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	05/28/2025

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 0686 Level of Harm - 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** Based on record review, and interview, the facility failed to prevent the development of a stage II (partial thickness skin loss involving the dermis) coccyx wound that progressed to an unstageable (a full-thickness tissue loss where the base of the ulcer is obscured by slough [yellow, tan, gray, green, or brown tissue]) that resulted in actual harm when the resident required hospitalization and wound debridement for 1 of 3 residents reviewed for pressure ulcers (Resident B). Findings include: A confidential concern during the survey indicated a family member was not happy with Resident B's care while in the facility. Concerns included the resident was not being repositioned, or having his brief changed. Resident B had been in the facility for 30 days and in that time had developed a bed sore near his anus that had worsened. Resident B's clinical record was reviewed on 5/27/25 at 2:15 p.m. The diagnoses included nontraumatic intracerebral hemorrhage (stroke), aphasia (difficulty in communicating and understanding verbal and written language), dysphagia (difficulty swallowing), and pressure ulcer. The resident was admitted to the facility on [DATE]. On 3/17/25, an Admission/re-admission Screener indicated the resident had no skin impairment upon admission. A progress note, dated 3/17/25 at 8:00 p.m., indicated Resident B was brought to the facility on a stretcher by emergency medical services (EMS), post hospitalization for altered mental status and right hemiparesis. He was non-verbal and did not follow commands. The resident's skin tone and turgor were normal, and there were no skin issues noted. On 3/17/25, a Baseline Care Plan indicated the resident required 1-person physical assistance for ADL's, bed mobility and transfers, and required no mobility devices. The resident was always incontinent of bowel and bladder. On 3/17/25, a Braden Scale for Predicting Pressure Sore Risk assessment indicated the resident was at high risk for skin breakdown. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A progress note, dated 3/18/25, indicated Resident B required maximum assistance of 2 staff members for transfers, and he used a wheelchair for mobility propelled by the staff. The resident was non-verbal, had right-sided hemiparesis, aphasia and dysphagia, and was non- ambulatory. A mechanical lift was used for transfers and to obtain his weight. On 3/18/25, an initial new admission skin evaluation was completed. Documentation indicated, due to co-morbidities, the resident was at increased risk for skin breakdown. Recommendations included: good hygiene and skin care to prevent skin breakdown, and application of emollients daily. There were no open wounds on assessment of the skin, keep the resident's skin clean and dry, apply barrier cream as necessary to prevent skin breakdown, and avoid pressure on any bony prominence by adhering to turning protocols The admission and state-optional Minimum Data Set (MDS) assessments, completed on 3/24/25, assessed Resident B as having no speech, rarely/never made himself understood, the resident usually understood others, and had no fall history in the past 6 months. The resident required extensive physical assistance from two plus people for bed mobility, transfers, toilet use, and mobility devices included a wheelchair. Resident B was at risk of developing pressure ulcers/injuries, had no current pressure wounds or skin problems, and did not have applications of ointments or medications to the skin. On 3/24/25, a Weekly Skin Check assessment indicated the resident had no skin breakdown. A care plan for Resident B, dated 3/25/25, indicated he was incontinent of bladder and bowel, and the goal was for him to be clean, dry and odor free. Interventions included peri care after every incontinent episode, and staff were to assist the resident with toileting as needed. A care plan for Resident B, dated 3/25/25, indicated he was at risk for skin breakdown related to impaired mobility, and the goal was for him to be free of skin breakdown. Interventions included performing a Braden scale assessment quarterly and as needed, keeping the resident clean and dry, and completing skin assessments per facility policy. A progress note, dated 3/26/25 at 4:00 p.m., indicated Resident B was alert to self, non-verbal, incontinent of bowel and bladder, dependent of staff for ADL assistance, and transferred with 2 persons assist. The resident continued with bolus tube feedings via peg tube site. Medication Administration Records (MARs), dated March 2025, lacked documentation of physician's orders for preventive skin care. The clinical record lacked documentation that emollients (substances, often found in moisturizers, that soften and soothe the skin) or barrier creams had been used per the Wound NP recommendations on 3/18/25, or nursing interventions to include turning and repositioning, keeping the resident clean and dry, or off-loading had been initiated. On 3/28/25, a Weekly Wound Evaluation indicated the resident had an in-house acquired Stage 2 wound on his right buttock that measured 5.0 centimeters (cm) by (x) 3.0 cm x 0.1 cm. Nursing progress notes, dated 3/28/25, lacked documentation a stage 2 pressure wound had been identified on Resident B's coccyx, the root cause of the wound, the physician or family had been notified, or nursing interventions had been initiated. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A physician order, on 3/30/25, indicated to cleanse a right buttock/coccyx wound with wound cleanser, and pat dry, apply collagen particles (a type of wound dressing to promote healing) to the wound bed and cover with silicone super absorbent foam, and change the dressing daily and as needed. The order was discontinued on 4/1/25. A wound assessment, on 4/1/25, indicated the resident was seen for a new DTI on the coccyx, that measured 9.0 cm x 5.5 cm x 0.1 cm. Exposed tissues included: subcutaneous, dermis, and dark maroon/purple discoloration noted in the wound bed. New recommendations included a low air loss (LAL) mattress, strict incontinence management, and offloading in bed. All preventative measures were discussed with the staff. A physician order, on 4/2/25, indicated to cleanse the right buttock/coccyx wound with Dakin's solution (a care product containing sodium hypochlorite - a form of household bleach), and pat dry, apply Medihoney (medical grade honey with antibacterial actions, promoting a moist environment, and aides in debridement -removal of dead skin) to the wound bed, and cover with silicone super absorbent foam. Staff were to change the dressing daily and as needed. The order was discontinued 4/16/25. A wound assessment, on 4/9/25, indicated the resident was seen for an unstageable (where the base of the wound cannot be seen due to slough or eschar) coccyx wound that measured 10.0 cm x 5.5 cm x 2.0 cm. A surgical debridement was performed to remove necrotic tissue and keep the wound in an active state of healing. A grievance, dated 4/10/25, indicated Resident B's family member was concerned about a large wound on the resident's coccyx. A wound assessment, on 4/15/25, indicated the resident was seen for an unstageable coccyx wound, that measured 9.0 cm x 5.0 cm x 2.0 cm. Exposed tissues included: subcutaneous, dermis, and adipose. A surgical debridement was performed to keep the wound in an active state of healing. A physician order, on 4/17/25, indicated to apply a nickel thick amount of Santyl External Ointment (a debriding agent) topically to the coccyx wound base every day for wound care, bolster the wound with lightly packed normal saline moistened gauze, and cover with bordered foam dressing. Staff were to change the dressing daily and as needed. A care plan for Resident B, dated 4/17/25, indicated his skin integrity was impaired related to an unstageable pressure ulcer to the coccyx. Interventions included, notify the physician and family of change in condition, observe for signs and symptoms of increase in size of the area, observe vital signs as indicated, pressure reducing mattress on the bed, and treatment as ordered. An update to the care plan, dated 4/23/25, indicated the goal was for the resident's wound to resolve without complications. Interventions included administering nutritional supplements for wound healing as ordered. A wound assessment, on 4/22/25, indicated the resident was seen for a coccyx wound that was worsening, and measured 7.5 cm x 5.0 cm x 3.5 cm. There was undermining from 12 o'clock to 3 o'clock measuring 2.0 cm. Exposed tissues included: subcutaneous, dermis, adipose, bone, and black discoloration noted in the wound bed. The resident was experiencing an increase in pain, and wound cultures were obtained at bedside. A surgical debridement was performed to keep the wound in an active state of healing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A physician order, on 4/23/25, indicated to cleanse a coccyx wound with Dakin's 0.125% solution, apply skin prep on the surrounding tissue, apply a nickel thick amount of Santyl with Dakin's moistened gauze packed into the wound, and cover with boarder foam dressing. Staff were to change the dressing daily and as needed. A progress note, dated 4/24/25 at 3:51 p.m., indicated a Registered Nurse (RN) from an infectious disease doctor's office had called and informed the facility the infectious disease doctor wanted Resident B was sent immediately to a local medical center emergency room (ER) via ambulance. A progress note, dated 5/2/25 at 3:44 p.m., indicated facility staff had contacted Resident B's spouse for follow-up information regarding his recent trip to the hospital. The spouse indicated she was considering moving Resident B to another facility when he was discharged from the hospital. During an interview on 5/27/25 at 2:50 p.m., Wound NP 5 indicated she had been asked to assess Resident B after he had developed a stage II pressure ulcer on his coccyx and within a week deteriorated to a Deep Tissue Injury (a pressure-related injury to sub-cutaneous tissue under intact skin, as a result of prolonged compression of bony prominences on underlying soft tissue, particularly muscle). Wound NP 5 and a colleague saw the resident weekly where they measured and documented a description of the wound. The coccyx wound subsequently deteriorated to an unstageable pressure wound, which they surgically debrided to remove slough and help with wound healing on more than one visit. During Wound NP 5's fourth visit she observed the coccyx wound to be worsening. She suggested the resident be seen by an infectious disease doctor associated with a local hospital. During an interview on 5/28/25 at 11:58 a.m., the Regional Nurse Consultant indicated Resident B had a standard pressure reducing mattress on his bed upon admission, that had been changed to a LAL mattress at the recommendation of Wound NP 5 on 4/1/25. The Regional Nurse Consultant indicated after reviewing Resident B's clinical record, she had no further information or documentation to provide regarding the prevention or treatment of Resident B's pressure wound on his coccyx. There was no documentation to indicate preventative measures were in place prior to the development of the pressure ulcer, if the wound was preventable or not, or that a personalized skin care plan was developed before the coccyx wound was identified. During an interview on 5/28/25 at 12:41 p.m., Licensed Practical Nurse (LPN) 6 indicated upon admission to the facility, and during his first assessment by Wound NP 5, Resident B had no skin breakdown. The resident was incontinent of bladder and bowel and was totally dependent on staff for his ADL needs, he relied on staff to check and change him as needed. A few weeks later, Qualified Medication Aide (QMA) 13 reported she had observed blood on Resident B's bottom after she had changed his brief. A LAL mattress was provided after the wound was identified. LPN 6 indicated the management team were responsible for creating and updating care plans. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/28/25 at 3:30 p.m., the Regional Nurse Consultant provided a policy titled, Guidelines For Prevention/Treatment Of Pressure Injuries, dated 10/9/23, and indicated the policy was the one currently being used in the facility. The policy indicated, .A Risk Assessment is considered the starting point for prevention of pressure injury .It is important to note that an [at risk] resident can develop a pressure injury within hours of the onset of pressure. For this reason the [at risk] resident must be identified, and have specific interventions put promptly in place and care planned in an effort to prevent formation of a pressure injury .If upon any assessment an actual pressure ulcer/pressure injury is found immediate steps will be taken to ensure that a treatment is in place as well as any appropriate interventions related to area[s]. These will be added to the resident's care plan .Protecting and monitoring the condition of the resident's skin is important for preventing pressure sores and for identifying Stage 1 sores early so they can be treated before they worsen .Skin must be cleaned promptly after every episode of incontinence pH balanced skin cleaners should be used. Moisturizers are recommended as well This citation relates to Complaint IN00459052. 3.1-40(a)(1) 3.1-40(a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure fall prevention interventions were individualized and implemented, and fall follow-up assessments and interventions were completed for 1 of 3 residents reviewed for falls (Residents B). Findings include, A confidential concern during the survey indicated Resident B had fallen out of bed while an aide was providing care on an unknown date, and there were questions concerning whether the staff member had been qualified to provide care. Resident B's clinical record was reviewed on 5/27/25 at 2:15 p.m. The diagnoses included, nontraumatic intracerebral hemorrhage (stroke), aphasia (difficulty in communicating and understanding verbal and written language), dysphagia (difficulty swallowing), and pressure ulcer. An admission physician's note, dated 3/17/25, indicated Resident B had been hospitalized with right sided weakness and aphasia following a large left-sided intercranial hemorrhage. The resident was unsteady on his feet, and staff were to utilize fall precautions per facility policy. A Fall Risk Review, dated 3/17/25, indicated Resident B was at high risk for falls. A progress note, dated 4/10/25 at 8:05 a.m., indicated Resident B had rolled out of bed during check and change. The incident was witnessed by CNA 11 and a nurse, and there were no injuries. An electronic physician notification, dated 4/10/25 at 8:51 a.m., indiated Resident B had a fall. Per the nurse, the resident was rolled off the bed by an aide around 5:30 a.m. The nurse reported the resident was non-verbal, at his prior level of alertness, and had expressed pain, although the resident was not able to express where the pain was located. Review of a grievance on 4/10/25 indicated, Resident B's family member was upset he had fallen out of bed, and wanted to know why a new staff member was working with the resident. The admission and state-optional MDSs (Minimum Data Set) assessments, completed on 3/24/25, assessed Resident B as having no speech, rarely/never made himself, usually understood others, and had no fall history in the past 6 months. The resident required extensive physical assistance from two plus people for bed mobility, transfers, toilet use, and mobility devices included a wheelchair. A care plan, dated 3/25/25, indicated Resident B had the potential for falls related to new surroundings and his goal was to have no falls. Interventions included call light in reach, encourage the resident to ask for assist with transfer or ambulation as needed, and keep paths free of clutter. Resident B's clinical record lacked documentation that fall follow up was completed to include 72 hours of assessments with vital signs, a Post Fall Review assessment, or updates to the care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/25 at 12:08 p.m., the Director of Nursing (DON) indicated, on 4/10/25, Resident B was being turned onto his side during care, and he rolled off the bed. The Certified Nursing Aide (CNA) was a newly hired aide, and she had been caring for the resident by herself. In her opinion, the fall was potentially the result of a low air loss mattress (LAL) that was on the bed. Before the fall, the care plan lacked resident specific interventions and was not updated after the fall. The DON indicated that MDS Nurse 10 was responsible for the development of care plans. During an interview on 5/28/25 at 12:39 p.m., Licensed Practical Nurse (LPN) 6 indicated Resident B had required total care per staff for his ADL (activities of daily living) care to include turning and repositioning every 2 hours. On 4/10/25, LPN 6 had been instructed during shift report to document fall follow up for Resident B after he had fallen out of bed. LPN 6 indicated CNA 11 had been providing care and changing Resident B's brief by herself when the resident fell out of bed. LPN 6 indicated the management team, to include the DON, were responsible for creating and updating care plans. On 5/28/25 at 3:30 p.m., the Regional Nurse Consultant provided a Guidelines For Incidents/Accidents/Falls policy, dated 6/30/23, and indicated the policy was the one currently being used in the facility. The policy indicated, .9. Documentation of the physical and mental status of the resident[s] involved will be completed each shift [every 8 hours minimally] over at least the next 72 hours or until the resident[s] condition improves . 11. All falls will have a site investigation by appropriate staff in an effort to determine the [root cause] of the fall. This will help provide information to enable staff to roll out interventions to prevent another similar occurrence. Note: Each fall needs a new care plan interventions rolled out .Residents are assessed for FALL RISK upon admission, re-admission, quarterly and when there is a change of condition to include a fall .15. Based on the results of the incident/accident/fall, the resident's care plan will be addressed to ensure that any needed points of focus have measurable goals with appropriate interventions in place This citation relates to Complaint IN00459052. 3.1-45(a)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and interview, the facility failed to ensure medication and biologicals were stored according to facility policy for 1 of 1 treatment carts observed for medication and biological storage. Findings include: During a random observation on 5/28/25 at 12:31 p.m., an unlocked treatment cart containing tubes and bottles of biological (medications used to treat skin conditions and wounds) was positioned near the nurse's station, outside the main dining room, and near the entry to the 100 hallway. The top drawer of the treatment cart was opened exposing insulin and blood glucose testing supplies to include a box of exposed lancets (small disposable needles), bottles of blood glucose strips, packaged dressings, and alcohol pads. There was a plastic medication cup with unidentified pills and capsules sitting unsecured on top of the treatment cart. There were 8 residents observed sitting in the main dining room within view of the treatment cart, and Resident H was standing beside the treatment cart. Licensed Practical Nurse (LPN) 7 was observed sitting down inside the nurse's station approximately 12 feet away and out of sight of the treatment cart. A visitor stood near the unsecured treatment cart talking to Resident H for over 2 minutes, before the nurse was observed walking out of the nurse's station towards the treatment cart. When LPN 7 observed the treatment cart with the top drawer opened, she quickly grabbed the cart, shut the drawer and locked the cart, and stored it inside the nurse's station. On 5/28/25 at 12:35 p.m., LPN 7 indicated she should not have left the treatment cart unlocked but got caught up with another resident and had forgotten about it. On 5/28/25 at 3:30 p.m., the Regional Nurse Consultant provided a Medication Storage In The Facility policy, dated March 2023, and indicated the policy was the one currently being used in the facility. The policy indicated, .3. Medication rooms, carts, and medication supplies are locked or attended by person with authorized access: a. Licensed Nurse .7. External medications including ointments for skin irritations and medication for application to wounds should be kept in a treatment cart, or in a separate drawer in the medication cart which is labeled as such 3.1-25(m)