| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155272 | A. Building<br>B. Wing | 09/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Allison Pointe Healthcare Center | 5226 E 82nd Street<br>Indianapolis, IN 46250 |

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) |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34850<br><br>Based on interview and record review, the facility failed to ensure monitoring was completed of a resident on anticoagulant medications for 1 of 3 residents reviewed for medications. (Resident B)<br><br>Findings include:<br><br>The clinical record for Resident B was reviewed on 9/20/24 at 1:00 p.m. The diagnoses included, but was not limited to, lung cancer and pulmonary embolism (blood clot in the lungs). The resident was admitted to the facility on [DATE].<br><br>A hospital discharge medication list, dated 9/13/24, indicated Resident B was to receive 0.7 milliliters (ml) enoxaparin injection medication (anticoagulant medication) twice a day while receiving 5 milligrams (mg) of warfarin (anticoagulant medication) daily. The staff was to obtain daily international normalized ratio (INR) test (blood test measures how long it takes the blood to clot) until he becomes therapeutic with INR levels within a 2-3 range; then discontinue the enoxaparin and continue with the daily warfarin.<br><br>A physician order, dated 9/13/24, indicated the resident was to receive 0.7 ml of enoxaparin injection twice a day. Continue while giving warfarin with daily INR until INR becomes within 2-3 range, d/c [discontinue] enoxaparin.<br><br>A physician order, dated 9/13/24, indicated the resident was to receive 5 mg of warfarin daily.<br><br>A physician order, dated 9/19/24, indicated the staff was to obtain PT/INR (Prothrombin Time Test and INR) daily. The order was discontinued on 9/20/24.<br><br>A physician order, dated 9/20/24, indicated the staff was to obtain a PT/INR STAT (immediately).<br><br>A September 2024 medication administration record indicated Resident B received the anticoagulant medications, 0.7 ml of enoxaparin injection twice a day and 5 mg of warfarin once a day from 9/14/24 through the morning of 9/20/24 as ordered.<br><br>Resident B's medical record did not include a developed care plan for anticoagulant usage nor INR test results that had been obtained as ordered.<br><br>(continued on next page) |



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

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted with the Assistant Director of Nursing (ADON) and the Nurse Consultant (NC) on 9/20/24 at 4:32 p.m. The ADON and the NC indicated the Nurse Practitioner (NP) wanted the resident to receive dosages of the warfarin and enoxaparin for at least a week before obtaining INR test results. They were unable to provide documentation that indicated the NP wanted to delay in obtaining INR results. The NC indicated she had developed the resident's care plan for anticoagulant usage that day. There was an order, on 9/19/24, to obtain the INR test, but the lab technician had missed it, and it was not obtained. An order was placed, on 9/20/24, for a STAT INR test to be conducted.<br><br>A warfarin monitoring policy was provided by the NC on 9/20/24 at 4:48 p.m. It indicated, .Procedure: A. The prescriber/physician will provide an order for INR monitoring for warfarin use. B. The frequency of the monitoring is specific to each resident based upon their medical history, reason for anticoagulation therapy, and medical condition. II. Communication Method. A. The facility will have an established communication method between the facility and the prescriber/physician for monitoring residents on the drug warfarin. B. The communication for documenting the INR labs by resident is in the form of a log .V. Assessments. A. The nurse will monitor the resident for signs/symptoms that may include but are not limited to . i. Unusual or excessive bleeding .ii. Unusual or excessive bruising of the skin. VI. Care plan. A. Information regarding anticoagulant therapy is placed on the care plan for the purpose of monitoring excessive bruising, or bleeding in the event of a fall, head injury or other injury. B. The reason for the anticoagulation therapy and the INR therapeutic range, if known<br><br>This citation is related to Complaint IN00440656.<br><br>3.1-37(a) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>34850<br><br>Based on interview and record review, the facility failed to record urine outputs for residents utilizing a urinary catheter for 2 of 3 residents reviewed for urinary catheters. (Resident F and Resident G)<br><br>Findings include:<br><br>1. The clinical record for Resident G was reviewed on 9/20/24 at 1:30 p.m. The diagnoses included, but was not limited to, paraplegia and neuromuscular dysfunction of bladder (bladder problems due to nerve/spinal cord damage).<br><br>A care plan, dated 8/16/24, indicated Resident G had an indwelling and suprapubic (tube that drains urine from the bladder through a small incision in the lower abdomen) urinary catheters.<br><br>A physician order, dated 8/15/24, indicated the resident had an 18 French (size of catheter) Foley Catheter (type of urinary catheter) to be changed every 30 days.<br><br>A physician order, dated 8/15/24, indicated the staff was to measure and record the urine output every shift.<br><br>A physician order, dated 8/15/24, indicated the staff was to empty the urostomy bag (an opening in the abdominal wall to redirect urine away from the bladder) every shift.<br><br>The September 2024 Medication and Treatment Administration Records (MAR/TAR) indicated the following days the staff had not recorded any urine outputs for Resident G:<br><br>Foley catheter:<br><br>9/1/24 - evening shift,<br><br>9/5/24 - evening and night shift,<br><br>9/14/24 - day shift,<br><br>9/16/24 - evening and night shift, and<br><br>9/18/24 - night shift.<br><br>Urostomy bag:<br><br>9/1/24 - evening and night shift,<br><br>9/2/24 - evening shift - documented as NA (not applicable),<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 9/5/24 - evening shift - documented as NA,<br><br>9/13/24 - night shift - documented as NA,<br><br>9/14/24 - day shift,<br><br>9/16/24 - evening and night shift, and<br><br>9/18/24 - night shift.<br><br>40287<br><br>2. The clinical record for Resident F was reviewed on 9/20/24 at 1:30 p.m. The diagnoses included, but were not limited to, neurogenic bladder.<br><br>A care plan, last revised on 3/5/24, indicated Resident E had a suprapubic catheter. The goal was for him to be free from catheter-related trauma. The interventions included, but were not limited to, provide catheter care every shift and as needed and notify medical provider if urine was of abnormal color, consistency, or odor.<br><br>A physician's order, dated 5/7/24, indicated to measure and record output from urinary catheter every shift.<br><br>A Quarterly Minimum Data Set assessment, dated 6/10/24, indicated he had an indwelling urinary catheter, and continence was not rated due to him having an indwelling catheter.<br><br>The September 2024 TAR did not contain the amount of urine emptied from the urinary catheter on the following days and shifts:<br><br>9/6/24 - evening shift,<br><br>9/7/24 - evening shift documented as N/A,<br><br>9/9/24 - night shift documented as N/A,<br><br>9/10/24 - night shift,<br><br>9/11/24 - night shift,<br><br>9/14/24 - night shift documented as N/A,<br><br>9/15/24 - night shift, and<br><br>9/19/24- evening and night shift documented as N/A.<br><br>An interview was conducted with the Assistant Director of Nursing on 9/20/24 at 3:13 p.m. She indicated the staff should be documenting urine output on the TAR for Resident F and Resident G every shift.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | This citation is related to Complaint IN00440656.<br><br>3.1-41(a)(2) |