STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. Building B. Wing	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37982 Based on observation, interview and record review, 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 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 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: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 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, 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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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, 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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. 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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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, 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 [DATE]. 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 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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 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 within 30 days prior to admission (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 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 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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. Building B. Wing	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 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 38768 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 3:58 p.m., Resident C's medical record was reviewed. She was admitted to the facility on [DATE] 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 discharge summary for the hos [TRUNCATED]