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	09/26/2024

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. 37981 Based on observation, interview, and record review the facility failed to ensure dignity for a female resident with long facial hair for 1 of 1 resident reviewed for dignity (Resident 33). Findings include: During an interview, on 9/23/24 at 11:10 a.m., Resident 33 indicated she did not like the long hair on her face and would prefer to be shaved. She indicated she was unable to do it alone and needed assistance with this task. The hair on her face was observed to be long. During an interview, on 9/24/24 at 11:42 a.m., Resident 33 indicated she talked with the facility staff yesterday about wanting to have the facial hair removed, but nothing had happened yet. Her long facial hair was still intact. On 9/24/24 at 1:47 p.m., Resident 33's record was reviewed. Her diagnoses included, but were not limited to, supraventricular tachycardia (irregularly fast or erratic heartbeat), chronic respiratory failure (long-term condition that occurs when the body's respiratory system can't effective function), and age-related debility (physiological decline). A care plan, dated 11/6/23, indicated Resident 33 had a self-care deficit with impaired dressing and grooming. An intervention was to recognize she may have fluctuations in her normal day to day Activities of Daily Living (ADL) assistance and staff support needs due to my chronic disease process and /or any acute exacerbations. A care plan, dated 11/6/23, indicated Resident 33 had late loss ADLs and required staff assist with ADL's. On 9/24/24 at 2:58 p.m., Resident 33 was observed in her power wheelchair, in the main lobby of the facility, talking with a friend. The issue with her facial hair was not resolved and was still present on her face. A progress note, dated 9/24/24 at 3:05 p.m., indicated the DON spoke with Resident 33 about wanting to be up by 9:30 a.m. for the Resident Council meeting. She was asked at this time if she wanted assistance with shaving. Resident 33 indicated she was waiting for a certain staff member to help her. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 9/25/24 at 10:54 a.m. Resident 33 indicated unidentified staff members had been to her room yesterday (9/24/24), and the day before (9/23/24), to ask if she wanted her facial hair removed. She told them yes, but no one had come back to do it. She indicated she was hesitant about doing it herself because she nicked her face once. Her facial hair was observed to be long. During an interview, on 9/25/24 at 11:26 a.m., the Director of Nursing (DON) indicated she just found out Resident 33 preferred only a certain staff member to shave her face. She indicated she created a new care plan of the same. A new care plan, dated 9/25/24, indicated Resident 33 had indicated she preferred to have her facial hair shaved only by specific staff of her choice. An intervention was to reassess as needed for changed in her daily preferences. During an interview, on 9/26/24 at 10:31 a.m., the DON indicated Resident 33's face had been shaved. The person she preferred for facial grooming was Qualified Medication Assistant (QMA) 16. On 9/26/24 at 1:30 p.m., QMA 16's actual schedule was reviewed. She worked the evening shift from 3:00 p. m. to 11:00 p.m. on 9/23/24 to 9/25/24. A current policy titled, Guidelines for Observing and Implementing - Resident Rights, dated 7/12/23, was provided by Regional Consultant 9. A review of the policy indicated, .Each resident has the right to be treated with dignity and respect .The preference and goals of the resident should be honored 3.1-3(a) 3.1-3(t)

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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. 38768 Based on interviews and record review, the facility failed to ensure Resident Council grievances were followed up on and reported back to the Resident Council for review and approval. This deficient practice had the potential to effect 4 of 54 residents who attended the Resident Council meeting. Findings include: On 9/24/24 at 10:00 a.m., the Resident Council minutes were reviewed. A meeting was held on 2/22/24 with new and old business which indicated, Residents want to go out for outings like eating/shopping. There was no documentation of a response to the Resident Council's request. A meeting was held on 3/21/24 which indicated, old business was not discussed and they requested more outing again. Two separate grievances were hand written on behalf of two residents related to wanting to go on more outings and general nursing care concerns. There was no documentation of a response to the Resident Councils requests, and/or the individual grievances. The next meetings were held on 6/20/24, 7/18/24, and 8/15/24 which discussed general care concerns which included, but were not limited to items of call light response time, staff speaking different language and using earbuds or cell phones etc. There was no documentation of responses to the Resident Councils minutes. On 9/25/24 at 10:00 a.m., a Resident Council meeting was held with Residents 25, 33, 29, and 41. All four residents agreed and indicated, it seemed like with the Activity staff turn-over many of their concerns and grievances were not responded to in a timely manner and sometimes were not responded to at all. During an interview on 9/26/24 at 9:24 a.m., the Activity Director (AD) indicated Residents did complain since she had started that sometimes they did not receive responses. The AD indicated the process after Resident Council meetings should include the submission of response forms to the appropriate department heads so that at the next meeting, the residents could have a response and review it to determine if they accepted it or not. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/25/24 at 1:56 p.m., Regional Consultant (RC) 8 provided a copy of current facility policy titled, Resident Council Policy, revised 2/9/16. The policy indicated, .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 . 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: improves communication between staff and residents . helps identify quality of life issues . It is vital to establish an atmosphere of trust and responsibility for concerns to be voiced. This encourages members to openly discuss issues that impact them and/or other residents . The council group members who voice a concern usually expect a timely response about the resolution to their concern. This must happen. The Administrator monitors this process . A concern is any issue identified by the group that requires a response from the facility in the form of a resolution to some degree that satisfies the group with an explanation a comment 3.1-3(l)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46414 Based on record review and interview, the facility failed to accurately code the Minimum Data Set (MDS) for 5 of 5 residents reviewed for MDS accuracy (Resident 9, 47, 12, 11, and 33). Findings include: 1. On 9/26/24 at 10:00 a.m., a record review was completed for Resident 9. She had the following diagnoses which included, but were not limited to, hypertension (high blood pressure) (HTN), diabetes mellitus type 2 (blood sugar disorder) (DM), and weakness. She had a physician's order for aspirin 81mg (antiplatelet) by mouth daily. Her Minimum Data Set (MDS) assessment, dated 8/20/24, indicated she took an anticoagulant (blood thinner). She did not have an order for an anticoagulant. Her aspirin should have been coded as an antiplatelet on the MDS. She had a care plan, dated 9/8/22, that indicated she was at risk for abnormal bleeding related to the daily use of aspirin with an increased risk for bruising and/or bleeding. 2. On 9/25/24 at 11:21 a.m., a record review was completed for Resident 47. He had the following diagnoses which included, but were not limited to, major depressive disorder, post-traumatic stress disorder (PTSD), and dementia (neurological decline disease). Resident 47's MDS, dated [DATE], indicated he did not require a PASRR (pre-admission screening and resident review) Level II. He had a notice of PASRR, dated 2/10/22, which indicated he required a Level II based on his diagnoses. He had a care plan, dated 9/24/22, which indicated he had a Level II in place related to a mental health condition. 3. On 9/26/24 at 10:15 a.m, a record review was completed for Resident 12. She had the following diagnoses which included hyperlipidemia (HLD), hypertension (HTN), and atherosclerotic heart disease (ASHD) (ASHD is caused by plaque buildup in the coronary arteries, which supply blood to the heart). Her MDS, dated [DATE], indicated she took an anticoagulant. She did not have an order for an anticoagulant. She had an order for aspirin 81mg daily and Plavix (is an antiplatelet drug you can take to prevent blood clots. It keeps platelets in your blood from coming together and making clots). The MDS, dated [DATE], did not indicate she was on an antiplatelet. Her care plan, dated 10/10/18, indicated she took a low dose of aspirin and Plavix. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 9/24/24 at 11:17 a.m., a record review was completed for Resident 11. He had the following diagnoses which included but were not limited to ASHD, HLD, and old myocardial infarction (MI) (which is also known as a heart attack). He took aspirin 81mg daily which is an antiplatelet. His MDS, dated [DATE], indicated he took and anticoagulant instead of an antiplatelet. His care plan, dated 4/3/23, indicated he was on aspirin. 37981 5. On 9/24/24 at 1:47 p.m., Resident 33's record was reviewed. Her diagnoses included, but were not limited to, supraventricular tachycardia (irregularly fast or erratic heartbeat), chronic respiratory failure (long-term condition that occurs when the body's respiratory system can't effective function), and age-related debility (physiological decline). Her MDS assessment, dated 8/15/24, indicated she was on an anticoagulant (blood thinner). A review of her orders indicated she was not on a anticoagulant. During an interview, on 9/25/24 at 3:20 p.m., the Director of Nursing (DON) indicated Resident 33 was not on an anticoagulant for the 8/15/24 MDS. During an interview with the Regional Nurse Consultant on 9/26/24 at 10:46 a.m., she indicated there was no policy for MDS accuracy. They follow the rap instrument assessment (RAI) manual. 3.1-31(d)(3)(i)

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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. 46414 Based on record review and interview, the facility failed to add comprehensive care plans for 2 of 2 residents reviewed for comprehensive care plans (Residents 47 and 12). Findings include: 1. On 9/25/24 at 11:13 a.m., a record review was completed for Resident 47. He had the following diagnoses which included but were not limited to end stage renal disease (ESRD), dementia, hypertension (HTN), and age-related physical debility. His medical record lacked a care plan addressing his nutritional needs related to ESRD with dialysis (a treatment that removes waste and extra fluid from the blood when the kidneys are unable to do so). A care plan, dated 4/10/24, was provided by the Director of Nursing (DON) on 9/25/24 at 1:48 p.m. It indicated Resident 47 was at risk for potential complications related to dialysis, ESRD. 2. On 9/25/24 at 10:58 a.m., a record review was completed for Resident 12. She had the following diagnoses which included but were not limited to dementia, chronic kidney disease, major depressive disorder, and anxiety. She was ordered to take melatonin 3 milligrams (mg) 1 tablet by mouth one time daily with 1mg tablet to total 4 mg at bedtime (HS) for difficulty sleeping. Her difficulty sleeping and use of melatonin was not addressed on the care plan. A policy titled; Baseline Care Plan Assessment/Comprehensive Care Plans was provided by the Regional Nurse Consultant (RCS) on 9/26/24 at 9:52 a.m. It indicated, .The comprehensive care plan will be finalized within 7 days of completion of the full comprehensive minimum data set (MDS) assessments and corresponding care assessment areas (CAAs) .The comprehensive care plan will include discharge planning as related . Act .). During an interview with the DON and RCS on 9/26/24 at 11:09 a.m., they indicated the care plans were added for Residents 12 and 47. 3.1-25(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46414 Based on record reviews and interviews, the facility failed to update care plans with changes in resident care for 2 of 3 residents reviewed for care plan revision (Resident 25 and 12). Findings include: 1. On 9/25/24 at 10:45 a.m., a record review was completed for Resident 25. She had the following diagnoses which included but not limited to depressive disorder, generalized anxiety disorder, and a history of opioid abuse. She had a care plan to address the use of medications to treat behaviors, Buspar (an antianxiety), trazodone (an antidepressant), duloxetine (an antidepressant), and mirtazapine (an antidepressant). The care plan failed to address Resident 25 refused to have gradual dose reductions (GDR) per her preference. 2. On 9/25/24 at 10:58 a.m., a record review was completed for Resident 12. She had the following diagnoses which included dementia, major depressive disorder, and insomnia. She had a care plan that indicated, at risk for decline in mood related to diagnosis of major depression single episode diagnosis and she is on an antidepressant. Her medication regimen did not include an antidepressant. During an interview with the Director of Nursing (DON) and Regional Nurse Consultant (RCS) on 9/26/24 at 11:09 a.m., the DON indicated she would add a refusal care plan and update the care plans. A policy titled; Baseline Care Plan Assessment/Comprehensive Care Plans was provided by the RCS on 9/26/24 at 9:52 a.m. It indicated, .The comprehensive care plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues . 3.1-25(c)(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 38768 Based on observation, interview, and record review, the facility failed to ensure a resident (Resident 11) who experienced a fall was not moved until after a medical assessment was completed to prevent the potential for worsening any known or unknown injuries for 1of 1 of residents reviewed for accidents. Findings include: On 9/24/24 at 11:18 a.m., Resident 11's medical record was reviewed. He was a long-term care resident with diagnoses which included, but were not limited to, history of a stroke, weakness/paralysis of his left side, vascular dementia, muscle wasting and atrophy, chronic pain syndrome and wedge compression fracture of the L1 vertebra. An Interdisciplinary team (IDT) progress note, dated 1/18/24 at 12:22 p.m., indicated Resident 11 had been in transit on the facility bus to a dental appointment when he slid out of his wheelchair and landed on his butt, on the floor of the bus. At the time of his fall, he complained of pain in his left shoulder/elbow and stated he hit his head on the wheelchair. Resident 11 was assisted back into his wheelchair on the bus and returned to the facility.Upon investigation, it was noted that he was not properly secured into the bus prior to leaving facility Resident 11 received neurological checks upon his return and were within normal limits. A nursing progress note, dated 2/5/24 at 2:40 p.m., indicated two coffee ground emesis noted after eating his meals. He was assessed by the ADON and an order was given to send out to hospital for evaluation and treatment. Resident 11's corresponding Hospital Record, dated 2/5/24 at 9:42 p.m., indicated, (through a Polish translator) .patient reports that he had acute onset of nausea that started this morning and has worsened throughout the day. Is unable to eat anything due to the nausea but is willing to try taking some water. He vomited 3 times and denies blood. However, called facility in nurse related that there was concerns of coffee-ground emesis which prompted them to call EMS . per nurse that was contacted over night she reports that he was in his usual state of health prior to today. Also notes that he had a fall out of his wheelchair while on a bus to a doctor's appointment on January 19th Incidentally CT abdomen and pelvis also revealed acute to subacute compression fracture of L1 with visible lucent fracture lines and mild height loss as well as chronic rib fractures. admitted for further medical management On 9/26/24 at 11:07 a.m., the Director of Nursing (DON) provided a copy of the investigation which included but was not limited to the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON's written statement dated 1/18/24 indicated, .writer was notified upon bus return that Resident had fallen out of wheelchair during transport. Writer went out to the bus, assessed resident and ensured resident was alright. ADON [Assistant Director of Nursing] took resident into facility. Upon inspection, it was noted that resident had not been properly secured/buckled in. Writer reeducated Administrator [ADM], Bus Driver and Maintenance Director on proper securement of residents prior to transporting residents. New skill validations created that are specific to our bus and verified with all drivers by DON. All drivers to have second person (whom is verified to check off on them) verify the resident is properly secured prior to leaving the facility. Both maintenance and bus driver were educated that next time to have ADON or DON ride along and assess resident if another fall is to happen on the bus during transport The Bus Driver's witness statement dated 1/18/24 indicated, .I was driving [Resident 11] to . an appointment. I was stopped at the stop light when resident yelled out. I looked back and saw him sitting on the floor. I then immediately put on the break, assisted him back to the wheelchair and called my supervisor at 11:37 a.m. I then moved the vehicle to a parking lot adjacent to where I was at the light and waited on my supervisor to arrive. My supervisor arrived, spoke with resident and told me to bring resident back to facility. Once back at the facility I was met by DON, ADON and Administrator The Maintenance Director's witness statement dated 1/18/24 indicated, .At 11:37 a.m., I received a phone call from [Bus Driver] requesting me to get to his location because a resident had fallen on the bus. I arrived to [Bus Driver] at approximately 11:40 a.m., and got on to the bus and asked resident if he was alright. He stated his head hurt. I then directed [Bus Driver] to get resident back to facility. I returned to facility and notified DON, ADON and ADM During an interview on 9/26/24 at 10:05 a.m., the Maintenance Director indicated, he received a call from the Bus Driver and was told that Resident 11 had fallen out of his wheelchair. The Maintenance Director immediately left the facility to meet the Bus Driver. When the Maintenance Director got to the bus, (which was less than a mile away from the facility at the time of the accident) he found Resident 11 on the floor of the bus. The Maintenance Director indicated, he and the Bus Driver picked Resident 11 up, under the arms, and assisted him back into the wheelchair. The Maintenance Director indicated he did not remember if the resident complained of pain or not, but they immediately brought him back to the facility. On 9/26/24 at 10:42 a.m., the facility bus was observed with RC 8, the DON, ADON, Maintenance Director and current facility bus driver present. The DON indicated, and demonstrated how she was told Resident 11 landed on his bottom. He slid from the chair and was fully seated on his bottom on the floor of the bus with his back against the wheelchair. During an interview on 9/26/24 at 11:00 a.m., the DON indicated, the Bus Driver and Maintenance Director should not have moved Resident 11 until after he had been assessed by a medical professional because it could cause or worsen any known or unknown injuries he may have sustained. The Bus Driver and Maintenance Director should have called the DON before moving the resident to determine if 911 should be called, or if she and/or the ADON should go and meet the bus and sit with the Resident upon his return. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/24 at 12:55 p.m., the DON provided a copy of current facility policy titled, Guidelines for Incident/Accidents/Falls, dated 6/30/23. The policy indicated, .It is the policy of the facility to ensure that any incident/accident to include falls is reported immediately to the nurse or appropriate person designated to be in charge. After the resident has had immediate attention and their safety is established, a report will be entered . if a resident is involved in an incident/accident an immediate assessment of the resident will be completed by a nurse. First aid will be provided as necessary. Note: Whether or not the resident can be moved or repositioned will be determined by the assessing nurse 3.1-37(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 38768 Based on observation, interview, and record review, the facility failed to ensure a resident, (Resident 35) received treatments and services to prevent the worsening of contracture in her hand and wrist for 1 of 1 residents reviewed for range of motion. Findings include: On 9/23/24 at11:32 a.m., Resident 35 was initially observed. The fingers of her right hand were contracted into a fist, and her wrist was contracted upward at a slight angle. There was no splint or palm protector observed in her room at that time. On 9/24/24 at 9:36 a.m., Resident 35 was observed. She did not have a palm protector in place. On 9/24/24 at 2:03 p.m., Resident 35 was observed. She did not have a palm protector in place. On 9/24/24 at 2:10 p.m., Resident 35's medical record was reviewed. She was a long-term care resident who resided on the secured memory care unit and had diagnoses which included, but were not limited to, dementia, muscle weakness, and contracture of her left hand. An Occupational Therapy (OT) referral summary, dated 5/9/24, indicated, Resident 35 had been referred for therapy services due to increased contractures in both hands with exacerbation of/and decrease in range of motion, decrease in skin integrity and joint instability. On 7/16/24 Resident 35 met her therapy goals and was discharged with the following summary, .discussed discharge with Interdisciplinary team and patient. Recommendations: continued assistance with hand hygiene. Passive Range of Motion [PROM], and palm protector wear time to prevent skin breakdown and increase joint mobility . Resident 35's record lacked documentation of PROM services. Resident 35's record lacked documentation of order to wear a palm protector. Resident 35's comprehensive care plan lacked documentation/revision to receive PROM or wear a palm protector to help prevent the worsening of her contractures. On 9/25/24 at 2:53 p.m., Resident 35 was observed with the Director of Rehab (DOR) and an OT assistant. The DOR indicated, Resident 35 had completed therapy after meeting a goal of decreasing the degree of her contracture to 20 degrees. With the OT Assistant's help, the DOR measured the angle of Resident 35's contracture, and indicated it had increased by 3 degrees to 23 degrees. The DOR indicated, the increase was not enough to warrant a new referral to therapy, but she should have been receiving PROM to help prevent the contracture from worsening and she should wear her palm protector since her fingers contracted into her palms and could cause skin breakdown. (continued on next page)

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	155717	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/24 at 11:40 a.m., The Director of Nursing (DON) indicated, there was no policy for Range of Motion treatments and services, but the DON would want nursing staff to follow therapy recommendations.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38768 Based on observation, interview, and record review, the facility failed to prevent the potential for accidents when transportation staff were not trained on new bus equipment and failed to install a safety lap belt, which resulted in actual harm when a resident slid out from his wheelchair on the bus and sustained a L1 vertebra fracture with a 20% height loss for 1 of 2 residents reviewed for falls (Resident 11). The deficient practice was corrected by 1/18/24 prior to the start of the survey and was therefore Past Noncompliance. Findings include: On 9/24/24 at 11:18 a.m., Resident 11's medical record was reviewed. He had diagnoses which included, but were not limited to, history of a stroke, weakness/paralysis of his left side, vascular dementia, muscle wasting and atrophy, chronic pain syndrome and wedge compression fracture of the L1 vertebra. An Interdisciplinary team (IDT) progress note, dated 1/18/24 at 12:22 p.m., indicated, Resident 11 had been in transit on the facility bus to a dental appointment when he slid out of his wheelchair and landed on his butt, on the floor of the bus. At the time of his fall, he complained of pain in his left shoulder/elbow and stated he hit his head on the wheelchair. Resident 11 was assisted back into his wheelchair on the bus and returned to the facility.Upon investigation, it was noted that he was not properly secured into the bus prior to leaving facility A nursing progress note, dated 1/22/24 at 3:28 p.m., indicated, .He complains that pain is worse in left knee since his fall on 1/19/24. X-rays were ordered of left elbow and left knee last week. Staff have no other complaints for him today. Assessment: He has a history of left sided hemiplegia and hemiparesis along with osteoarthritis resulting in chronic pain. He takes Percocet, acetaminophen, and Lyrica for pain relief. Recent x-ray of left elbow was negative for acute injury but did show osteoarthritis. A x-ray of right knee was completed with no acute injury noted. Reordered left knee x-ray today STAT A nursing progress note, dated 1/23/24 at 8:39 a.m., indicated Resident 11's left knee x-ray results were reviewed with no acute findings. A nursing progress not, dated 2/5/24 at 2:40 p.m., indicated two coffee ground emesis noted after eating his meals. He was assessed by the ADON and an order was given to send out to hospital for evaluation and treatment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 11's corresponding Hospital Record, dated 2/5/24 at 9:42 p.m., indicated, (through a translator) . patient reports that he had acute onset of nausea that started this morning and has worsened throughout the day. Is unable to eat anything due to the nausea but is willing to try taking some water. He vomited 3 times and denies blood. However, called facility in nurse related that there was concerns of coffee-ground emesis which prompted them to call EMS . per nurse that was contacted over night she reports that he was in his usual state of health prior to today. Also notes that he had a fall out of his wheelchair while on a bus to a doctor's appointment on January 19th Incidentally CT abdomen and pelvis also revealed acute to subacute compression fracture of L1 with visible lucent fracture lines and mild height loss as well as chronic rib fractures. admitted for further medical management On 9/26/24 at 11:07 a.m., the Director of Nursing (DON) provided a copy of the investigation which included but was not limited to the following: The DON's written statement, dated 1/18/24, indicated, .writer was notified upon bus return that Resident had fallen out of wheelchair during transport. Writer went out to the bus, assessed resident and ensured resident was alright. ADON [Assistant Director of Nursing] took resident into facility. Upon inspection, it was noted that resident had not been properly secured/buckled in. Writer reeducated Administrator [ADM], Bus Driver and Maintenance Director on proper securement of residents prior to transporting residents. New skill validations created that are specific to our bus and verified with all drivers by DON. All drivers to have second person (whom is verified to check off on them) verify the resident is properly secured prior to leaving the facility. Both maintenance and bus driver were educated that next time to have ADON or DON ride along and assess resident if another fall is to happen on the bus during transport The Bus Driver's witness statement, dated 1/18/24, indicated, .I was driving [Resident 11] to . an appointment. I was stopped at the stop light when resident yelled out. I looked back and saw him sitting on the floor. I then immediately put on the brake, assisted him back to the wheelchair and called my supervisor at 11:37 a.m. I then moved the vehicle to a parking lot adjacent to where I was at the light and waited on my supervisor to arrive. My supervisor arrived, spoke with resident and told me to bring resident back to facility. Once back at the facility I was met by DON, ADON, and Administrator The Maintenance Director 's witness statement dated 1/18/24 indicated, .At 11:37 a.m., I received a phone call from [Bus Driver] requesting me to get to his location because a resident had fallen on the bus. I arrived to [Bus Driver] at approximately 11:40 a.m., and got on to the bus and asked resident if he was alright. He stated his head hurt. I then directed [Bus Driver] to get resident back to facility. I returned to facility and notified DON, ADON and ADM On 9/26/24 at 11:55 a.m., the Bus Driver and Maintenance Directors employee files were reviewed. The Bus Driver's file lacked documentation of job-specific orientation and/or training/education for transportation via facility bus. During an interview on 9/26/24 at 9:56 a.m., Regional Consultant (RC) 8 indicated, job-specific and/or training for the facility bus and transportation safety was not found in the employee files. The new facility bus was delivered on 1/3/24 by a dealership associate who reviewed basic functions with the Administrator and RC 8 at the time of delivery. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/26/24 at 10:42 a.m., the facility bus was observed with RC 8, the DON, ADON, Maintenance Director (MD) and current facility bus driver present. The DON indicated, after Resident 11's she was called to the bus where she and the ADON assessed him. The ADON assisted the Resident back inside while the DON investigated how he slid out of the wheelchair. The DON indicated, the lap-belt was found still in its original packaging, inside a covered storage bin located behind the last seat of the bus. The DON indicated the cross-belt was used to secure the resident but had been buckled into the adjacent seat's clip, across the aisle which was incorrect. During an interview on 9/26/24 at 11:00 a.m., the DON indicated she pulled the buses safety card and created a full and detailed skills validation and training checklist which she had the bus driver, MD and Administrator complete on 1/18/24. On 9/26/24 at 12:55 p.m., the DON provided a copy of current, but undated facility policy, which had been signed by the Bus Driver and MD as documentation of education on the use of seat belts. The policy was titled, Use of Seat Belts, and indicated, .transport driver and passengers must wear safety seat belts at all times during transport . place seatbelt around resident's lap area and lock The deficient practice was corrected by 1/18/24 prior to the start of the survey and was therefore Past Noncompliance. The facility implemented a systemic plan that included staff education, skills validation and ongoing monitoring was put in place. 3.1-45(a)

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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. 46414 Based on record review and interview, the facility failed to obtain a resident's blood pressure and pulse prior to administering metoprolol (an antihypertensive medication) as ordered for 1 of 6 residents reviewed for medications(Resident 14). Findings include: On 9/24/24 at 2:19 p.m., a record review was completed for Resident 14. She had the following diagnoses which included but were not limited to hypertension (HTN). She was prescribed a medication, metoprolol (a medication used to treat hypertension). The order was to take 25 milligrams (mg), give 1 tablet by mouth two times daily for HTN, hold for systolic blood pressure less than 100 or pulse less than 60. The medication administration record (MAR) for August 2024 and September 2024 were reviewed and they lacked documentation of a blood pressure and pulse prior to administering the medication, metoprolol. Resident 14 had a care plan that indicated she had HTN dated 7/12/24. The goal, dated 10/30/24, indicated her blood pressure would remain stable through the next review. An intervention, dated 11/7/22, indicated to administer the medication as ordered and to monitor her blood pressure per Medical Doctor (MD) order or facility policy. During an interview with the Director of Nursing (DON) and Regional Nurse Consultant (RCS) on 9/26/24 at 11:09 a.m., the DON indicated she completed an audit on residents with metoprolol orders and added the parameters to each order as needed. A policy titled, Drug Administration-General Guidelines, was provided by the RCS on 9/26/24 at 10:24 a.m. It indicated, .When a medication administration is dependent upon vital sign measures, this monitoring should be performed before the administration of the prescribed medication. The vital signs are recorded per facility policy . 3.1-48(a)(1) 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5) 3.1-48(a)(6)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 38768 Based on interview and record review, the facility failed to ensure a pharmacy recommendations to reduce an psychotropic medications were declined with adequate documentation of symptoms for 2 of 5 residents reviewed for unnecessary medications (Residents 34 and 9). Findings include: 1. On 9/24/24 at 1:20 p.m., Resident 34's medical record was reviewed. She was a long-term care resident who resided on the secured memory care with diagnoses which included, but were not limited to, dementia, schizoaffective disorder, bipolar type and anxiety. A pharmacy recommendation, dated 1/3/24, indicated Resident 34 was scheduled for a trail reduction of an antianxiety medication. The doctor declined the recommendation and indicated Resident 34 was symptomatic. Resident 34's December 2023 and January 2024 behavior monitoring was reviewed. There were not documented days of symptoms. Resident 34's nursing progress notes lacked documentation of symptoms. Resident 34's record lacked documentation of symptoms. During an interview on 9/26/24 at 11:40 a.m., the Director of Nursing (DON) indicated that Resident 34 had a medication adjustment in October when her Sertraline (an anti-depressant which is also used to treat anxiety) had been increased. There were no symptoms of increased or worsening anxiety and the recommendation should have been accepted or a different reason for declining the recommendation should have been offered. 46414 2. On 9/25/24 at 9:53 a.m., a record review was completed for Resident 9. She had the following diagnoses which included but were not limited to schizoaffective disorder, bipolar type, delusional disorder, major depressive disorder, and adult failure to thrive. She was prescribed sertraline (an antidepressant) 25 mg daily, clonazepam 0.5 mg every Wednesday for anxiety (anxiolytic), and Geodon (an antipsychotic) 40 mg at bedtime. Several recommendations were made by the Pharmacist to attempt a reduction (gradual dose reduction (GDR) in these medications but the request was declined indicating resident remained symptomatic and a reduction in dose was likely to induce behaviors that would cause danger to the patient and or to others. Resident 9's medical record lacked any documentation of the monitoring of behaviors on a daily basis. Resident 9's record lacked documentation of behaviors. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She had a care plan dated 6/3/20 that indicated she has bipolar disorder, current episode depressed severe with psychotic features as well as major depressive disorder. She sometimes gets sad and maybe once in a while tearful and indicated she does not know why. She becomes hostile when she misses Electroconvulsive therapy (ECT) (is a medical treatment that can be used to treat depression when other treatments have been unsuccessful). The goal dated 6/3/20 indicated she would report no problems with her mood through the next review. Another care plan dated 6/3/20 indicated she had a diagnosis of schizophrenia, paranoia and delusional disorder. The goal dated 6/3/20 indicated she would be observed for signs and symptoms of schizophrenia and delusions through the next review. The care plans lacked non-pharmacological interventions to address any of the care plans behaviors identified. On 9/26/24 at 11:09 a.m., during an interview with the Director of Nursing (DON) and Regional Nurse Consultant (RCS) they indicated they were going on their third psychiatric provider. They had a new one starting for the facility. The DON indicated they need detailed reasons why they were not doing a GDR. They added behavior monitoring to the resident's medical record. A policy titled; Guidelines for Psychotropic Medication, was provided by the DON on 9/26/24 at 12:58 p.m. It indicated, .Based upon individual assessment, determine non-pharmacological interventions that can be implemented prior to the use of psychotropic medications. Identify non-pharmacological interventions that can be utilized to use the lowest possible dose and to work in conjunction with the goal of reduction and/or discontinuation. Documentation will reflect attempts to implement care planned, non-pharmacological interventions/approaches and ongoing effectiveness of these interventions .Ongoing documentation must include the root cause analysis of behavioral indicators or symptoms, monitoring for efficacy/effectiveness and adverse consequences . Identified target behaviors for each resident will be monitored each shift along with individualized interventions as well as supporting documentation in the medical record . The goals of psychotropic medication and non-pharamcological approaches/interventions will be addressed in the resident's care plan . 3.1-48(b)

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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. 46414 Based on observation and interview, the facility failed to date medications when opened for 1 of 3 medication carts reviewed (medication cart 300) and 1 of 3 treatment carts (treatment cart 3). Findings include: 1. On 9/23/24 at 10:21 a.m., the 300-hall treatment cart was observed with Qualified Medication Assistant (QMA) 13. Resident 5 had a Lantus pen (insulin, used to treat diabetes) in the treatment cart. It lacked a date to indicate when it was opened. Resident 36 had a Humalog pen (insulin) in the treatment cart. It lacked a date to indicate when it was opened. 2. On 9/23/24 at 10:32 a.m., the 300-hall medication was observed with QMA 13. It contained Resident 5's flonase (used for allergies) in the cart with no date to indicate when it was opened. Resident 21 had a bottle of ear drops in the cart. It lacked a date to indicate when it was opened. A policy titled; Medication Storage in the Facility was provided by the Regional Nurse Consultant (RCS) on 9/26/24 at 9:53 a.m. It lacked information regarding the dating of medications when opened. The RCS indicated this was the only policy she could find. 3.1-25(j) 3.1-25(m) 3.1-25(n)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. 37981 Based on observation, interview, and record review the facility failed to ensure an x-ray was completed for 1 of 1 resident reviewed for x-rays (Resident 33). Findings include: On 9/24/24 at 1:47 p.m., Resident 33's record was reviewed. Her diagnoses included, but were not limited to, supraventricular tachycardia (irregularly fast or erratic heartbeat), chronic respiratory failure (long-term condition that occurs when the body's respiratory system can't effective function), and age-related debility (physiological decline). A Nurse Practitioner (NP) progress note, dated 9/21/24 at 12:00 p.m., indicated Resident 33 complained of left (L) mid-foot pain. She believed it got tangled in the Hoyer lift pad. He ordered 3 view x-ray of her left foot to rule out acute injury, reduced mobility, and acetaminophen extra strength 500 mg. Staff to administer 2 capsules by mouth every 6 hours for pain. Resident 33 indicated the pain was 10 out of 10 when pressure was applied. At other times, the pain was 2-3. A further review of Resident 33's record showed no x-ray results for her left foot. During an interview, on 9/25/24 at 10:54 a.m., Resident 33 indicated her left foot was still sore and could not push herself up in bed. No one had x-rayed her left foot yet. She believed her left foot was hurt by pushing on the box on the Hoyer lift. During an interview, on 9/26/24 at 10:31 a.m., the Director of Nursing (DON) indicated Resident 33 received the left foot x-rays last night. A current policy titled, Guidelines for Observing and Implementing - Resident Rights, dated 7/12/23, was provided by Regional Consultant 9. A review of the policy indicated, .Resident are to have their well-being and self-esteem and self-worth enhanced during all care and services interactions .Care for each resident in a manner and environment that promotes the maintenance of/or enhances the resident's quality of life 3.1-49(g)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46414 Based on observation and interview, the facility failed to properly sanitize a blood glucometer meter for 1 of 5 glucometer meter (Resident 103) stored on the treatment cart. Findings include: On 9/25/24 at 11:34 a.m., LPN 12 performed a blood sugar for Resident 103. The machine was on top of the cart before the procedure. LPN 12 indicated the machine was clean from the use before. She proceeded to complete the blood sugar for Resident 103 as ordered. Upon completion, she took a Sani-wipe and wiped the monitor and sat on a Kleenex for it to dry. When she was asked about how long the machine needs to sit to dry, she responded that it would sit for 5 minutes before she put the machine back into its box. A policy titled Policy and Procedure, Cleaning/Disinfecting/Maintaining Glucose Meters was provided by the Director of Nursing (DON) on 9/25/24 at 12:01 p.m. It indicated, .3. Open the towelette or package and remove one towelette, 4. Wipe the entire surface or the meter 3 times horizontally and 3 times vertically using one towelette to clean blood and other body fluids, 5. Dispose of the towelette, 6. Obtain a second towelette and wipe the entire surface of the meter 3 times horizontally and 3 times vertically to remove blood and blood borne pathogens. The meter must be maintained wet for 2 minutes with Super Sani cloth wipe. When utilizing any other type of sanitizing (bleach) wipe, the meter must be maintained wet per towelette manufacturer's recommendation. A 1/10 bleach solution requires a 10-minute contact time. When glucometers are being discontinued from isolation, the glucometer is to be discarded in biohazard . 3.1-18(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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37981 Based on interview and record review, the facility failed to ensure the influenza vaccination was offered and the pneumonia and COVID-19 vaccinations were completed for a resident who requested them for 1 of 5 residents reviewed for vaccinations (Resident 102). Findings include: On 9/26/24 at 11:15 a.m., Resident 102's record was reviewed. His diagnoses included, but were not limited to, diabetes mellitus (DM) (blood sugar disorder), chronic kidney disease (long-term kidney disease), and chronic hepatitis (long-term liver infection). His immunizations were reviewed in his electronic medical record. The areas for influenza, pneumonia, and COVID-19 immunizations were blank. On 9/25/24 at 1:41 p.m., Resident 102's influenza, pneumonia, and COVID-19 immunization records were requested from the Infection Preventionist (IP) /Assistant director of Nursing (ADON). On 9/25/24 at 2:56 p.m., Resident 102's influenza, pneumonia, and COVID-19 immunization records were requested from the IP/ADON. The DON provided Resident 102's signed consent to receive the pneumococcal vaccination and the COVID-19 vaccine, both dated 9/6/24. The pneumonia vaccination consent document was also signed by the IP/ADON. No document was provided for acceptance or declination of the influenza vaccine. During an interview, on 9/26/24 at 10:53 a.m., the DON indicated Resident 102 did not get his pneumonia vaccination according to his wishes, on admission because the pneumonia vaccination was not in yet. She preferred to do all the immunization, during a clinic, at the same time, for residents who wanted to them. A CDC (Center of Disease Control and Prevention) Vaccination Information sheet, titled, Influenza (Flu) Vaccine (Live, Intranasal): What You Need to Know, dated 8/6/21, was provided with the admission agreement. A review of the document indicated, .CDC recommends everyone 6 months and older get vaccinated every flu season A CDC Vaccination Information sheet, titled, Pneumococcal Polysaccharide Vaccination (PPSV23): What You Need to Know, dated 10/13/2019, was provided with the admission agreement. A review of the document indicated, .PPSV23 is recommended for all adults [AGE] years or older : A CDC Vaccination Information sheet, titled, Pneumococcal Conjugate Vaccine: What You Need to Know, dated 2/4/2022, was provided with the admission agreement. A review of the document indicated, .Adults [AGE] years of older .should received either: a single dose of PCV 15 followed by a dose of PPSV23, or a single dose of PCV20 (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	09/26/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A CDC Vaccination Information sheet, titled, Myths and Facts about Covid-19 Vaccines, dated 7/20/2022, was provided with the admission agreement. A review of the document indicated, .Getting a Covid-19 vaccination is a safer and more dependable way to build immunity to Covid-19 than getting sick with Covid-19 .causes a more predictable immune response that infection with the virus that causes Covid-19,,,, 3.1-13(a)