conducted upon her discharge and her skin was noted to have a large healing burn on her back and neck and left lower extremities with "healing areas." The discharge summary did not indicate Resident C had any gangrene or necrotic tissue. Resident C's admission orders, (initiated upon her admission on 2/28/22) were reviewed. There were no admission orders for treatment to her burns and skin wounds.An admission nursing progress note 2/28/22 at 1:58 p.m., Resident C admitted with diagnoses of closed non-displaced fracture of 5th metatarsal bone of left foot			

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	04/13/2022

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
	with delayed healing, weakness, history of CVA (stroke), burn, severe protein- calorie malnutrition and vitamin D deficiency. Resident C was alert with periods of confusion and disorientation, but able to ambulate with boot on left foot. Her skin was noted to have multiple areas of impairment including sacrum, coccyx, left foot and toes, and left hip. The admission progress note lacked documentation of the description of the wound areas and did not indicate any area of her body with gangrene or necrotic tissue. A comprehensive nursing admission assessment dated 2/28/22 at 1:58 p.m. indicated the following wound locations, description and measurements:a. Wound 4 was a burn, located on her face that measured 4 centimeters (cm) long, by 2 cm wide, by 0.5 cm deepb. Wound 26 was an unstageable pressure ulcer, located on her left hip that measured 5 cm long by 2.5 cm wide, and 0 cm depth. c. Wound 52 was an unstageable pressure ulcer, located on her left toes that measured 1.5 cm long, by 2.0 cm wide, and 0.1 cm deep.d. Wound 50 was an unstageable pressure ulcer, located on her left heel that measured 3.5 cm long, by 3.0 cm wide, and 0 cm depth.e. Wound 53 was a suspected deep tissue injury, located on her sacrum that measured 2 cm long, by 1.5 cm wide, by 0 cm depth.f. Wound 23 was a stage 4 pressure ulcer,			

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	04/13/2022

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
	located on her coccyx that measured 3 cm long, by 2 cm wide, by 0.3 cm deep. The record lacked documentation that Resident C had been referred to, and/or evaluated by SWAT, (skin and wound team). Resident C was seen via a tele-health video conference call on 3/1/22 at 10:12 a.m. The tele-health progress note indicated Resident C had pain in her foot, that was constant and aching. The note did not indicate which foot, and upon a physical exam, the note did not indicate Resident C's feet had been examined. No new orders were given, and the treatment plan for the Resident's pain was to continue Norco 5/325 mg as needed and follow up with orthopedics (ortho) as scheduled.Resident C's baseline care plan, dated 3/1/22, lacked documentation of the above noted skin integrity concerns Another tele-health progress note, dated 3/2/22 at 1:33 p.m., incorrectly documented Resident C as a male.Treatments for Resident C's multiple wounds which included but were not limited to her left foot and toes were not initiated until 3/4/22, 4 days after her admission. On 3/4/22 at 4:16 p.m., an acute tele-health video visit was conducted for the chief complaint of pain. The progress note indicated, "...dry gangrene of the LE [left extremity]... Patient appears anxious and uncomfortable during visit, she states she is in severe pain. Pain is 10/10 located at her			

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	04/13/2022

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
	lower extremities, she has a difficult time describing the pain however per nurse report it has been excruciating and inhibiting her from normal functioning/obtaining adequate sleep. She appears ill and very cachectic. She denies other symptoms however her pain level appears to be inhibiting her from being able to accurately answer questions... severe pain 2/2 dry gangrenous skin lesions...." New orders were given to increase her pain medication by adding Oxycodone 10 mg every 6 hours.On 3/11/22 Resident C was placed on Hospice. An admission hospice narrative 3/11/22 at 12:00 p.m., indicated "...patient came to facility with necrotic extremity...." although as noted above, the admission documentation lacked any description of necrotic or gangrenous tissue. A nursing progress note, dated 3/31/22 at 12:14 p.m., indicated Resident C had been sent to the ED (emergency department) due to a declineA hospital admission note, dated 3/31/22, indicated, "[Resident C] presents to ED via EMS [emergency medical staff] from ECF [extended care facility] for further evaluation of necrotic left lower extremity. Per EMS, ECF stated necrosis has been getting progressively worse and started to drain.... upon arrival... LLE with gangrene to left knee from plantar aspect of foot, concerns for wet gangrene... she has			

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	04/13/2022

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
	extensive dry gangrene of the left lower leg extremity involving nearly the complete lower leg. She has evidence of wet gangrene on the distal left thigh most notably on the posterior aspect... patient was deemed a poor surgical candidate as CTA (Computed tomography angiography) demonstrates occlusion of the bilateral iliac as well as superficial femoral on the left...." Further the hospital record indicated, "...patient present to the hospital with acute mental status change and LLE gangrene. Patient has been in a nursing facility and has a previous history of stroke and residual left side weakness. Patient was seen by ortho before for previous left foot fracture treated non-operatively. She had multiple scabs on her foot at that time. She has been in an ECF for the past month. She presents today with gangrenous extremity up to the knee...."During an interview on 4/13/22 at 3:10 p.m., the Regional Director of Clinical Operations, (RDO) indicated, Resident C had not been referred to SWAT because of staffing issues the facility had in March. When the RDO was informed of the limited and inaccurate documentation of Resident C's wounds (as compared to the hospital records which noted increased in size and severity from a couple of scabs on her left toe, to full wet/dry gangrene from her foot to her ankle), the RDO indicated the			

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	04/13/2022

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
	documentation was lacking and it was very important to capture the full extent of a resident's wound upon admission to better serve the resident.During an interview on 4/13/22 at 3:17 p.m., the Director of Nursing (DON) indicated, Resident C admitted to the facility on 2/28/22 and had necrotic toes at that time. She went down to see the resident and the toes on her left foot looked like they" could fall off at any time. "She was seen by the doctor the day after she admitted and treatments for the area remained the same. They were going to monitor the area until she was supposed to have a follow up ortho visit on 3/28/22 but the DON indicated she had "too much going on," and she "forgot the appointment." Then the resident had a decline in her health and since she was a full code status, she was sent to the ED. When discrepancies between the hospital discharge paperwork and facility's admission documentation related to the wounds were questioned, the DON agreed the facility's admission documentation did not reflect the severity of the level of necrosis and gangrene to the left foot/toes.4. On 4/4/22 at 7:24 p.m., Resident D's legal guardian indicated the last time she went to see Resident D there was a lot of dried blood in her hair. No one had cleaned up her head when her head wound was seeping blood. The facility indicated she			

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	04/13/2022

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
	possibly had a fight with another resident. This was about 2-3 months ago. On 4/06/22 at 10:11 a.m., Resident D's record was reviewed. Resident D's diagnoses included, but were not limited to, schizoaffective disorder (disorder of mood, hallucinations and delusions), dementia (chronic disorder of mental processes), epilepsy (sudden recurrent episode of sensory disturbance with loss of consciousness), and anoxic (lack of oxygen) brain damage. A nursing progress note, on 1/19/22 at 1:30 a.m., Licensed Practical Nurse (LPN) 11 indicated Resident D was observed sitting in an upright position on the floor in her room. Resident D stated, her and her boyfriend had gotten into a fight, and he hit her, and she hit him. She had a minimal amount of dried blood on her neck and to the back of her left head area. Resident D was hard to understand due to confusion and slurred speech. She denied pain. Emergency Medical Technicians (EMT) notified to send Resident D to the hospital for further evaluation.A nursing progress note, on 1/19/2022 at 2:00 a.m., indicated she called Resident D's legal guardian about the fall with injury. The legal guardian was concerned because Resident D had 2 falls in the last 2 days and requested the resident be sent to the hospital. A nursing progress note, on 1/19/2022 at 2:02 a.m., indicated the			

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	04/13/2022

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
	Director of Nursing (DON) was notified and updated on Resident D's fall with injury. On 1/19/22 at 2:09 a.m., Resident D left the facility via stretcher and was transported to the hospital. An IDT (interdisciplinary team) note, dated 1/20/22 at 12:28 p.m., indicated Resident D had a fall on 1/19/22. The immediate intervention was to send to the hospital emergency room (ER) for evaluation of increased falls. There was no mention of the laceration to the back of her head needing 6 staples. A nursing note, dated on 1/24/22 at 3:35 p.m., indicated Resident D arrived via stretcher from the hospital. She called her legal guardian to give her an update and spoke with the hospital nurse related to medication changes and the laceration. Resident D had a laceration to her scalp with staples that needed to be removed after 1/26/22. On 1/26/22 at 4:00 p.m., a physician telehealth visit was conducted. Resident D had a scalp laceration with staples to be removed in 7 to 10 days. Continue current course of treatment, no new orders. No notes were found in the chart regarding the staples, from the 1/19/22, fall being removed.On 2/11/2022 at 1:55 p.m., a summary for the doctor was reported as a change in condition. It indicated Resident D seemed more sleepy and not able to ambulate without a fall. The recommendation was to			

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	04/13/2022

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
	change the orders of some of her medications. The summary did not identify the medications that needed change. On 2/11/22 at 7:00 p.m., a QMA noted Resident D in the hallway and tripped on her own feet and fell to the floor. This event caused her to have a laceration on the back of her head. 911 was called and the resident was taken to the hospital. On 2/11/22 at 7:06 p.m., a nursing note indicated a call was placed to the physician, Administrator, and Resident D's legal guardian and orders were received to send Resident D to the hospital. A nursing progress note, dated 2/12/2022 at 1:04 p.m., indicated Resident D returned to the facility with sutures/staples in the back of her head. She stated she had a headache. An IDT (interdisciplinary team), dated 2/14/22 at 9:18 a.m., indicated Resident D was at the end of the hallway trying to get out of the facility, there was a loud crash, and nursing saw the resident lying on her back up against a glass door. She was on the floor, she had a small laceration on the back of her head, she was assessed, and the area cleaned with saline and a dressing was applied. An IDT note, dated 2/14/22 at 6:24 p.m., indicated Resident D tripped over her own feet and fell to the floor. This was witnessed by a QMA. The fall reopened a previous head laceration. Resident D was currently being			

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	04/13/2022

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
	reviewed for the previous fall with head laceration, with medication review and labs to be drawn as a next lab day. Resident was care planned for impulsive behaviors and making poor choices/judgment decisions. She was also care planned for exit seeking behaviors and inability to be re-directed by nursing staff related to history of traumatic brain injury (TBI). The new intervention of Resident D wearing protective head gear had been refused in the past, but she stated and demonstrated a willingness to a try new "cooling" type protective headgear to prevent injury to head. The new head gear was more fashionable as well as functional and appealed to the resident with hopes of encouraging compliance and aid in increasing self-esteem when worn. A nursing progress note, dated 2/21/22 at 6:23 p.m., indicated Resident D was doing well with keeping her helmet on, and the back of her head still had staples.A nursing progress note, dated 2/25/22 at 11:00 a.m., indicated a call was placed to the hospital in reference to removing the staples out of Resident D's head. These were staples from the 2/11/22 fall, they should have been removed in 7-10 days. On 4/11/22 at 12:08 p.m., the DON indicated her expectation was for the nurse to take the staples out in 7-10 days. A current policy, titled, "Resident Rights," with no date, was provided by the Administrator,			

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	04/13/2022

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 4/13/22 at 10:20 a.m. A review of the policy indicated, " ...The facility must care for you in a manner and environment that enhances or promotes your quality of life ...."On 4/5/22 at 2:46 p.m., the Administrator provided a current, undated policy, titled "Admission Guidelines." This policy indicated "...All applicants for admission will be individually assessed for reasonable accommodation, ensuring that no barriers to admission of whole diagnostic groups or conditions occurs. The pre-admission evaluation of each prospective resident must ensure that only those individuals are admitted whose medical/psychosocial needs can be met by the facility. The facility must have an order for immediate care written by a currently licensed physician for admission of an individual to the facility. An evaluation of each resident shall be made, prior to admission, which shall include personal or telephone interviews with the resident, the resident's physician, or the representative of the facility from which the resident is being transferred, if applicable. At the time each individual is admitted, the facility must have physician's orders for immediate care that are based on a physical examination performed by a currently licensed attending physician or his /her designee, written on the day of admission or within 30 days prior to			

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	04/13/2022

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
	admission...."On 4/5/22 at 2:46 p.m., the Administrator provided a current, undated policy, titled "Physician's Orders- (Following Physician Orders)." This policy indicated "It is the policy of the facility to follow the orders of the physician. At the time of admission, the facility must have physician orders for the resident's immediate care. The facility will have orders to provide essential care to the resident, consistent with the resident's mental and physical status upon admission. The facility must have orders upon admission from the physician for: dietary, drugs (if necessary), routine care to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan. AS assessments are completed, orders will be received from the physician to address significant findings of the assessments. Orders that accompany the resident on admission will be clarified by the physician through action of the nurse who will contact the physician for clarification upon the resident's admission...." This Federal tag relates to Complaint IN00376905. 3.1-37(a)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician			

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	04/13/2022

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
	orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, interview, and record review, the facility failed to follow standards of care practices of changing peripherally inserted central catheter (PICC) site dressings and labeling and dating intravenous (IV) tubing with each use for a resident with IV antibiotics for 1 of 1 resident reviewed for intravenous care (Resident E). Findings include: On 4/4/22 at 10:31 a.m., during an observation and interview, Resident E was watching television seated in a recliner in her room. An intravenous (IV) pole was on her right. A completed bag of IV antibiotic medication hung on the pole. There was no date or time on the tubing or hang time on the bag. A peripherally inserted central catheter (PICC) was visible in the resident's upper right arm. The dressing was dated 3/22/22. The Resident indicated she had come to the facility for rehab and IV antibiotics. She had surgery on her foot because of an infection and sore from her diabetes. She was supposed to go home soon, maybe a week or so, because her two or three weeks of antibiotics would be finished. Her PICC line dressing had not been changed since she came to the facility. The dressing she had on was done at the hospital. On 4/7/22 at 8:46 a.m., the medical record was reviewed for Resident E. The diagnoses included, but were not limited to diabetes, sepsis, hypertension (high blood pressure). A progress notes, dated 4/6/22 at 9:43 p.m., indicated Resident remained on IV antibiotic for infection in left foot. No adverse reaction to	F 0694	F694-Parental/IV fluids 1. Resident E's PICC line was pulled on 4/18/22. Resident E did not have any adverse outcomes related to the deficient practice. 2. Any resident with an IV or PICC line have the potential to be affected by the deficient practice. A full house audit was completed to ensure any resident with a PICC/ IV had dressing change and tubing change orders. 3. DON/designee will educate nurses on the policy/procedure's PICC Line Dressing and Infusion Maintenance Table to include changing and dating IV tubing on or before 5/11/22. DON/designee will audit orders to ensure any resident who receives/or is admitted with any IV therapy has orders in place for dressing and tubing changes. 4. Audit will be completed weekly x 4 weeks, 2x month x 4 weeks, then monthly x 4 months. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. 5. DON 5/12/22.	05/12/2022

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	04/13/2022

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

antibiotic therapy noted. Midline (type of central line catheter) to right upper arm flushes well with normal saline and was patent.

A review of Resident E's physician orders included, but were not limited to:
Cefepime HCl Solution (antibiotic) 1 gram (gm) per (/) 50 milliliters (ml) administer 1 gram intravenously every 8 hours for infection related to sepsis until 4/12/2022 at 10:00 p.m.

Flush PICC line before and after IV antibiotic infusion every 8 hours for infection in left foot ordered 3/25/2022 at 6:00 a.m.

There were no physician orders for PICC line dressing changes, or assessment of the insertion site.

There were no care plans for IV therapy, antibiotic treatment, or diabetic care in the medical record.

On 4/7/22 at 9:00 a.m., during an observation and interview, Resident E was observed up in the recliner having breakfast. The PICC line dressing had been changed on Monday. Resident E indicated that was the only time it was changed at the facility since her admission. The clear plastic dressing covering the catheter had a gauze pad over the insertion site and it was not possible to assess the site. The IV pump was beeping and the message bar indicated "infusion complete." There was still approximately ¼ of the fluid still in the bag. The tubing was not connected to the resident's arm. There was no date or time on the tubing or start time on the bag. The resident indicated the nurse had disconnected her from the pump so she could go to the bathroom.

On 4/7/22 at 10:45 a.m., during an observation and

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	04/13/2022

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
	interview the Director of Nursing (DON), at Resident E's bedside, she indicated the PICC line dressing should have been changed every 7 days and not be occlusive (unable to see the insertion site). It should have only had gauze from the packet used for the initial (first) dressing. There should have been an order for the PICC line dressing and IV tubing change. Tubing should have been dated when hung. On 4/11/22 at 2:35 p.m., Resident E was observed from the doorway as she slept in the recliner. The IV pole had 2 small IV bags hanging on the pump. The pole was pushed away from resident. The infusion was complete. There was no date or time on the tubing. On 4/12/22 at 2:27 p.m., during an observation and interview, Resident E's IV pump hung on the pole with a completed IV bag and tubing in place. There was no date or time on the IV tubing. On 4/7/22 at 10:30 a.m., the DON provided a current undated policy titled "PICC Line Dressing." This policy indicated, " ...The PICC catheter insertion site is a potential entry site for bacteria that could produce a catheter related infection...Initial PICC dressings are changed 24 hours after placement of the line. Transparent dressings are changed every 7 days...assessment of the catheter insertion site ...." On 4/7/22 at 10:30 a.m., the DON provided a current undated policy, from the pharmacy, titled "Infusion Maintenance Table." This table indicated "...for PICC: transparent dressing changes 24 hours post insertion then every week & prn [as needed]. Measure upper arm circumference and external catheter length ...."			

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	04/13/2022

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
	3.1-47(a)(2)			
F 0725 SS=F Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.			
	Based observation, interview, and record review, the facility failed to ensure an adequate amount of licensed nursing staff were available to ensure daily clinical assessments were comprehensive and complete, and timely wound treatments were provided; and the facility failed to ensure staffing numbers were implemented according to the most recent Facility Assessment. These deficient	F 0725	F725-Sufficent Nursing Staff 1.) Resident C and E no longer reside at this facility. Resident D continues to reside on Memory Care. Memory Care has at least 1 C.N.A. on Nightshift and 1 Q.M.A. who works as a C.N.A. as needed. The leaves 2 staff	05/12/2022

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	04/13/2022

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
	practices had the potential to effect 57 of 57 residents residing in the facility who required skilled nursing services. Findings include: 1. During an interview on 4/5/22 at 11:10 a.m., LPN (Licensed Practical Nurse) 9 indicated, the facility was usually staffed with 1 (sometimes 2) floor nurses, 3 Qualified Medication Aide (QMA) for one on each medication cart (med cart), and 4 Certified Nursing Assistants (CNA). The QMAs could pass medication and check blood sugar, but they did not have access to the computer system to document the blood sugars. So, they just wrote the blood sugar checks on a scrap piece of paper, then gave it to LPN 9 at the end of their shift. LPN 9 would then log the blood sugars and call the doctor if needed based off any parameters on the order. A log of the blood sugars should be kept in the nursing communication log, which was a binder at the nurses' station, but when reviewed at this time it was empty. LPN 9 indicated they ended up being thrown away. LPN 9 indicated it would be very helpful to have more Licensed nursing staff to help with responsibilities that the QMAs could not perform, as well as help complete nursing assessments. It was unreasonable for 1 nurse to be responsible for 57 residents with no administrative oversite. During an interview on 4/6/22 at 10:27 a.m., CNA 28 indicated they had worked at the facility a long time and seen a lot of staff come and go. If the facility could hold on to more staff, it could make everyone's work load a little more manageable. For as much turn over as there was, CNA 28 never saw cooperate or support staff on the floor. The few times they came to the building, they would typically be in the front office.		members on Memory Care with a nurse on the main unit. Which is the unit that resident D resides on. Staffing during the dayshift and evening now has at least 2 nurses on days and evenings with 1 QMA on 300 hall and 1 on 200 hall which frees up the nurse on 300 to do nursing assessments and treatments. The floor nurse is being asked to do normal floor nurse activities. The DON and the ADON continues to assist as needed. The C.N.A.'s during the dayshift and evening shift at this time attempt to have 2 C.N.A.' and a QMA on the memory care unit for 20 residents as census continues to increase more staff will be added. 2.) All residents have the potential to be affected by the deficient practice. 3.) Hiring of licensed nurses has continued and will continue until maximum numbers met. DON, ADON, and IP nurses will continue to assist where needed. 4.) DON or designee will continue to look through Appoli to interview for licensed staff in an attempt to promote more sufficient staff in an effort to meet the needs of the residents in the facility beginning 5/6/22 and continuing as on-going. Interviews will be set as soon as possible to get staff oriented and ready for the floor. The DON or designee is continuing to audit the new	

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	04/13/2022

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
	During an interview on 4/6/22 at 2:23 p.m., the Director of Nursing (DON) indicated she had to use a lot of agency staff, but she always overstaffed to anticipate potential call offs. She staffed at a 3.12 for PPD (patient per day) which was considered overstaffing, and she was "getting in trouble for it" but she had to take some action because, "we have some that don't really want to do their jobs." On a typical day and evening shift, the DON indicated there should be 1 nurse, 3 QMAs, and 6 CNAs. On a typical night shift, there were 2 nurses, 1 QMA, and 3 to 4 CNAs. During an interview on 4/7/22 at 11:56 a.m., QMA 30 indicated she had been on staff at the facility for about 2 years and in her opinion, she thought the building was overstaffed with QMAs. It was great to have a QMA on each cart to pass medicines, but they did not have access to nursing documentation other than initialing in the Medication Administration Record (MAR) and they could not administer insulin. The nurse could probably use more help with all she had to do. During an interview on 4/12/22 at 11:42 a.m., LPN 9 indicated there was definitely a system failure related to staffing. The facility brought in QMAs to help with medications, but they could not help with insulin administration, nursing assessments, or nursing documentation. If they had the time they could only work as a CNA, but usually medications took up all their time. There was definitely a likelihood of things that could go wrong or clinical issues that could be missed because the nurse was stretched too thin. It felt like they kept piling more and more on the floor nurse instead of delegating or getting assistance from the DON of ADON.		admissions and re-admissions the next morning after admission or on Monday if admitted over the weekend to ensure that all diagnosis's and medications are correct. Will call the on-call MD/NP for any further orders needed. Audits of new admissions/re-admissions will be done five times weekly for the next 6 months and then as needed. Administrator/designee will audit open positions weekly x 4 weeks, twice a month x 2 months, then monthly x 3 months. 5.) DOC 5/12/22.	

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	04/13/2022

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

During an interview on 4/13/22 at 10:19 a.m., an Activity Assistant (AA) and CNA 32 both indicated the facility needed more staff. Usually there was only 1 CNA on the Memory Care unit, and if things "got out of hand" there was a potential for accidents. Then there were a lot of agency staff that were not the same from day to day, so the residents got confused and anxious about it, which in turn created more behaviors. CNA 32 indicated it would be nice to see the Administrator, DON ,or ADON come to help at busy times like meals to help assist with feeding or getting residents to and from their rooms.

During an interview on 4/12/22 at 10:58 a.m., the Regional Director of Operations (RDO) indicated, he was still new to the building and getting to understand some of the systemic issues. In his assessments thus far, the RDO indicated he did not believe the facility was equipped with adequate competent nursing staff by means of education and understanding of how to work with the population of residents in the facility. There were a lot of residents with histories of drug and alcohol abuse, and many of them were very manipulative. The staff did not have the training to deal with some of those behaviors and could potentially be one of the reasons for higher burn out. The building should be able to utilize and implement effective training and provide adequate amounts of licensed nursing staff to address the needs of the facility's unique population.

2. The facility failed to treat a resident with Diabetes Meletus as ordered by the hospital discharge instructions for diabetic medication and diabetic wound care resulting in Resident B having significant risk of hypo/hyperglycemia and wound deterioration or infection and the facility

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	04/13/2022

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
	also failed to ensure care was given for diabetic wound care, IV antibiotics (Resident E), and non-pressure wound care (Resident C and D) for 4 of 9 residents reviewed for quality of care. During an interview on 4/4/22 at 4:45 p.m., the Director of Nursing (DON) indicated at first, she was not aware of a Resident B's diabetic diagnosis, then indicated the resident had received insulin on a sliding scale while in the hospital, but the orders were not carried over during his admission to the facility. The DON reviewed the resident's hospital discharge summary then indicated the insulin orders and diabetic diagnosis would need to be re-evaluated. Additionally, the DON could not confirm at that time if the resident's blood sugars had been checked at all since his admission. When the DON was asked about the resident's current leg infection, she indicated the leg were wrapped and he had completed a course of antibiotics in the hospital, therefore there was nothing under the leg wraps. When asked what the signs/symptoms of cellulitis were, the DON indicated redness and swelling, then confirmed she had not removed the leg dressing to evaluate for continuing sign/symptoms of cellulitis. These deficient practices resulted in an immediate jeopardy. On 4/7/22 at 10:45 a.m., during an observation and interview the DON talked to Resident E about when her wound was last cared for. The DON indicated wound care "should have been done yesterday. The PICC line dressing should have been changed every 7 days and not be occlusive (unable to see the insertion site). It should have only had gauze from the packet used for the initial (first) dressing. There should have been an order for the PICC line dressing and IV tubing change. Tubing should have been dated when hung. She			

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	04/13/2022

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
	would have Licensed Practical Nurse (LPN) 9 change the dressing. During an interview on 4/13/22 at 3:17 p.m., the Director of Nursing (DON) indicated, Resident C admitted to the facility on 2/28/22 and had necrotic toes at that time. She went down to see the resident and the toes on her left foot looked like they "could fall off at any time." She was seen by the doctor the day after she admitted and treatments for the area remained the same. They were going to monitor the area until she was supposed to have a follow up ortho visit on 3/28/22 but the DON indicated she had "too much going on," and she "forgot the appointment." Then the resident had a decline in her health and since she was a full code status, she was sent to the ED. When discrepancies between the hospital discharge paperwork and facility's admission documentation related to the wounds were questioned, the DON agreed the facility's admission documentation did not reflect the severity of the level of necrosis and gangrene to the left foot/toes. An IDT (interdisciplinary team) note, dated 1/20/22 at 12:28 p.m., indicated Resident D had a fall on 1/19/22. The immediate intervention was to send to the hospital emergency room (ER) for evaluation of increased falls. There was no mention of the laceration to the back of her head needing 6 staples. A nursing note, dated on 1/24/22 at 3:35 p.m., indicated Resident D arrived via stretcher from the hospital. She called her legal guardian to give her an update and spoke with the hospital nurse related to medication changes and the laceration. Resident D had a laceration to her scalp with staples that needed to be removed after 1/26/22.			

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	04/13/2022

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 1/26/22 at 4:00 p.m., a physician telehealth visit was conducted. Resident D had a scalp laceration with staples to be removed in 7 to 10 days.

No notes were found in the chart regarding the staples, from the 1/19/22, fall being removed.

Cross reference F684.

3. The facility failed to maintain the dignity of residents by not cleaning up urine in a timely manner, and not cleaning up a resident with food spilled on her who required assistance to eat for 2 of 3 residents reviewed for dignity (Residents 30 and 36).

During a random observation, Resident 30 was left with urine-soaked linen at her bare feet for over an hour. During staff interviews, it was indicated there were no housekeepers available at the time to clean up the urine, the agency CNAs (Certified Nursing Assistant) did not know where to find supplies, and the CNAs were busy passing breakfast trays, so they would have to get to it later.

On 4/08/22 at 9:25 a.m., Resident 36 was observed as the last person eating in the Well Springs (memory care) dining room. The remaining trays, dishes, and food had been removed and the tables cleaned up. She was trying to eat cereal in milk. The cereal and milk were observed spilled down the front of her shirt, in her lap, and on the thigh and calf of her pants. Cereal and milk were observed in a puddle of the floor. No staff members were present in the memory care dining room.

Cross Reference F550

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	04/13/2022

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
	4. A copy of the most recent Facility Assessment was provided upon survey entrance during the entrance conference on 4/4/22 at 9:27 a.m. At that time, the Administrator and DON indicated they were the two staff member responsible for reviewing and updating the assessment on an annual basis. It had originally been provided by the cooperate office and updated annually thereafter. On 4/12/22 at 8:54 a.m., a comprehensive review of the Facility Assessment was completed. The assessment was most recently updated on 1/15/22. The purpose of the assessment was to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies, and it was used to make decisions about the facilities direct care staff needs. On average, the daily resident census was 50 to 54 residents. Approximately 50 residents at a time required mental/behavioral health needs. Additionally at the time of the Facility Assessment review, approximately 41 residents were in their chairs or bedfast most of the time. The assessment indicated it would be optimal to have 8 direct licensed nurse staff per day, along with 3 additional nursing personnel with administrative duties. During an interview on 4/12/22 at 9:52 a.m., the DON indicated the facility assessment was not correct, and the direct licensed nurses per day should actually be 6. The DON provided a second copy of the Facility Assessment tool with an updated revision date of 4/12/22, and the direct licensed staff number had been changed from 8 to 6. A review of the actual worked nursing schedule			

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	04/13/2022

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
	from 3/28/22-4/3/22 revealed an average of only 4.4 licensed nurses, which did not meet the optimal 8, and minimum of 6 as indicated by the DON above. During an interview on 4/12/22 at 10:41 a.m., the Regional Director of Operations (RDO) indicated the facility was budgeted for 2.8 total direct care, which included licensed nursing staff, CNAs and QMAs. According to the Facility Assessment, 8 was the optimal number of licensed staff, but hiring and maintaining licensed staff had been a struggle. The facility assessment was a guide the facility should try to adhere to as closely as possible to ensure residents received the highest practicable quality of care. The RDO was made aware of the discrepancies of the direct staff number being changed from 8 to 6, and the weekly nursing schedule was reviewed which did not meet either documented number. The RDO agreed there was a staffing concern and as he was new to this building it would be one of his highest priorities to address. Additionally, during the above interview, the RDO reviewed the facilities recruitment software and indicated he could see that there were a couple recent applications which had not been followed up on. With staff being hard to come by and the high rate of agency usage in the facility, the facility could not afford to not follow up, and this concern would also be addressed. 3.1-17(a)			
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and			

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	04/13/2022

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
	emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on observation, interview, and record review, the facility failed to ensure deceased and discharged residents' medications had the correct disposition of medications according to the facility's policy for 8 of 8 discharged residents' medications observed (Residents 52, 6, 55, 106, 107, 108, 110, and 111). Findings include:	F 0755	F 755- Pharmacy Services/Procedures 1. The identified resident's medications were immediately inventoried, placed in a bin in a locked medication room for return to pharmacy. The doorknob was replaced on the medication storage room on memory care.	05/12/2022

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	04/13/2022

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 4/11/22 at 11:20 a.m., during a tour of the Memory Care (MC) area with Maintenance Staff, the MC Storage Room was observed unlocked. The Maintenance Staff indicated the lock was broken. Three medication carts were stored. The first medication cart (Med Cart 1) had one medication for Resident 52. It was latanoprost, the sticker on it indicated to keep refrigerated. The second medication cart (Med Cart 2) was empty. The third medication cart (Med Cart 3) had a box of medication punch cards on top of it. Medication punch card held 30 days of medication that were pushed through into a medication cup for the resident to take according to the physicians' orders. The box had 46 medication punch cards in it. Drawer two had 61 medication punch cards in it and 9 loose medication bottles. Drawer three had 49 medication punch cards in it. On 4/11/22 at 11:22 a.m., the Maintenance Staff indicated he needed to go and get tools to fix the broken MC Storage room doorknob. On 4/11/22 at 11:51 a.m., the Director of Nursing (DON) indicated the box on top of Med Cart 3 were medications for a Resident 6 who had passed away on 1/11/22. Those medications were ready to count and to send back to pharmacy. Medications should not have been in the MC storage room. All medications should have been in the regular medication storage room. She told unidentified staff members 3 weeks ago to get those medications out of there. She would provide a list of all resident names and medications. On 4/12/22 at 12:39 p.m., the DON provided a list of the medications and medication punch cards from the unlocked MC Storage room for current		2. All residents have the potential to be affected by the deficient practice. An audit was completed on all medication carts to ensure any medications for discharged residents were removed. 3. DON/designee will educate all nurses/QMA's on the correct procedure for disposition of medications for deceased/discharged residents on or before 5/11/22. DON/designee will audit medication rooms to ensure any medications no longer needed are inventoried and returned to pharmacy as per policy. 4. Audits will be completed by DON/designee 5 days a week for 4 weeks; 4 days a week for 4 weeks; 3 days a week for 4 weeks; 2 days a week for 4 weeks; weekly for 4 weeks; then monthly for 2 months. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. 5. DOC 5/12/22.	

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	04/13/2022

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

and discharged residents. For the 17 current residents there were 102 medication punch cards. Of the 8 discharged residents' medications for disposition were:
a. Resident 6 had passed away on 1/11/22 and had 14 different medications in 35 medication punch cards.
b. Resident 106 was a Medicaid recipient and had 8 different medications in 16 medication punch cards.
c. Resident 55 was a Medicaid recipient and had 12 medications in 13 medication punch cards.
d. Resident 111 was a Medicaid recipient and had 5 medications in 5 medication punch cards.
e. Resident 108 was a Medicaid recipient and had 3 medications in 4 medication punch cards.
f. Resident 110 was a Medicaid recipient and had 3 medications in 3 medication punch cards.
g. Resident 107 was a Medicaid recipient and had 1 medication in 2 medication punch cards.
h. Resident 52 had unknown insurance and had 3 medications in 3 medication punch cards.

A current policy, titled, "Disposition of Medication upon Resident Discharge to the Community," with no date, was provided by the Administrator, on 4/13/22 at 10:20 a.m. A review of the policy indicated, " ...Resident's who are under Medicaid coverage ...will have all medication provided at the time of discharge as medicaid programs will not refill medications that have been ordered with in [sic] the last 15-30 days ...."

A current policy, titled, "Medication Return Policy," with no date, was provided by the Administrator, on 4/13/22 at 10:20 a.m. A review of the policy indicated, " ...(name of pharmacy) has the unique opportunity to accept the return of certain unused medications for credit ...This time period is 30 days from the time the medication was

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	04/13/2022

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
	dispensed. Items received after this period (31 days and beyond) will not be issued credit ...." 3.1-25(m) 3.1-25(o) 3.1-25(p) 3.1-25(q) 3.1-25(r) 3.1-25(s)(1) 3.1-25(s)(2) 3.1-25(s)(3) 3.1-25(s)(4) 3.1-25(s)(5) 3.1-25(s)(6) 3.1-25(s)(7) 3.1-25(s)(8)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or			

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	04/13/2022

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
	§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review, the facility failed to acquire and provide the physician with adequate monitoring of laboratory (lab) testing as ordered every 3 months by the physician for 1 of 24 residents reviewed for lab testing (Resident 35). Findings include: On 4/7/22 at 1:08 p.m., Resident 35's medication orders were reviewed and included but were not limited to the following: Humalog KwikPen (insulin injector system) administer subcutaneously (injected into fat under the skin) before meals and at bedtime related to diabetes mellitus (DM). Lispro insulin, inject 25 units subcutaneously two times a day related to DM. On 4/11/22 at 9:51 a.m., Resident 35's medical chart was reviewed. The physician ordered CBC (complete blood count), BMP (basic metabolic panel), and A1C (measures how well the body had controlled the sugar in the blood for the past three months) every 3 months during the day shift starting on the 4th, related to his diagnoses of schizophrenia (breakdown in thought, emotion and behavior), diabetes mellitus (DM) (blood sugar disorder), and hypertension (high blood pressure). These lab tests were missing on Resident 35's chart. Resident 35 refused the test on 1/14/22. On 4/8/22 at 2:15 p.m., a request was made from the facility to provide Resident 35's A1C lab results for the past year.	F 0757	F757-Drug regimen is free from unnecessary drugs 1. Resident 3's duplicate insulin order was discontinued. MD was notified of medication error. Resident 3 had no adverse outcomes related to the deficient practice. 2. All residents have the potential to be affected by the deficient practice. A full house audit was completed on all residents orders to ensure there were no duplicate orders on 5/9/22. Any issues identified were immediately corrected. 3. DON/designee will educate nurses on the proper procedure to follow when an order is received for a medication increase or decrease on or before 5/11/22. The policy "Ordering Medications" will be reviewed. DON/designee will review orders to ensure any resident with an increase or decrease in a medication dose has the old order discontinued. 4. Audits will be completed 5x weekly x 4 weeks, 4 x's weekly x 4 weeks, 3 x's weekly x 4 weeks, then monthly By the DON or designee. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance	05/12/2022

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	04/13/2022

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 4/11/22 at 9:21 a.m., no labs results were provided. A behavioral care plan, dated 3/28/19, was provided by the Administrator on 4/13/22 at 10:20 a.m. It indicated Resident 35 had the potential for behaviors during care or treatment, he may be combative or sexually inappropriate related to moderately severe vascular dementia without behavior disturbance. He had a paraphilia (abnormal sexual desire involving dangerous activities) diagnosis. Interventions included to contact psych (psychiatric care) or MD (physician) if his behaviors were interfering with his care. If Resident 35 was upset with care or inappropriate, stop. Explain why and try again later. Explain all procedures keep environment calm and quiet. As of exit conference on 4/13/22, no lab results were provided. A policy, titled, "Resident Rights," with no date, was provided by the Administrator on 4/13/22 at 10:20 a.m. A review of the policy indicated, " ...The facility must consult with you and notify your physician and interested family member of any significant change in your condition or treatment ...." 3.1-48(a)(3)		committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved 5. DOC 5/12/22.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record	F 0759	F759-Free of Med Error Rates 5%	05/12/2022

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	04/13/2022

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
	review, the facility failed to administer medications without errors for 2 of 3 residents observed during a medication administration observation on the 100 Hall, resulting in an 8% medication error rate for 3 of 25 medications administered when a Qualified Medication Aide (QMA) administered a chewable aspirin by the wrong route and an unavailable medication was documented as given (Residents 164 and 166). Findings include: On 4/12/22 during a continuous observation from 8:30 a.m. to 9:15 a.m., Qualified Medication Aide (QMA) 15 was observed as she passed morning medications to the 100 Hall residents. On 4/12/22 at 8:40 a.m., QMA 15 prepared medications, on the medication cart for Resident 164. Verifying medications with the electronic record she removed 9 oral medications from the medication punch cards and transferred them to a medication cup. One of the medications, aspirin chewable tab 81 mg indicated it should have been chewed. QMA carried the medication cup into the room and instructed the resident to swallow the medications. The resident poured all of the pills into her mouth and swallowed all of them. The aspirin chew tab was swallowed whole, without chewing. On 4/12/22 at 8:54 a.m., QMA 15 prepared medications for Resident 166 on top of the medication cart. Verifying medications with the electronic record she removed 5 oral medications from the medication punch cards and transferred them to a medication cup. The resident's orders included a scheduled dose of Miralax 17 grams (laxative powder). QMA 15 searched several bottles in the medication cart drawers and		or more 1. Resident 164's ASA was changed from chewable to regular pill form on 4/8/22. Resident 166's Miralax is now available and being administered per order. Resident 164 and 166 had no adverse outcomes related to the deficient practice. 2. All residents have the potential to be affected by the deficient practice. DON/designee reviewed all residents orders to ensure any resident receiving ASA had the correct pill form. Any discrepancies were immediately corrected. 3. DON/designee will educate nursing staff on the policy "Unavailable Medications" along with making sure medication is given per MD orders on or before 5/12/22. DON/designee will audit MARS to ensure any medication not given has correct documentation. 4. Audits will be completed 5x weekly x 4 weeks, 4 x's weekly x 4 weeks, 3 x's weekly x 4 weeks, then monthly By the DON or designee. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is	

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	04/13/2022

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
	indicated there was no Miralax for Resident 166. She entered the room and administered the pills from the medication cup. She returned to the cart and documented all the medications as given. She indicated she would check the medication room later to see if the medication had come in. On 4/12/22 at 2:08 p.m., during an interview at the Nurses' Station, QMA 15 indicated she had not been able to locate any Miralax for Resident 166 , it was not in the medication room and she reordered it. It should be in tomorrow. He did not receive a dose on 4/12/22. On 4/12/22 at 2:10 p.m., a review of Resident 166's Medication Administration Record indicated QMA 15's initials were entered for the 9:00 a.m. dose of Miralax 17 grams for Resident 166 which indicated it was administered. There was no code number or note to indicate the medication was reordered or not given during the morning medication administration. On 4/7/22 at 10:30 a.m., the Administrator (ADM) provided a current, undated policy, titled "Unavailable medications." This policy indicated "...When a missed dose is unavoidable, the facility nurse should document an explanation of the medication shortage and the action taken for resolution ...." On 4/7/22 at 10:30 a.m., the ADM provided an undated policy, titled "Medication Administration." This current policy indicated "...The Medication Administration Record will be signed after each medication administered to the resident. Medications that are refused by the resident or not administered for other reasons will be circled on the particular day of no administration. The reason for not administering		resolved. 5. DOC 5/12/22.	

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	04/13/2022

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 medication will be documented on the back of the medication Administration Record." 3.1-48(c)(1)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to follow standards of practice to previous medication orders once new dosage changes had been ordered for 2 different medications for 1 of 5 residents reviewed for unnecessary medications (Resident 3). Findings include: On 4/11/22 at 9:57 a.m., the medical record was reviewed for Resident 3. The diagnoses included, but were not limited to diabetes, lumbar sacral (lower back) spondylosis (age related deterioration, worsening), left leg below the knee amputation, chronic kidney disease and congestive heart failure. a. A Pharmacy Medication Record Review, dated 1/14/22, and signed by the Nurse Practitioner (NP), as "agreed" with order changed, on 2/1/22 indicated current order trazodone 100 mg at bedtime for insomnia. Date started 7/9/21. Recommend changed (gradual dose reduction) to 75 mg . A nurse progress note dated 3/1/22 at 10:17a.m., indicated "Upon review of medications found duplicate order for trazodone 100 mg. Medication was not found in the medication cart. DON, MD [Medical Doctor], resident and family member	F 0760	F 760-Free of Significant Medication Errors Resident 3's duplicate insulin order was discontinued on 4/11/22. MD was notified of medication error. Resident 3 had on adverse outcomes related to the deficient practice. All residents have the potential to be affected by the deficient practice. A full house audit was completed on all residents orders to ensure there were no duplicate orders. Any issues identified were immediately corrected. DON/designee with educate nurses on the proper procedure to follow when an order is received for a medication increase or decrease on or before 5/12/22. The policy "Ordering Medications" will be reviewed. DON/designee will review orders to ensure any resident with an increase or decrease in a medication dose has the old order discontinued. Audits will be completed 5x weekly x 4 weeks, 4 x's weekly x	05/12/2022

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	04/13/2022

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
	notified of medication error. Resident VS [vital signs] = 136/74-80-18-97.9-SAO [oxygen saturation] @ 98% on RA [room air]. Resident is alert and oriented x3 and expressing verbal understanding of medication error. Resident expressing need for MD to increase his anxiety medication. Assured resident that nursing staff would relay his concerns to MD." The reviewed MAR for February and March indicated Resident 3 received both doses of trazodone at bedtime from the order date 2/1/22 until the incident note date 3/1/22. On 4/11/22 at 10:10 a.m., during an interview the Director of Nursing (DON) indicated the resident had received duplicate trazodone (indicated for insomnia) orders and had written the incident note on 3/1/22. A copy of the incident was provided by the DON on 4/11/22 at 2:35 p.m. The report was completed by the Assistant Director of Nursing (ADON) on 3/1/22. This report indicated "Upon review of medications found duplicate order for trazodone 100 mg. Medication was not found in the medication cart. DON, MD, resident and family member notified of medication error. Resident is alert and oriented x3 and expressing verbal understanding of medication error ..." No follow up or future prevention measures were noted on the incident documentation. b. The current medication orders included but were not limited to, an order, dated 3/29/22, Lantus (insulin) inject 22 units two times a day related to diabetes. A second insulin order, dated 8/4/22, indicated Lantus (insulin) inject 20 units two times a day related to diabetes.		4 weeks, 3 x's weekly x 4 weeks, then monthly by the DON or designee. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. DOC 5/12/22.	

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	04/13/2022

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
	A review of Resident 3's Medication Administration Record (MAR) showed both orders of Lantus insulin as being administered each day at 9:00 a.m. and 5:00 p.m., since 3/29/22. On 4/11/22 at 12:29 p.m., during an interview the Director of Nursing (DON) when resident 3 got a new order for Lantus they forgot to take out the old order. On 4/11/22 at 2:35 p.m., the DON provided an undated policy, titled "Ordering Medications." This current policy indicated "...Medication order changes should be entered into the electronic medical record as a new or updated order. The previous order should be discontinued..." 3.1-48(c)(2)			
F 0761 SS=E 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 §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			

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	04/13/2022

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
	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, interview, and record review, failed to ensure a medication storage room on the memory care (MC) unit was locked with a functioning doorknob lock that contained a 2 unlocked medication carts and 25 of 25 residents' medications stored in the medication room (Residents 52, 3, 6, 2, 11, 7, 36, 34, D, 39, 10, 28, 33, 17, 4, 54, 3, 43, 8, 55, 106, 107, 108, 110, and 111). The facility failed to ensure all open medications had open dates and expiration dates (Resident 54) and failed to ensure all medications had a resident identifier on them for 1 of 2 medication carts reviewed for resident identifiers on medication. Findings include: 1. On 4/11/22 at 11:20 a.m., during a tour of the Memory Care (MC) area with the Maintenance Staff, the MC Storage Room was observed unlocked. The Maintenance Staff indicated the lock was broken. Three medication carts were stored in the room. The first medication cart (Med Cart 1) had one medication for Resident 52. It was latanoprost, the sticker on it indicated to keep refrigerated. The second medication cart (Med Cart 2) was empty. The third medication cart (Med Cart 3) had a box of medication punch cards on top of it. Medication punch card held 30 days of medication that were pushed through into a medication cup for the resident to take according to the physicians' orders. The boxes had 46	F 0761	F 761-Label/Store Biological Medications 1. The identified resident's medications were immediately inventoried, placed in a bin in a locked medication room for return to pharmacy. Eye drops for resident 54 were disposed of and new eye drops ordered. The 2 glass vials of Haldol were disposed of. The identified residents had no adverse outcomes related to the deficient practice. The doorknob was replaced on the medication storage room on memory care. 2. All residents have the potential to be affected by the deficient practice. An audit was completed on all medication carts to ensure all medications had resident identifiers, date opened and expiration dates by DON/designee on or before 5/10/22. 3. DON/designee will educate all nurses/QMA's on the correct procedure for dating/labeling resident's medications on or before 5/11/22. Nurses were also educated on the correct procedure	05/12/2022

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	04/13/2022

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
	medication punch cards in it. Drawer two had 61 medication punch cards in it and 9 loose medication bottles. Drawer three had 49 medication punch cards in it. Drawer four had 30 medication punch cards in it and a box of nicotine transdermal patches for Resident 3. On 4/11/22 at 11:22 a.m., the Maintenance Staff indicated he needed to go and get tools to fix the broken MC Storage room doorknob. On 4/11/22 at 11:51 a.m., the Director of Nursing (DON) indicated the box on top of Med Cart 3 were medications for a Resident 6 who had passed away on 1/11/22. Those medications were ready to count and to send back to pharmacy. Medications should not have been in the MC storage room. All medications should have been in the regular medication storage room. She told unidentified staff members 3 weeks ago to get those medications out of there. She would provide a list of all resident names and medications. On 4/12/22 at 12:39 p.m., the DON provided a list of the medications and medication punch cards from the unlocked MC Storage room for current and discharged residents. For the 17 current residents there were 102 medication punch cards: a. Resident 2 had 27 medication punch cards. b. Resident 11 had 22 medication punch cards. c. Resident 7 had 15 medication punch cards. d. Resident 36 had 6 medication punch cards. e. Resident 34 had 6 medication punch cards. f. Resident D had 6 medication punch cards. g. Resident 39 had 6 medication punch cards. h. Resident 52 had 3 medication punch cards. i. Resident 10 had 3 medication punch cards. j. Resident 28 had 1 medication punch card. k. Resident 33 had 1 medication punch card. l. Resident 17 had 1 medication punch card.		for disposition of medications no longer ordered and discharged resident's medications by DON/designee on or before 5/11/22. DON/designee will audit medication carts to ensure all medications are dated and labeled. DON/designee will audit medication rooms to ensure any medications no longer needed are inventoried and returned to pharmacy as per policy. 4. Audits will be completed 5x weekly x 4 weeks, 4 x's weekly x 4 weeks, 3 x's weekly x 4 weeks, then monthly by the DON or designee. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. 5. DOC 5/12/22.	

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	04/13/2022

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

m. Resident 4 had 1 medication punch card.
n. Resident 54 had 1 medication punch card.
o. Resident 3 had 1 medication punch card.
p. Resident 43 had 1 medication punch card.
q. Resident 8 had one medication punch card.

The 8 discharged residents' medications for disposition were a combined total of 83 medication punch cards:
a. Resident 6 had 14 different medications in 35 medication punch cards.
b. Resident 106 had 8 different medications in 16 medication punch cards.
c. Resident 55 had 12 medications in 13 medication punch cards.
d. Resident 111 had 5 medications in 5 medication punch cards.
e. Resident 108 had 3 medications in 4 medication punch cards.
f. Resident 110 had 3 medications in 3 medication punch cards.
g. Resident 107 had 1 medication in 2 medication punch cards.
h. Resident 52 had 3 medications in 3 medication punch cards.

On 4/11/22 at 12:04 p.m., the Administrator indicated all medications should have been behind locked doors.
2. On 4/11/22 at 1:44 p.m., during a medication storage observation with the Director of Nursing (DON) she indicated the facility only had one medication storage room. It was located adjacent to the 300 Hall, across from the nurses' station.

On 4/11/22 at 1:57 p.m., the Memory Care medication cart was observed with Licensed Practical Nurse (LPN) 17. The top drawer of the cart contained two plastic envelopes with natural tears eye drops for Resident 54. A bottle dated as

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	04/13/2022

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

dispensed from pharmacy was dated 1/19/22 and had a green sticker on the bottle for open/expired dates but had no dates entered on the sticker. The second bottle dated as dispensed from pharmacy 4/3/22 had no sticker or open dates on the bottle.

The cart drawer contained 2 glass vials of injectable haldol (antipsychotic medication) 5 milligrams (mg) per (/) 1 milliliter (ml). Both vials had been opened. They were loose in the drawer without any labels affixed to the vials. There were no resident identifiers or open dates on the vials. No empty plastic dispense envelopes were found for the vials in the drawer.

On 4/11/22 at 2:21 p.m., during an interview Licensed Practical Nurse (LPN) 17 indicated she was "agency" it was her first day working at the facility and she was not familiar with the facility's policies.

On 4/11/22 at 9:15 a.m., the DON provided an undated policy titled, "Medication Storage In The Facility." This current policy indicated, " ...Medication and biological [sic] are stored safely, securely, and properly following the manufacturer or supplier recommendations. The medication supply accessible only to licensed nursing personal, or staff members lawfully authorized to administer medications...Medications are not to be transferred medications [sic] in containers in which they were received. Medication rooms, carts, and medication supplies are locked or attended by person with authorized access...Medications requiring 'refrigeration' or temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit are kept in a refrigerator...Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will

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	04/13/2022

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
	be immediately withdrawn from the stock. They will be disposed of according to drug disposal procedures, and reordered from pharmacy if a current order exists...Facility staff will assure that the multidose vial is stored following manufacturer's suggested storage conditions ...." 3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(k)(3) 3.1-25(k)(4) 3.1-25(k)(5) 3.1-25(k)(6) 3.1-25(k)(7) 3.1-25(m) 3.1-25(n) 3.1-25(o) 3.1-25(q)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

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	04/13/2022

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
	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure dating of open foods and temperature logs for the reach-in refrigerator for the kitchen that served food to 57 of 57 residents residing at the facility. The facility failed to have temperature logs for the memory care (MC) refrigerator, MC refrigerator was unlocked and contained unlabeled and undated food, and staff food for 1 of 1 observation. The facility failed to ensure hand hygiene of dietary staff for 1 of 1 observation of preparing pureed food for 4 of 4 residents receiving pureed food. Findings include: 1. On 4/4/22 at 9:24 a.m., a tour of the kitchen was completed with the Dietary Manager (DM). The kitchen walk-in freezer was observed. There was frost on the boxes and shelves on the right side of the freezer. The DM indicated the sealing gasket was broken. There were 4 boxes of frozen foods on the floor. The walk-in refrigerator had open, undated foods: a container of resident soup, a 2 to 3 pound package of ground pepperoni, a single serving of green beans, and a single serving a pudding. In the dry storage area, a box of Styrofoam containers was sitting on the floor. A large undated, open bag of panko breadcrumbs was rolled down to close it. The DM indicated she would put it in a sealed container with a label. The kitchen reach-in refrigerator had no	F 0812	F 812 – Food Procurement, Store/Prepare/Serve-Sanitary 1. All opened and undated food was discarded. Items in walk in freezer and dry storage were removed from the floor. Temp logs have been placed on walk in freezer, walk in refrigerator, kitchen reach in refrigerator and the refrigerator on Memory Care. A lock was placed on the refrigerator on the Memory Care. Dietary Services Director was educated on the policy for dating items, keeping items off of floor and completing temp logs on all refrigerators/freezers. 2. All residents have the potential to be affected by the deficit practice. 3. Administrator/designee educated the dietary employees on the labeling and dating of foods, keeping items off of floor and ensuring that there were temp logs on refrigerators in kitchen and on Memory Care and on the walk in freezer. This education will be completed on or before 5/11/22. 4. Audits will be completed on the proper storage of food and supplies, temp logs, and dating and labeling of food. Audits will be done 5 days a week for 4 weeks; 4 days a week for 4 weeks; 3	05/12/2022

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	04/13/2022

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
	temperature log for April. On 4/11/22 at 2:52 p.m. the DM provided the temperature logs for April. There were no temperature log sheets for the reach-in refrigerator. A current policy, titled, "Labeling and Dating of Foods," with no date, was provided by the Administrator, on 4/7/22 at 3:26 p.m. A review of the policy indicated, " ...All foods stored will be properly labeled and dated ...Once opened, all ready to eat, potentially hazardous food will be re-dated with the date the item was opened and a use by date according to safe food storage guidelines or by the manufacturers expirations date...." 2. On 4/05/22 at 9:17 a.m., the memory care (MC) refrigerator was observed to be unlocked with open, undated employee food inside. There was a package of partially dried out salami, a partially open, almost empty container of prepared spaghetti with sauce, and a Klosterman's restaurant style white bread package with bread inside that was best by 2/23/22. On 4/05/22 at 9:40 a.m., Qualified Medication Aide (QMA) 14 indicated the MC refrigerator should have been locked and employee food should not have been in there. Her expectation was for the refrigerator to be locked and clean, with no employee food in it. On 4/11/22 at 12:09 p.m., the Administer indicated the foods should be dated and after 3 days thrown out. The temperature logs should have been completed every day. On 4/5/22 at 9:17 a.m., there was no temperature		days a week for 4 weeks; 2 days a week for 4 weeks; weekly for 4 weeks; then monthly for 2 months. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. 5. DOC 5/12/22.	

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	04/13/2022

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

log observed on the MC refrigerator.

On 4/11/22 at 2:52 p.m. the DM provided the temperature logs for April. There were no temperature log sheets for the MC refrigerator.

A current policy, titled, "Labeling and Dating of Foods," with no date, was provided by the Administrator, on 4/7/22 at 3:26 p.m. A review of the policy indicated, " ...All foods stored will be properly labeled and dated ...Once opened, all ready to eat, potentially hazardous food will be re-dated with the date the item was opened and a use by date according to safe food storage guidelines or by the manufacturers expirations date...."

3. On 4/11/22 at 11:36 a.m., Cook 36 was observed as she washed her hands. She turned the water faucet off with her bare hands and then dried them with a paper towel. Then she pureed mixed vegetables in the blender for four residents. She washed her hands again, turning the faucet off with her bare hands and pureed 6 boneless pork chops for 4 residents.

A current policy, titled, "Hand Hygiene Guidelines," with no date, was provided by the Administrator, on 4/11/22 at 9:15 a.m. A review of the policy indicated, " ...Wet hands with warm water ...Apply generous amount of soap to hands and run hands together vigorously for at least 20 seconds ...Rinse hands with warm water while keeping hands down and elbows up then dry thoroughly with a disposable towel ...Use towel to turn off faucet and exit the area...."

3.1-21(i)(3)

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	04/13/2022

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 0835 SS=F Bldg. 00	483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on resident interviews and staff interviews, review of administrative records, policies and procedures, and review of resident medical records, it was determined that the facility's administration failed to assume full responsibility for implementing and monitoring policies governing the facility's total operation to ensure effective oversite of the facility; failed to monitor and maintain successful day to day clinical operations with adequate, competent nursing staff, which included but was not limited to: nursing admission assessments, nursing chart audits, nursing documentation, secured medication storage, and staff knowledge of the facilities policies and procedures; failed to maintain upkeep of the building and grounds; failed to ensure resident council grievances were responded to in a timely manner while maintaining a meaningful daily activity program to improve the quality of life for the residents; and failed to maintain an effective infection control program throughout a global pandemic. These deficient practices had the potential to effect 57 of 57 residents residing in the facility. Findings include: 1. A review of citations the facility received in the last year revealed; multiple citations at F684 for quality of care, including a previously cited immediate jeopardy on 6/12/21, with two additional immediate jeopardies related to	F 0835	F835 Administration No residents were directly affected by the cited deficient practice. All residents have the potential to be affected by the cited deficient practice. Regional Director of Operations (RDO) and Regional Nurse Consultant (RNC) educated and in-serviced Administrator and Director of Nursing on Daily/Weekly/Monthly responsibilities on 5/9/22. RDO will conduct weekly meetings with Administrator and Director of Nursing beginning 5/6/22 and will continue weekly meetings for 6 weeks, then every other week for 6 weeks, then monthly for 3 months. The meetings will focus on high level concerns at the facility with an emphasis on significant areas of focus, to be determined each week. The facility Administrator shall require employees to conduct room rounds no less than weekly, beginning 5/9/22, and the results of said weekly rooms rounds shall	05/12/2022

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	04/13/2022

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
	accidents and advance directives. Breaches of infection control were cited repeatedly on 6/12/21, 9/12/21, 12/16/21 and 1/12/22. Concerns related to the environment, equipment and/or pest control were cited repeatedly on 4/23/21, 6/12/21, 9/28/21, 1/12/22, and 3/2/22. Grievances had previously been cited on 4/23/21. During an interview on 4/13/22 at 9:22 a.m., the Administrator indicated administrative staff had been made aware of concerns related to nursing department heads and agreed there were egregious concerns that had been discussed with them on previous occasions, related to audits follow up, new admission reviews, and complete and accurate documentation. The administrator indicated when she first came to the building, no one told her about the previous immediate jeopardies and she had not received any formal orientation, she felt buried in disorganized paperwork. The new Regional Director of Operations (RDO) had been coming around much more than anyone before, so the Administrator was optimistic that he would be able to help her implement the change the facility needed. Cross reference: F684, F759, F760, F761, and F725. 2. Throughout the survey period, multiple resident rooms were observed and found to have gouges in the walls, dirty, sticky floors, flying insects and other various stains, debris, and/or trash on the floors. Call lights were observed out of reach for several residents on multiple occasions. Residents complained of gnats, and lack of housekeeping staff. Cross reference: F550, F558, F584 and F924, and F925.		be discussed on the aforementioned calls. The facility Administrator shall conduct weekly activities audits, beginning 5/9/22, and the results of said activities audits shall be discussed on the aforementioned calls. The audits will include reviewing with the Activities Director which activities will be conducted each week, as well as verifying random activities are actually being conducted. Finally, the facility shall conduct weekly infection control audits, beginning 5/9/22 for 6 weeks, then every other week for 6 weeks, then monthly for 3 months; and the results of said infection control audits shall be discussed on the aforementioned calls. The RDO and RNC shall ensure the aforestated calls are conducted no less than the frequency stated above. The RDO and/or RNC/designee shall perform site visits at the facility no less than weekly for 4 weeks, then no less than 2x each month for 2 months, then no less than monthly for 3 months. All concerns shall be addressed and correctly immediately and the results of said visits shall be reported to the facility QAPI committee. DOC 5/12/22.	

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	04/13/2022

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
	3. Over the 8-day survey period, Bingo was the only organized group activity observed. During multiple resident and staff interviews, concerns related to meaningful activities were shared. There was a high rate of residents who smoked who expressed on many occasions they did not believe there were enough smoke breaks, and they were only allotted 2 cigarettes at each break. The residents indicated this made them feel like children, or that they were in prison because of the lack of independence they had. The resident were upset about the facilities unmoving restrictions surrounding the resident's right to smoke, and the facility refused to compromise. The residents expressed their wish to go on more outings or being able to do something as simple as go outside and sit in the sun when they wanted. Cross reference F656 and F679. 4. Multiple breaches of infection control were observed though the survey period. Staff failed to don appropriate PPE (personal protective equipment) before entering TBP (transmission based precaution) rooms, missed opportunities for hand hygiene and infection control concerns were observed during a medication administration observation. Cross reference F880 3.1-13(q)			
F 0880 SS=F 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			

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	04/13/2022

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
	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 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			

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	04/13/2022

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 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 necessary.			
	Based on observations, interviews and record reviews, the facility failed to ensure appropriate infection control practices were implemented to prevent the potential for the spread of COVID-19 Coro when staff failed to follow required Personal Protective Equipment (PPE) before entering transmission-based precautions (TBP) isolation rooms and perform hand hygiene at appropriate times; the facility failed to ensure glucometers (instrument for measuring blood glucose concentration) were not shared between residents and were cleaned according to policy between residents (Resident 157 and 159) and cleaned before putting back into the memory care (MC)	F 0880	F880 – Infection Prevention It is the practice of this facility to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease. All residents residing in the facility have the potential to be affected; however, no resident was affected. Staff and vendors were educated on or before 5/11/22 by DON/Designee, the following was	05/12/2022

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	04/13/2022

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
	medication cart; the facility failed to ensure a Qualified Medication Aide (QMA) wore clean gloves during an accu-check for Resident 157 and Resident D; and the facility failed to ensure hand hygiene was completed between resident care (Resident 157 and 159). These deficient practices had the potential to effect 57 of 57 residents residing in the facility. Findings include: 1. During an interview on 4/6/22 at 3:17 p.m., the Medical Director (MD) indicated he had been in MD position at the facility since May of 2021. He visited the facility on a weekly basis, every Wednesday and believed very strongly that in-person, face-to-face assessments were very important. During a continuous observation on 4/13/22 from 10:54 a.m., until 11:13 a.m., the MD was observed as he rounded with a medical student in training (MS). Through the observation the MD was observed to wear a K-N95 face mask, with a face shield. His medical student in training wore an N95 face mask, but the bottom strap hung lose so that a seal was not created and she did not wear eye protection. At 10:54 a.m., the MD and MS entered room 104 which was noted to have a yellow stop sign on the door which indicated Transmission Based Precautions (TBP) contact droplet isolation. Instructions to wear an N95 face mask, have eye protection in place, donning of an isolation gown and gloves were visible and posted in several locations down the 100 hall. The MD and MS entered room 103 without performing hand hygiene, or donning the appropriate PPE.		reviewed: A.) Proper PPE for zone B.) Hand Hygiene C.) Demonstration of the correct way to wear a N95 D.) Return demonstration of donning a N95 Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. Newly hired staff will receive the in-servicing prior to working. This will be tracked and documented by the Administrator/DON/Designee. A Root Cause Analysis was conducted by the Infection Preventionist, Administrator, Nurse Consultant, and the Medical Director to determine the Root Cause of the facility's Infection Control Citation. The facility has an opportunity to improve its education, and to ensure that all staff has adequate knowledge of the facility's infection control practices, proper donning and doffing, hand hygiene, and proper way to wear a N95. Reviewed and updated the LTC infection control assessment was completed on 5/9/22. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure that proper PPE for zone, hand hygiene being performed when needed and N95 mask are being worn properly. DON/Designee will	

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	04/13/2022

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
	At 10:56 a.m., the MD and MS exited room 103 without performing hand hygiene. At 10:58 a.m., the MD and MS entered room 105 which was also noted to have a Yellow Stop sign with PPE instructions. The MD and MS entered the room without performing hand hygiene or donning appropriate PPE. They left the room after less than a minute and did not perform hand hygiene. At 10:59 a.m., the MD used an alcohol based hand gel, before he entered the next room. The MS did not perform hand hygiene. The MD and MS entered room 106 without donning appropriate PPE as noted by the Yellow Stop sign on the door. During this visit the MD briefly spoke to both roommates then exited the room at 11:03 a.m. At 11:04 a.m., the MD and MS entered room 108 without performing hand hygiene. The room was noted to have a Yellow Stop sign with PPE instructions that the MD and MS did not follow. At 11:06 a.m., the MDS and MS exited room 108. The MD used hand gel. At 11:07 a.m., the MD and MS entered room 110 without performing hand hygiene. The room was noted to have a Yellow Stop sign with PPE instructions that the MD and MS did not follow. The resident complained of a cough and the MD listened to his lung sounds with the stethoscope from around his neck. When the MD exited room 110 at 11:07 a.m., he used hand gel for his hands but did not sanitize his stethoscope. At 11:10 a.m., the MD and MS entered room 111 without performing hand hygiene. The room was noted to have a Yellow Stop sign with PPE		audit 3 random staff by skills validation for performing hand hygiene when required, proper PPE for zone and proper wearing of the N95 5 days a week for 6 weeks, 4 days a week for 6 weeks, 3 days a week for 8 weeks, and weekly for 4 weeks. Auditing will be done on various shifts and some weekend days/shifts. Staff in non-compliance will be re-educated or up to progressively disciplined. Any concerns will be addressed if found. Results of the monitoring will be presented to the QAPI committee weekly until compliance is achieved. Any patterns identified will be addressed immediately. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. Any written Action Plan will be monitored by the Administrator or designee until resolved. DOC 5/12/22.	

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	04/13/2022

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

instructions that the MD and MS did not follow. The MD listened to the resident's lung sounds with the stethoscope from around his neck, which had not been sanitized after its use on the previous isolation resident.

During an interview related to the facility's QAPI program 4/13/22 at 12:38 p.m., the Administrator (ADM) and Regional Director of Operations (RDO) were present. The ADM indicated, the infection control program was one of the facilities top identified areas of concern and it would be important for the MD to follow PPE procedures as a figurehead of the building, to set an example for the rest of the staff.
2. On 4/11/22 at 2:43 p.m., Certified Nurse Aid (CNA) 21 was observed as she entered the facility through the back door from the employee parking area. She wore no mask or face shield. She walked down the 100 Hall past residents 4, 19 and 47 who were in the hall. She walked to the nurses' station and looked at a posting on the wall of employee schedules. She then left the nurses' station and walked through the main hallway to the front reception desk.

On 4/11/22 at 2:50 p.m., during an interview, CNA 21 indicated she came in the back door because she parked back there. She did not bring a mask with her. She was supposed to wear a mask in the building.

On 4/12/22 at 8:25 a.m., during a medication pass observation, Qualified Medication Aid (QMA) 15 she was preparing an updated, handwritten list of 100 Hall residents, from her morning report. She wore a surgical mask and a face shield. She indicated she had been off for a few days and there were several new residents admitted to the 100 Hall. An Accucheck (for blood sugar

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	04/13/2022

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

monitoring) was laying in an open alcohol wipe box on top of the medication cart. The box contained a stack of alcohol wipes and the bottle of strips used to obtain the blood sample.

On 4/12/22 at 8:31 a.m., QMA 15 removed the Accucheck machine from the box and carried it to the resident room. She entered the room of Residents 162 and 164. There was a green sign on the residents' door which indicated no isolation or quarantine. Just inside the room door, the bathroom door was open and immediately visible. The bathroom door had a yellow sign which indicated isolation precautions in place. This sign directed those entering the room to wear a gown, eye protection, gloves and an N-95 mask. QMA 15 did not put on any additional PPE (personal protective equipment) to enter the room. She approached resident 162 and asked him about his roommate. Resident 162 indicated his roommate was his wife. He had been here for a week before she came to join him on Friday (4/8/22). QMA 15 then put on gloves and checked Resident 162's blood sugar. She removed her gloves and sanitized her hands. After checking the blood sugar, she returned the Accucheck machine to the box on top of the cart. She did not clean the machine before or after using it. QMA 15 returned to the room and administered Resident 162's medication. She wore no additional PPE into the room.

On 4/12/22 at 8:40 a.m., QMA 15 prepared medications for Resident 164 and re-entered the room with the medications. She wore a surgical mask and a face shield. She did not put on any additional PPE.

On 4/12/22 at 8:54 a.m., QMA 15 prepared medications on the medication cart for Resident

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	04/13/2022

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
	166. She then entered his room carrying the medications. A yellow sign on the door directed those entering the room to wear a gown, eye protection, gloves and an N-95 mask. QMA 15 did not put on any additional PPE (personal protective equipment) to enter the room. A therapist (PT) was at the bedside fully dressed in PPE (gown, gloves, face shield and N95 mask) as she worked with the resident. QMA 15 leaned forward over the resident, who was seated in a chair, to assist with the medications. Her face shield fogged up. She pushed it up onto the top of her head and remained in direct contact with the resident, up against his chair and poured the pills from the medication cup into his hand, where he dropped one onto his clothing. She located it and handed it back to the resident with her ungloved hand. She then exited the room with her face shield on top of her head and sanitized her hands. On 4/12/22 at 8:54 a.m., Resident 165 (admission date 4/8/22) came out of her room without wearing a mask. She was observed out in the halls walking around talking with staff and several unidentified residents by the nurses' station. Then she entered Resident 166's room. The room had a yellow sign on the door which indicated isolation precautions in place. This sign directed those entering the room to wear a gown, eye protection, gloves and an N-95 mask. A therapist (PT) was seated at the bedside wearing full PPE (gown, gloves, N95 mask and face shield). Resident 165 came out of the room went into her room and went back into Resident 166's room. Resident 165 was approached by Licensed Practical Nurse (LPN) 9 and QMA 15. They instructed Resident 165 to stay in her room and showed her the yellow sign on Resident 166's door. Resident 165 indicated she had a yellow sign on her door too. She was			

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	04/13/2022

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
	fully vaccinated and did not know why there was a sign on her door. She went into her room. On 4/12/22 at 9:01 a.m., Resident 165 came back out of her room wearing an N95 mask and asked QMA 15 again why she could not be out and visiting other residents. The resident then indicated she was going up front to talk with the administration. On 4/12/22 at 9:09 a.m., Resident 165 returned and went back into Resident 166's room. She was directed by QMA 15 to not enter room again. She returned to her room. On 4/12/22 at 9:55 a.m., during an interview, the Director of Nursing (DON) indicated if a resident is totally vaccinated and had a booster they are green when they come in, there should not be a yellow sign on the door. On 4/5/22 at 2:46 p.m., a current undated policy, titled "Blood Glucose Monitoring" was provided by the Administrator (ADM). This policy indicated " ...clean the accucheck machine per policy/procedure ...."3. On 4/07/22 at 11:06 a.m., Qualified Medication Aide (QMA) 13 was observed not wearing a face shield, he indicated he did not need a face shield because the Administrator told him since he was fully vaccinated, he did not need to wear a face shield. He entered Resident 157's room and put on gloves, dropped the alcohol wipe on the floor, and picked it up with his gloved fingers. He did not change gloves before checking Resident 157's blood sugar. He removed his gloves and wiped the glucometer with a folded alcohol wipe using his unprotected index finger. He put the glucometer back into the accu-check bin. He did not do hand hygiene after leaving Resident 157's			

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	04/13/2022

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

room or before entering Resident 159's yellow zone room.

On 4/07/22 at 11:10 a.m., QMA 13 walked into Resident 159's yellow zone (resident for whom Covid has not been ruled out) room without additional PPE. He wore a surgical mask only, no face shield or gown. He put on gloves to get Resident 159's blood sugar and used the same glucometer he used on Resident 157. He removed his gloves, did not wash his hands, and cleaned the glucometer with a folded alcohol wipe using his index finger. There was a PPE cabinet, signs on the door, and instruction signs on how to wear PPE observed outside Resident 159's room.

On 4/07/22 at 11:17 a.m., QMA 13 indicated he was charting Resident 157 and 159's blood sugar levels in the computer. He was not aware Resident 159's was in a yellow zone room for contact precautions. If he had realized Resident 159 was contact precautions, he would have worn the correct PPE.

On 4/07/22 at 12:04 p.m., the Director of Nursing (DON) indicated QMA's cannot document on the resident's medical record in the computer.

On 4/08/22 at 10:25 a.m., QMA 14 brought Resident D into her room to do an accu-check. Resident D removed her protective helmet while sitting on her bed. QMA 14 put on gloves to show the staples had been removed from Resident D's scalp. She did not change gloves or wash her hands before she did Resident D's accu-check. QMA 14 was followed out of the resident's room to the medication cart. She was observed putting the glucometer in the medication cart with other accu-check supplies. She indicated she wiped the glucometer with an alcohol wipe, this action was

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	04/13/2022

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

not observed.

On 4/11/22 at 12:10 p.m., the DON indicated the glucometers should not be shared. Each resident had their own glucometer.

On 4/11/22 at 12:11 p.m., the Administrator indicated the staff should have used different glucometers for each resident and should have used the correct PPE. The glucometer should have been cleaned with the appropriate cleanser according to the glucometer manufacturer's instructions.

A current job description, titled, "Qualified Medication Aide," with no date, was provided by the Administrator, on 4/7/22 at 2:36 p.m. A review of the job description indicated, " ...QMA's are NOT allowed to do any of the following: Accuchecks ...."

A current policy, titled, "Cleaning/Disinfecting/Maintaining Glucometers," with no date, was provided by the Administrator, on 4/11/22 at 9:15 a.m. A review of the policy indicated, " ...The Glucose meters will be disinfected between each resident use to prevent the spread of microorganisms including blood borne pathogens. Disinfection of the machine will be completed the PDI Super Sani Germicidal wipe or Bleach Wipes as per guidelines of the manufacturer of the glucometer. All glucose meters (that are used for resident on isolation precautions) will remain in isolation rooms through the completion of the isolation and used solely for the resident in isolation. On final discontinuation of the isolation the glucometer will be discarded in biohazard ...Cleaning and Disinfecting ...Don nonsterile gloves ...Open the towlette [sic] container or package and remove

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	04/13/2022

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
	one towlette [sic] ...Wipe the entire surface of the meter 3 times horizontally and 3 time [sic] vertically using one towelette to clean blood and other body fluids ...Dispose of the towlette [sic] ...Obtain a second towelette and wipe the entire surface of the meter 3 times horizontally and 3 times vertically to remove blood borne pathogens. The meter must be maintained wet for 2 minutes with the Super Sani cloth wipe ...Dispose of the used towelette ...Remove gloves ...Wash hands ...." A current policy, titled, "Hand Hygiene Guidelines," with no date, was provided by the Administrator, on 4/11/22 at 9:15 a.m. A review of the policy indicated, " ...When hands are visibly soiled, exposure to a spore forming organism has been suspected or proven ...hands should be washed with a non-microbial or anti-microbial soap ...When criteria above have not been met it is appropriate e to use a waterless alcohol-based agent ...." 3.1-18(b)(1) 3.1-18(l)			
F 0924 SS=E Bldg. 00	483.90(i)(3) Corridors have Firmly Secured Handrails §483.90(i)(3) Equip corridors with firmly secured handrails on each side. Based on observation, interview, and record review, the facility failed to ensure all the handrails in the memory care (MC) area were firmly secured to the walls. This deficiency had the potential to affect 20 of 20 residents residing in memory care. Findings include: On 4/04/22 at 1:00 p.m., the handrail near the	F 0924	F 924 – Corridors have Firmly Secured Handrails 1. Handrails on the Memory Care were tightened by the maintenance man on 4/11/22, when he was made aware that it was loose. 2. All residents on the Memory Care unit have the potential to be	05/12/2022

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	04/13/2022

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
	memory care (MC) storage room was observed to be extremely loose. It had five brackets to hold it on the wall. One bracket was no longer connected to the wall, the next two brackets were being held on the wall with the only screw that was half-way pulled out of the wall. On 4/5/22 at 9:47 a.m., the handrail near the MC storage room was observed to be extremely loose. The brackets and screws were in the same condition as the previous day. It was not secure enough for the residents to use, the facility was notified. During an interview on 4/11/22 at 11:56 a.m., the Director of Nursing (DON) indicated the MC handrail should have been fixed immediately. During an interview, on 4/11/22 at 12:05 p.m., the Administrator indicated the handrail should have been tightened because it could come off the wall. A current policy, titled, "Resident Rights," with no date, was provided by the Administrator, on 4/13/22 at 10:20 a.m. A review of the policy indicated, " ...The facility must provide a safe, clean, comfortable, home-like environment...." A current policy, titled, "Physical Plant - Monthly Inspections," with no date, was provided by the Administrator, on 4/11/22 at 9:15 a.m. A review of the policy indicated, " ...Hallway Hand Rails: Inspect all hand rails throughout the facility for loosened fasteners or connectors, sharp edges, paint or stain touch-ups. Make any needed repairs immediately...." 3.1-19(f)(3)		affected by the deficient practice. 3. Administrator/designee will educate maintenance on the importance of completing repairs asap and tour the facility with maintenance to ensure no handrails are in need of repair. This education was completed on 5/6/22. 4. Audits will be completed by the Administrator/designee of handrails 5 days a week for 4 weeks; 4 days a week for 4 weeks; 3 days a week for 4 weeks; 2 days a week for 4 weeks; weekly for 4 weeks; then monthly for 2 months. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. 5. DOC 5/12/22.	

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	04/13/2022

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 0925 SS=E Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview, and record review, the facility failed to ensure the memory care (MC) area was free of insects. This deficiency had the potential to effect 20 of 20 residents who resided in MC. Findings include: On 4/4/22 at 10:24 a.m., two small flying insects were observed flying around in the dining room. On 4/4/22 at 10:26 a.m., a small flying insect was observed flying around in Resident 36's room. She was lying in bed. On 4/4/22 at 10:30 a.m., a small flying insect was observed flying around near the nurses' station near Resident 7. On 4/4/22 at 10:47 a.m., a small flying insect was observed flying around near the nurses' station. On 4/4/22 at 10:51 a.m., a small flying insect was observed flying around the entrance to the MC dining room. On 4/4/22 at 11:43 a.m., a small flying insect was observed flying around in Resident 34's room. She was lying in bed. On 4/4/22 at 12:36 p.m., a small flying insect was observed flying around in Resident 33's room. On 4/4/22 at 1:03 p.m., a small flying insect was observed flying around in the MC hallway.	F 0925	925 – Maintain Effective Pest Control Program 1. Pest control company was called as soon as Administrator was notified that there were gnats; they promptly and treated the Memory Care Unit. 2. All residents on the Memory Care Unit have the potential to be affected by the deficient practice. 3. Administrator/designee educated staff on reporting of pests and recording of them on the pest log. This education was completed on or before 5/12/22. 4. Audits will be completed by Maintenance/Designee of Memory Care to ensure there are no gnats or other pests. Audits will be completed by the Maintenance/designee of 2 rooms on memory care 5 days a week for 4 weeks; 4 days a week for 4 weeks; 3 days a week for 4 weeks; 2 days a week for 4 weeks; weekly for 4 weeks; then monthly for 2 months. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee	05/12/2022

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	04/13/2022

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 4/5/22 at 9:42 a.m., a small flying insect was observed flying around in the MC dining room. On 4/5/22 at 12:33 p.m., a small flying insect was observed landing on Resident 7's hair during lunch. On 4/5/22 at 12:34 p.m., two small flying insects were observed circling around Resident 35's lunch while he was eating. On 4/8/22 at 10:02 a.m., a large flying insect was observed flying around in the MC hallway. A continuous tour with the Maintenance Staff on 4/11/22 from 10:23 to 11:30 a.m., the following insects were observed. A small flying insect was observed flying around in Resident 28 and 36's restroom. Five to six small flying insects were observed swarming over Resident 17's upper body as she lay in bed. The Maintenance Staff indicated he observed the insects as well. Resident 17 indicated she did not like all the bugs. Resident 34 was also in the room. In Resident 2 and 8's room, spider webs were observed to the left side of the PTAC (packaged terminal air conditioner). The PTAC was observed with cracked caulking. In Resident 7's room, spider webs were observed to the left side of the PTAC. In Resident 46's room spider webs were observed in the top corner of the room by her bed.		will monitor monthly until they are confident the deficiency is resolved. 5. DOC 5/12/22.	

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	04/13/2022

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
	A small flying insect was observed in Resident 48's bathroom. On 4/11/22 at 11:31 a.m., the Maintenance Staff indicated he did not go into every room, just a scattered amount of MC rooms. He did not receive work requisitions, nor any concerns were told to him verbally. On 4/11/22 at 11:57 a.m., the Director of Nursing (DON) indicated the facility would like to not have flying insects in MC. On 4/11/22 at 12:06 p.m., the Administrator indicated the flying insects should not be the MC unit. A current policy, titled, "Pests," with no date, was provided by the Administrator, on 4/11/22 at 9:15 a.m. A review of the policy indicated, " ...It is the policy of the facility to ensure that an effective Pest Control Program is in place. An effective pest control is defined as - measures to eradicate and contain common house hold pests ...The maintenance staff and all other staff will be cognizant of the necessity to maintain a clean, safe and comfortable, homelike environment that is free of pests ...Upon a sighting of any pest or rodent or any evidence of a pest or rodent by any person in the facility, the Administrator will be notified. The problem will be addressed to include contacting the Pest Control vendor should an off schedule visit be necessary ...." 3.1-19(f)(4)			
F 9999 Bldg. 00	3.1-14 PERSONNEL	F 9999	State Tag 9999	05/12/2022

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	04/13/2022

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
	(q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education if applicable. (5) Professional licensure, certification, or registration number or dining assistant certificate or letter of completion if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with the facility's policy. (10) Date and reason for separation. (r) The employee's personnel record shall be retained for at least three (3) years following termination or separation of the employee from employment. (s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The		1. The employee files mentioned were reviewed; all employees have received a PPD. 2. All residents have the potential to be affected by this deficient practice. 3. Administrator educated the ABOM/HR on what needs to be in the employee files, including reference checks and PPDS. Education was completed on 5/9/22. 4. Audits of all new employee files will be completed by the BOM/designee. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. 5. DOC 5/12/22.	

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	04/13/2022

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
	tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination; and (B) reports of all employment-related health examinations. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired			

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	04/13/2022

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

residents and to gain understanding of the current standards of care for residents with dementia.

This state rule was not met as evidenced by:

Based on record review and interview, the facility failed to maintain employee records with the minimum required documentation for 5 of 10 randomly selected employees.

Findings include:

On 4/8/22 at 3:00 p.m. 10 randomly selected employee files were reviewed.

Dietary Aid 33 was hired on 2/15/15. Her employee file lacked documentation of an annual TB (tuberculosis) skin test or assessment, and there was no documentation of her general orientation or job specific orientation.

Housekeeping aid 34 was hired on 12/6/21. Her employee file lacked documentation of pre-employment screening reference checks, her second step TB skin test was not completed, and there was no documentation of her general orientation of job specific orientation.

Laundry Aid 35 was hired on 3/13/22. Her employee file lacked documentation of pre-employment screening reference checks, a 1st and 2nd TB skin test was not completed, and there was no documentation of her job specific orientation.

Certified Nursing Assistant (CNA) 26 was hired on 8/25/20. His employee file lacked documentation of an annual TB skin test or assessment.

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	04/13/2022

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 Infection Preventionist, Licensed Practical Nurse 11, was hired on 8/9/21. Her 1st and 2nd TB skin test was not completed. During an interview on 4/13/22 at 2:36 p.m., the Business Office Manager, (BOM) indicated, she double checked all the documents she had access to, and the remining above listed items were not on file. At that time, the employee files were considered incomplete according to state requirements.			