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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 38768 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. 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. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 recognition of your individuality . the facility must provide a safe, clean, comfortable, home-like environment 37981 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 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. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 37981 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: 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)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768 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. 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-[NAME] 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 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. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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)

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 37982 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 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)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37981 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 [DATE] at 3:56 p.m., a nursing progress note, dated [DATE] 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 get status changed. On [DATE] 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 [DATE], was reviewed. It indicated, to provide CPR (cardiopulmonary resuscitation: external cardiac massage and breathing). A care plan, dated [DATE], 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 [DATE] at 1:17 p.m., the Director of Nursing (DON) provided Resident D's discharge summary from her [DATE] to [DATE] 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 [DATE] at 7:27 p.m., the legal guardian for Resident D indicated she 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 [DATE] 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 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] 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 [DATE] 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 [DATE] 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 [DATE] at 1:37 p.m., the Administrator provided a new POST form for Resident D. It was dated [DATE], and indicated do not attempt resuscitation, comfort measure to allow a natural death. 37982 2. On [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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'. 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. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on [DATE] 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. During an interview, on [DATE] 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 [DATE] 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. 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 [DATE] 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 . 3XXX,d+[DATE](f)(4)(A)(ii) 3XXX,d+[DATE](f)(4)(B)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 37981 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). 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. 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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768 Based on observation, interview, and record review, the facility failed to ensure 2 of 7 residents were free of physical abuse from CNA 23. (Resident 29 and Resident 53). The deficient practice resulted in Resident 29 experiencing a soft tissue injury to the left wrist with increased pain. The facility failed to ensure 3 of 7 residents were free of verbal abuse by CNA 23. (Resident 26, Resident 25, and Resident 30). The deficient practice resulted in 5 of 7 residents overhearing the abuse and experiencing negative reactions or outcomes (Resident 29, Resident 39, Resident 53, Resident 9, and Resident 30). Findings include: 1. On 6/1/22 at 10:00 a.m., Resident 39 was interviewed. He indicated Resident 29 was hurt by Certified Nursing Assistant (CNA) 23. CNA 23 left marks all over his arm, and when his girlfriend came in to visit, she raised hell over it. CNA 23 was suspended then too, but they let him come back to work. On 6/1/22 at 10:40 a.m., Resident 29 was observed sitting up in his wheelchair beside his bed. At this time, he indicated his wrist hurt. His left wrist was observed resting across his lap. The wrist area was swollen and when Resident 29 lightly pressed it with his other hand he indicated it was tender to touch. Resident 29 indicated Certified Nursing Assistant (CNA) 23 had been too rough with him during a transfer a couple weeks ago when he yanked him up out of his wheelchair which caused his wrist to swell up and start hurting. Resident 29 indicated he usually had pain on his left side because that was the side which was taken out during his stroke, but the pain in his wrist was new and had not gone away since the incident with CNA 23. Resident 29 indicated he used to think CNA 23 was a pretty good worker, even if he was always in a hurry and sometimes made you feel like a pest. After Resident 29 complained about the pain in his wrist and what happened, everyone was really serious for the first few days, they got me an x-ray, and ice packs, but when the x-ray came back, they said it was fine and the pain was from his arthritis, so they let CNA 23 come back and everything went back to normal including CNA 23 caring for Resident 29. During a confidential interview, it was indicated CNA 23 was a serial abuser. They heard about the alleged incidents upon return to work, that CNA 23 had hurt Resident 29's arm and yelled at Resident 26. Also, CNA 23 yelled at Resident 25 all the time, but when that was investigated previously, and he was suspended and came back to work anyway. As for Resident 29, he knew exactly what happened to him. Everyone tried to say, he's making it up for attention, but that was simply not true. Yes, he would get fixated on certain things and had a distracted attention span because of his stroke, but he was telling the truth. Staff upon hire were told if you were suspended over allegations of abuse that was that and you would be fired. But not since CNA 23 had been suspended 3 or 4 times over abuse allegations. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/1/22 at 3:05 p.m., Licensed Practical Nurse (LPN) 19 indicated he was the nurse on shift when the concern with Resident 29's wrist was brought to his attention. Resident 29's girlfriend had been in to visit and came to him with the concern. He went to look at Resident 29's wrist and found it to be swollen, and the Resident complained of great pain when it was touched or tried to move. Resident 29 had constant pain on that side anyway, so staff had to be extra careful and gentle when moving his affected side. On 6/1/22 at 10:50 a.m., Resident 29's medical record was reviewed. He had admitted to the facility on [DATE] with active and current diagnoses which included, but were not limited to, hemiplegia and hemiparesis (paralysis and muscle weakness) following cerebral infarction (stroke), muscle wasting and atrophy, and abnormal posture. Nursing Progress Note, dated 2/14/22 at 10:00 a.m., indicated a telehealth video visit was conducted for his recent admission, medication refill, and covid screening. He takes Percocet 7.5/325mg for chronic bilateral LE pain. States pain is constant and aching. Medication does help with pain. He requires prescription today Nursing Progress Note, dated 2/18/22 at 11:28 a.m., indicated a telehealth video visit was conducted for . Chronic pain secondary to CVA (stroke) and hemiplegia . [Resident 29] states he has severe, chronic pain after experiencing MCA/CVA. He states his pain is 10/10 without his Norco and relived to 6/10 with his medication. Pain described as severe, debilitating and constant located at his back right lower extremity [which would be his lower left leg]. He denies associated constipation. He has no other complaints today. No h/a, dizziness, confusion, lethargy, sob, cp/abdominal pain today. No other concerns [Resident 29's] Chronic pain is well controlled with Norco Nursing Progress Note, dated 2/21/22 at 7:22 p.m., indicated Resident 29 complained of general right-sided pain, and received his as needed pain medication. Nursing Progress Note, dated 2/22/22 at 10:58 a.m., indicated Resident 29 complained of chronic right-sided pain he endorsed as nerve pain in the right arm/leg. Stated the pain was sharp at times and achy at other times. An order was placed to increase his Gabapentin. Nursing Progress Note, dated 2/25/22 at 5:09 p.m., indicated a telehealth video visit was conducted for general medical management and ongoing right sided pain in his upper and lower extremities. Pain had been present for several weeks and described and dull, achy, and progressive. The telehealth NP indicated the chronic pain and body aches were likely muscle atrophy/spasms related to his stroke and gave instructions to monitor pain and address if not improved in the next week. Nursing Progress Note, dated 3/15/22 at 11:00 a.m., indicated a telehealth video visit was conducted for regularly scheduled medical management and indicated Resident 29's pain was well controlled with the current medication regimen. Nursing Progress Note, dated 4/5/22 at 6:27 a.m., indicated Resident 29 complained of generalized leg pain and was administered medication which was affective. Nursing Progress Note, dated 4/7/22 at 11:02 a.m., indicated Resident 29 complained of generalized pain all over, and was administered pain medication which was effective. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Nursing Progress Note, dated 4/14/22 at 5:12 a.m., indicated Resident 29 complained of generalized leg and back pain and was administered pain medication which was effective. Nursing Progress Note, dated 5/4/22, indicated Resident 29 initially complained of pain in his left wrist after a transfer, a stat x-ray was ordered, additional pain medication, and ice were also ordered. A change of condition nursing progress note was entered on 5/4/22 at 6:07 p.m., which indicated, .On call ordered a stat [as soon as possible] x-ray of left wrist, ibuprofen, 600 mg (milligrams) every 6 hours as needed for pain and apply ice pack to left wrist every 2 hours off for 1 hour A telehealth Nurse Practitioner (Np) visit was conducted on 5/4/22 at 7:37 p.m., using synchronous video call. At this time Resident 29's wrist was evaluated. Left arm/wrist is noted to be in the extended position with moderate swelling/redness and limited ROM with wrist flexion due to pain/swelling . New orders were given at this time to perform a STAT (immediate) x-ray, elevate, ice and immobilize until x-ray results returned, continue oxycodone every 6 hours as needed for pain, and complete a follow up x-ray for further assessment. A nursing progress note, dated 5/4/22 at 11:43 p.m., indicated Resident 29's left wrist was observed swollen shortly after dinner by his caregiver, an assessment of the affected left wrist was done, MD (medical doctor) on-call ordered a stat x-ray of the left wrist, ibuprofen, and ice pack as needed. Resident 29 indicated the swollen wrist happened during a transfer sometime on 5/3/22. The initial x-ray results were received, on 5/5/22 at 6:48 a.m. and indicated no definite radiographic evidence of acute fracture or dislocation, but if there were persistent symptoms, follow up x-ray may be obtained as clinically warranted. On 5/5/22 at 10:32 a.m., a telehealth video visit was conducted for follow up to Resident 29's continued complaint oof left wrist pain. The resident continued to endorse pain, swelling and limited range of motion (ROM) and stated he could not complete therapy due to the pain. Nursing Progress Note, dated 5/11/22 at 6:32 a.m., indicated Resident 29 complained of arm pain, and was administered pain medication which was effective. Nursing Progress Note, dated 5/18/22 at 4:08 a.m., indicated Resident 29 was noted to be yelling out, and asked for his pain medication for his legs and wrist and stated, I'm really hurting bad. Nursing Progress Note, dated 5/19/22 at 10:31 p.m., indicated Resident 29 continued to complaint of pain to his left hand, upon assessment swelling was noted, and an ice pack was applied. Nursing Progress Note, dated 5/20/22 at 5:46 p.m., indicated a telehealth video visit was conducted for pain management. Voltern gel was requested for pain relief which was ordered at that time. Nursing Progress Note, dated 5/33/22 at 8:11 a.m., Resident 29 continued to complain of pain in his left hand. The record lacked documentation that a follow up x-ray had been completed as indicated in the summary of the initial x-ray and follow up NP visit. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident 29 had Pain Assessments completed upon admission on 2/7/22, 2/8/22 and again on 2/10/22. A Pain Assessment was completed on 5/4/22 after the allegation of abuse. Each assessment summarized Resident 29's pain as generalized aching throbbing, chronic all over. The 5/4/22 assessment indicated Resident 29's wrist appeared to be red and swollen. Actual worked nursing scheduled were reviewed and revealed CNA 23 had been on duty, assigned to the hall where Resident 29 resided on both 5/3/22 and 5/4/22. Resident 29's Point of Care (POC) responses entered by the assigned CNA caregiver who completed the tasks during that shift were reviewed from 5/3 to 6/3/22. On 5/3/22 and 5/4/22 CNA 23 transferred Resident 29. After returning from his suspension, CNA 23 transferred Resident 29 on 5/15, 5/19, 5/28, and 5/29. CNA 23 wrote a witness statement, dated 5/4/22, which indicated he had provided personal care and transferred Resident 29 into his wheelchair but never noticed any swelling or pain in his arm. CNA 23 indicated the last person to have physical contact with Resident 29 before he complained of pain was therapy, and therapy should have reported the injury. On 6/6/22 at 11:10 a.m., the Therapy Program Manager (TPM) was interviewed in regard CNA 23's witness statement and Resident 29's therapy participation. The TPM indicated even though he was new to the building, he had already heard rumors from staff and residents that CNA 23 had a bad mouth. He had heard the aid referred to as, mouth of the south. The TPM worked with Resident 29 a couple of days after the incident and noted some swelling in his left wrist and hand, so when they worked, he had to be careful when repositioning in order not to cause additional pain. As this time, the TPM provided copies of Resident 29's therapy progress notes. A Physical Therapy (PT) note, dated 5/3/22 at 12:37 p.m., indicated Resident 29 had participated in PT with no complaints of pain and no indication of injury to his left wrist. A PT note on the following day, dated 5/4/22 [time-stamp not provided], indicated, .pt [patient] presented [with] increased swelling on Left hand and elbow, unable to perform standing A Speech Therapy (ST) note, dated 5/5/22 at 12:42 p.m., indicated, .resident seen in his room and up in his wheelchair. New injury to hand with no recollection of procedures in place to improve it During an interview on 6/2/22 at 11:26 a.m., the Regional Director of Operations (RDO) indicated the facility planned to re-open the investigation into the abuse allegation related to Resident 29 and CNA 23. During an interview on 6/3/22 at 9:20 a.m., the RDO indicated Resident 29 had been sent to the hospital for further evaluation of his left wrist, but upon his arrival, indicated it was his shoulder that hurt instead. An x-ray had been completed on the left shoulder, and the hospital had not completed an x-ray on his left wrist. Resident 29 refused to be returned to the facility and insisted to be sent to a different facility. So, he was transferred the same day to a sister facility. Because an x-ray had not been completed on his wrist at the hospital, the RDO indicated another mobile x-ray would be completed as soon as possible. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 6/3/22 at 8:18 p.m., the x-ray results of Resident 29's wrist were received and indicated the presence of soft tissue swelling. 2. On 6/1/22 at 10:00 a.m., Resident 39 was interviewed. He indicated he had remaining concerns that CNA 23 was still working at the facility and continued to verbally abuse Resident 26, whose room was near Resident 39. Over the holiday weekend on 5/29/22, CNA 23 went off on Resident 26 again. Resident 26 had an incontinence accident and CNA 23 kept going up and down the hall and in and out of his room while getting him cleaned up screaming things like, G------ it man! You're too old for this s---! I can't believe you s--- yourself again, you're a f------ baby man! I should be up at the track the way you you've got me running around like this! This went on the whole time it took to get Resident 26 cleaned up. It was at least 10 minutes. Resident 39 indicated Resident 26 was so angry he was visibly shaking and asked Resident 39 to go with him to report it to management. Monday was a holiday, and no management was at the facility. So, first thing Tuesday morning Resident 39 went with Resident 26 to the Social Service Director (SSD). When they reported it to the SSD, she took over and notified the Administrator and Director of Nursing (DON). Resident 39 indicated all he knew at this time, was CNA 23 was suspended again but it probably wouldn't do any good since this was like his 3rd suspension. On 6/1/22 at 10:10 a.m., Resident 53 was interviewed. She indicated she knew who CNA 23 was and she had the same concerns she had shared during the previous survey visit. Resident 53 indicated she did overhear CNA 23 yelling at another resident over the holiday weekend, 5/29/22, after he had an incontinence accident. On 6/2/22 at 9:35 a.m., Resident 26 was observed as he sat up in his bed. He indicated he did not like CNA 23 at all. CNA 23 screamed and yelled at him all the time because he would have accidents on himself. It embarrassed him because the whole hall could hear it. Resident 26 wanted to get the hell out of this place, if he was going to be treated like that. Resident 26 indicated the last incident happened the previous weekend on 5/29/22. CNA 23 had yelled at him before as well, but he was fed up with it and wanted out of the building. During a follow up interview on 6/2/22 at 9:45 a.m., Resident 29 indicated, we've been warning yall about him [CNA 23]. Resident 29 indicated he had heard CNA 23 yell up and down the hall, especially at Resident 26. The aid said things like, I can't believe you f------ s--- on yourself! Man, I don't get paid enough to keep wiping you're a-- like this! It seemed like CNA 23 was just burnt out, he had a really short fuse, and you did not want to be on the wrong side when it went off. At this time Resident 29's roommate indicated he heard CNA 23 yell up and down the hall all the time. It was really off-putting, and he was thankful that he could still do most everything for himself because he did not want to have to ask CNA 23 for help. A state reportable incident was filed on 5/31/22 (two days after the incident occurred). The reportable indicated, Resident 26 reported the incident to the SSD. CNA 23 told him, You are too d--- old to be doing this s--- you know. I should be at the Indy 500 the way you have got me running! An investigation conducted and substantiated. The employee was terminated and reported to the Attorney General's office. Resident 39 and 26 both submitted confidential witness statements on 5/31/22 which were signed by the Administrator. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/2/22 at 10:50 a.m., Resident 26's family member indicated Resident 26 had seemed more depressed lately when she talked with him on the phone. The last conversation they had, there was an increased sense of urgency in Resident 26's voice when he told her he wanted to move out of the facility because of a recent incident between him and a staff member. Resident 26's family indicated she lived in another state at the moment but was looking for available placement for Resident 26 to transfer closer to her. On 6/2/22 at 2:05 p.m., with the Administrator present Resident 26 was re-interviewed and confirmed the story that CNA 23 had yelled and cursed at him for having an accident on himself. Resident 26's record was reviewed on 6/2/22 at 3:00 p.m. The most recent comprehensive assessment was a quarterly MDS assessment dated [DATE]. According to the MDS he was moderately cognitively impaired with a BIMS score of 11 of 15. There were no recently coded concerns related to behaviors, and he was frequently incontinent of both bowel and urine. 3. On 6/1/22 at 10:10 a.m., Resident 53 was interviewed. She indicated she knew who CNA 23 was and she had the same concerns she had shared during the previous survey visit. Resident 53 demanded CNA 23 to come off her caregiver assignment after he roughly transferred her from her wheelchair to her bed, and her knee whacked the side of the bed. Even though CNA 23 came off her assignment, he still came in to help her roommate, Resident 25. CNA 23 cussed at her all the time for falling. Even though Resident 25 was deaf, Resident 53 did not like to hear it, and it upset her on behalf of her roommate. On 6/2/22 at 2:00 p.m., with the Administrator present Resident 53 was re-interviewed and confirmed the previously stated allegation that CNA 23 was verbally abusive toward her roommate, Resident 25, and that because he had hurt her knee a while ago during a transfer, she had him taken off her assignment. Resident 53's record was reviewed on 6/2/22 at 3:00 p.m. Resident 53 had a current diagnosis which included but was not limited to bipolar disorder, and a comprehensive care plan (dated 3/10/22) for manipulative behaviors related to the bipolar disorder, the record lacked documentation of the recent or ongoing behaviors. Resident 53's most recent comprehensive assessment was a significant change Minimum Data Set (MDS) assessment dated [DATE]. According to the MDS she was cognitively intact with a BIMS (brief interview for mental status) score of 14 of 15, with no recently coded concern related to behaviors. 4. On 6/2/22 at 2:10 p.m., with the Administrator present Resident 9 indicated she had wanted to say something when survey was at the facility the last time during the Resident Council Meeting, but everyone had been treating her so good, she was afraid to say anything about CNA 23, and then have staff retaliate against her. Resident 9 indicated, yes, it was true, CNA 23 was really mean, and went all around cussing and fussing at everyone. Resident 9's room was near Resident 26's and Resident 30's. Resident 9 heard CNA 23 yell at Resident 26 for having an accident on himself and had overheard him belittling Resident 30 for being too fat. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 6/2/22 at 2:20 p.m., with the Administrator present Resident 30 with hesitation and anxiety, asked Do I have to tell the truth? The Administrator patiently and gently encouraged her to tell the truth. Resident 30 indicated, yes, CNA 23 was mean and told her things like she was too big, and made her roommate cry all the time. During an interview on 6/3/22 at 12:25 p.m., the RDO indicated another state reportable had been submitted related to a new allegation. When the Administrator conducted a follow up interview with Resident 9 related to the previous verbal abuse allegation, Resident 9 indicated she overheard CNA 23 say sexuality explicit things towards Resident 30. He told the resident he wanted to stick his d--- between her t------ and get off that way. During a follow up interview on 6/3/22 at 2:26 p.m., the RDO and Administrator indicated the investigation into the sexual verbal abuse had been conducted and would be substantiated. The RDO and Administrator both agreed they knew Resident 9 very well, had no reason to doubt her, and trusted what she said was true. The investigation was substantiated, and the CNA would be terminated. During the investigation it was determined the statement CNA 23 made to the resident was delivered with the intention of being a joke, and they did not believe he had any plans to act against Resident 30 or any other resident. The content of the joke, and language of the joke however were absolutely intolerable and inappropriate. Resident 9's record was reviewed on 6/2/22 at 3:00 p.m. The most recent comprehensive assessment was a quarterly MDS assessment dated [DATE]. According to the MDS she was cognitively intact with a BIMS score of 15 of 15 and there were no recently coded concerns related to behaviors. Resident 30's record was reviewed on 6/2/22 at 3:00 p.m. The most recent comprehensive assessment was a quarterly MDS assessment dated [DATE]. According to the MDS she was cognitively intact with a BIMS score of 13 of 15 and there were no recently coded concerns related to behaviors. Resident 30 had a comprehensive care plan dated 3/23/22 for manipulative behaviors, the record lacked documentation of any recent or recurring behaviors. CNA 23's employee file was requested and provided by the Administrator on 6/3/22 at 11:25 a.m. and reviewed at this time. A CNA specific job orientation checklist was present from the time of CNA 23's hire on 8/13/20. The orientation checklist only included the CNA's initials and signature. There was no preceptor's initials or signature to signify the individual skills had been checked off, and there was no nursing supervisor signature, that his skills had been checked off. Further his file included 5 Disciplinary Action Reports, 3 of which were specifically related to allegations of abuse or mistreatment. A Disciplinary Action Report, dated 4/4/22, indicated he had been suspended for allegations of verbal abuse. A Disciplinary Action Report, dated 5/4/22, indicated he had been suspended for allegations of abuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A Disciplinary Action Report, dated 5/31/22, indicated, suspended, waiting results of investigation. During an interview on 6/2/22 at 10:30 a.m., the RDO indicated there was no specific policy that included details or spoke to employee disciplinary actions. That staff disciplinary actions would be made as needed on a case-by-case incident. However, it was his personal expectation that there was a no tolerance policy when it came to abuse. If someone was suspended for abuse, then they would be termed (fired). As part of the plan of correction (POC) for two abuse deficiencies related to reporting abuse, and investigating abuse cited during the annual recertification survey on 4/13/22, the Administrator/DON/Designee were to educate staff on the Abuse Prevention Program. In-Services were held on 5/5/22 and 5/6/22. The sign in sheets for the In-Service were included in the POC binder and indicated handwritten in all caps at the top of the page, ALL EMPLOYEES. CNA 23 was not included on any of the 4 pages of staff sign-ins. As a part of the POC for two previously cited abuse deficient (F609 for reporting abuse, and F610 for investigating abuse), the Administrator/DON/Designee educated staff on the Abuse Prevention Program. In-Services were held on 5/5/22 and 5/6/22 and included the following material which served as the current facility policy and expectation: An undated policy titled, Abuse Prevention Program. The policy indicated, .This facility will not tolerate resident abuse or treatment [mistreatment] by anyone, including staff member, other residents, consultants, volunteers, staff or other agencies, family members, legal guardians, friends of other individuals . Abuse: the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, mental anguish or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being . Verbal Abuse: Any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability . Sexual Abuse: Including, but not limited to, sexual harassment, sexual coercion or sexual assault. Physical Abuse: hitting, slapping, kicking, etc. It also includes controlling behaviors through corporal punishment An undated policy titled, Dignity. The policy indicated, .As an extension of appropriate interactions between staff and residents, the following will be practices of the facility. NOTE: Depending on scope and severity; what appears to be a dignity issue often can be interpreted and even meet the criteria for abuse. Conversations 1.) Staff will be polite and respectful at all times. 2.) Staff will not speak in a manner that could be interpreted as even minimally condescending/critical or argumentative not in a volume any louder that is absolutely necessary as this can be interpreted as meting criteria for abuse. 6.) Staff will not make reference to a malodorous field caused by the resident. This includes commenting on the smell of bad breath, body odor, urine or BM [bowel movement] . this could cause the resident embarrassment. Care 1.) Staff will maintain resident privacy during all personal care . 3.) Should a resident have an episode of incontinence, staff will change them upon discovery of the episode 3.1-27(a)(1) (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	3.1-27(b)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37981 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: 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 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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 37981 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. 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 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37982 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 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, 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: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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). (continued on next page)

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	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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 37981 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 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. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768 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. On 4/7/22 the following activities were scheduled: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Music at 1:00 p.m. Sorry at 2:30 p.m. No organized activities were observed throughout 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-[NAME] 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. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 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 37981 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. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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., 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. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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)

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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: 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. (continued on next page)

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

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. (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 4/4/22 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. 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. (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 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 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 (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/7/22 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 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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/7/22 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. 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 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]

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768 Based on observations, interviews, and record reviews, the facility failed to ensure a new pressure ulcer was reported to the physician, Director of Nursing (DON) and the residents responsible party, which caused a delay in treatment for a resident with a history of pressure ulcers in the same location for 1 of 3 residents reviewed for skin integrity and pressure ulcers, (Resident 25). Findings include: On 6/1/22 at 9:30 a.m., a Post Survey Revisit (PSR) was opened. As part of the Plan of Correction (POC) for a previously cited deficiency, skin assessments were completed on all residents, which included Resident 25 on 4/4/22. At that time, Resident 25 had no open areas, or skin integrity concerns. An additional piece of the POC included the re-education and in-service training provided to nursing staff on the topics which included, but were not limited to, procedures for Skin Assessments. Licensed Practical Nurse (LPN) 19's name was included on a list titled, Alpha Home Nurses with a handwritten notation which indicated, .Evening- Done 4/6/22 per [Assistant Director of Nursing (ADON) initials] . Materials provided during that in-service included but were not limited to a policy/procedure titled, Skin Observation/Assessment (Shower/Bath). The Policy indicated, .Conditions that will be observed for include but are not limited to what appear to the care giver to be bruises, red areas, open areas, scratches, abrasions, blisters, discoloration, dry flaky skin, pressure ulcers, scars as well as any other condition of the skin. Only licensed nurses can assess the skin. If the care giver is not a nurse and they observe a change in the resident's skin, the care giver will notify the nurse immediately so that the nurse can perform a skin assessment and notify the physician/family as appropriate and also obtain as needed orders for treatment. Appropriate documentation and care planning will be completed as per policy. The residents name may need to be added to the list of residents to be reviewed and discussed in the S.W.A.T meetings going forward . 3. Nurses will do skin assessments at least weekly (or as indicated) . On 6/6/22 at 2:00 p.m., Resident 25 was selected as a sample resident to review for the POC related to the development of a new pressure ulcer. Her medical record was reviewed at this time. Resident 25 was initially admitted to the facility on [DATE]. Her most recent re-admission was on 3/15/22 after a hospital stay. On 6/3/22 at 10:00 a.m., Resident 25 was observed being escorted out of the facility on a stretched by two EMT (Emergency Medical Technicians). The DON was present at that time and indicated Resident 25 was being sent out for a change of condition after a recent fall. At the time of this focused review on 6/6/22 at 2:00 p.m., the record lacked documentation of a recent census event to indicated Resident 25 had left to the hospital, and no re-admission nursing progress note to indicated when she had returned. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon her re-admission from the 3/15/22 hospital stay, there were two identical Weekly Wound Round Assessments which indicated Resident 25 had readmitted with a stage II pressure ulcer, (at stage 2, the skin breaks open, wears away, or forms an ulcer or a shallow crater in the skin) to her left trochanter hip which measured 4.5 cm (centimeters) long by 0.25 cm wide and 0.1 cm deep. While one assessment indicated the area was not healed; the second assessment indicated the area was healed. A nursing progress note, (entered by LPN 19) dated 5/18/22 at 9:16 p.m., indicated, Resident 25 had a new open area on her Left Buttock. It measured 5.8 cm long, by 5.2 cm wide, with no depth. The wound was cleaned with normal saline, and an adhesive island dressing was put in place. The record lacked documentation the physician, DON, and/or the resident's representative had been notified. The record lacked documentation that a new skin event or skin assessment was opened, and the record further lacked and additional monitoring of the new area until 6/2/22. A nursing progress note, dated 6/2/22 at 10:45 a.m., indicated, .open area noted with bathing by CNA, [Certified Nursing assistant], on call notified and treatment orders received A new Weekly Wound Round assessment was initiated on 6/2/22 and indicated, Resident 25 had a Stage II pressure ulcer on her left trochanter hip which measured 4 cm long by 2 cm wide and had a depth of 0.1 cm. The assessment indicated Telehealth (without specification of the physician's name) ordered a new treatment for Calmoseptine every shift. The record lacked documentation that a Telehealth visit had been completed on 6/2/22 as stated in the Weekly Wound Round assessment. The most recent Telehealth visits for Resident 25 received were as follows: a. 5/31/22 for possible falls b. 5/13/22 after she fell from her wheelchair c. 5/10/22 for regularly scheduled medical management and review. At the time of the record review on 6/6/22 at 2:00 p.m., Resident 25's physician orders lacked documentation/reconciliation that Calmoseptine had been added to her physician orders set, so that it would automatically generate onto the Medication and/or Treatment Administration orders. On 6/6/22 at 3:00 p.m., Resident 25's pressure ulcer area was observed with LPN 11. LPN 11 assisted Resident 25 to the restroom, where she stood long enough for LPN 11 to pull her brief down for an observation of her left hip. There was no treatment in place at this time, (there was no evidence of fresh or dried calmoseptine, as ordered). The area was irregular in shape, with speckled peri-wounds of additional bruises. The area to her left hip appeared to be a Deep Tissue Injury (DTI). The right side of the wound was half-moon shaped and dark purple in color. There was a scant amount of serosanguineous drainage noted at center and bottom half of the wound. LPN 11 blanched the area, Resident 25 winced. LPN 11 indicated she did not know what kind of wound it was or how she got it, but it looked like a bad bruise. LPN 11 indicated, if a nurse needed to see what kind of treatment orders were required for new skin areas like that, they would look at the MAR for instructions. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/7/22 at 12:55 p.m., Resident 25's wound was observed a second time. The DON assisted Resident 25 to stand beside her bed. When the DON untied Resident 25's gown, the backside of her brief was visible. A moderate amount of brownish-red drainage was noted through the brief at the wound's location. The DON pulled the resident's brief down to visualize the wound. At first the DON indicated, oh that's just a scar. She wiped her gloved finger across the wound and Resident 25 winced and attempted to pull her brief back up. When asked about the drainage which was seen through the brief, the DON indicated it was just the treatment of Calmoseptine. While dried, pink, calmoseptine was noted to the left side of the wound and peri-wound, the moderate brownish-red drainage was visible through the brief, and a shiny film of scant serosanguineous drainage was noted to the right side of the wound. At the center of the wound was an exactly rectangular shape, which lined up nearly perfect to the height, width, and shape of Resident 25's electric wheelchair arm rest. Pieces of the arm rest padding had been ripped or torn away, which exposed a rectangular metal bar that was nearly identical to the shape at the center of her wound, as if a perfect impression had been made by falling onto it. The DON recanted her statement that the area was a scar, and then indicated the area may have developed from Resident 25's many falls. On 6/7/22 at 1:03 p.m., the DON indicated the facilities current policy was recently used as a piece of the POC re-education and in-service material, as also indicated above. The policy was undated, and titled, Skin Observation/Assessment (Shower/Bath). The Policy indicated, .Conditions that will be observed for include but are not limited to what appear to the care giver to be bruises, red areas, open areas, scratches, abrasions, blisters, discoloration, dry flaky skin, pressure ulcers, scars as well as any other condition of the skin. Only licensed nurses can assess the skin. If the care giver is not a nurse and they observe a change in the resident's skin, the care giver will notify the nurse immediately so that the nurse can perform a skin assessment and notify the physician/family as appropriate and also obtain as needed orders for treatment. Appropriate documentation and care planning will be completed as per policy. The residents name may need to be added to the list of residents to be reviewed and discussed in the S.W.A.T meetings going forward . 3. Nurses will do skin assessments at least weekly (or as indicated) . 3.1-40(a)(2) 3.1-40(a)(3)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 37982 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 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. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 1/4 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 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 3.1-47(a)(2)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768 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 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. 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. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 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 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. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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 [DATE] 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. 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. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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 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)

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	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37981 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: On [DATE] 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 [DATE] 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 [DATE] 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 [DATE]. 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 [DATE] 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. Of the 8 discharged residents' medications for disposition were: a. Resident 6 had passed away on [DATE] 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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 [DATE] 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 ,d+[DATE] days A current policy, titled, Medication Return Policy, with no date, was provided by the Administrator, on [DATE] 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 dispensed. Items received after this period (31 days and beyond) will not be issued credit 3XXX,d+[DATE](m) 3XXX,d+[DATE](o) 3XXX,d+[DATE](p) 3XXX,d+[DATE](q) 3XXX,d+[DATE](r) 3XXX,d+[DATE](s)(1) 3XXX,d+[DATE](s)(2) 3XXX,d+[DATE](s)(3) 3XXX,d+[DATE](s)(4) 3XXX,d+[DATE](s)(5) 3XXX,d+[DATE](s)(6) 3XXX,d+[DATE](s)(7) 3XXX,d+[DATE](s)(8)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 37981 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. 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)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 37982 Based on observation, interview, and record 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 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 the medication will be documented on the back of the medication Administration Record. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-48(c)(1)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37982 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 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. 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. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37981 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 [DATE] 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 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 [DATE] 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 [DATE] 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 [DATE]. 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 [DATE] 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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 [DATE] at 12:04 p.m., the Administrator indicated all medications should have been behind locked doors. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	37982 2. On [DATE] 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 [DATE] 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 dispensed from pharmacy was dated [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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 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 3XXX,d+[DATE](k)(1) 3XXX,d+[DATE](k)(2) 3XXX,d+[DATE](k)(3) 3XXX,d+[DATE](k)(4) 3XXX,d+[DATE](k)(5) 3XXX,d+[DATE](k)(6) 3XXX,d+[DATE](k)(7) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3XXX,d+[DATE](m) 3XXX,d+[DATE](n) 3XXX,d+[DATE](o) 3XXX,d+[DATE](q)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37981 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 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. (continued on next page)

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	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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 38768 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 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. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768 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 [NAME] 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) 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 [ROOM NUMBER] 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 [ROOM NUMBER] without performing hand hygiene, or donning the appropriate PPE. At 10:56 a.m., the MD and MS exited room [ROOM NUMBER] without performing hand hygiene. At 10:58 a.m., the MD and MS entered room [ROOM NUMBER] 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 [ROOM NUMBER] 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 [ROOM NUMBER] 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 [ROOM NUMBER]. The MD used hand gel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 11:07 a.m., the MD and MS entered room [ROOM NUMBER] 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 [ROOM NUMBER] 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 [ROOM NUMBER] 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 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. 37982 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 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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 (admitted [DATE]) 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 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 37981 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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 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 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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)

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. 37981 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 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)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 37981 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. 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. (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

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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)