STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155823	A. BUILDING 00 B. WING	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHPOINTE HEALTHCARE CENTER	4904 WAR ADMIRAL DRIVE INDIANAPOLIS, IN 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00395121, IN00392037, IN00396490, and IN00396733. Complaint IN00395121 - Unsubstantiated due to lack of evidence. Complaint IN00392037 - Unsubstantiated due to lack of evidence. Complaint IN00396490 - Unsubstantiated due to lack of evidence. Complaint IN00396733 - Unsubstantiated due to lack of evidence. Survey dates: December 13, 14, 15, 16, 19, and 20, 2022 Facility number: 013126 Provider number: 155823 AIM number: 300029591 Census Bed Type: SNF/NF: 94 Total: 94 Census Payor Type: Medicare: 16 Medicaid: 56 Other: 22 Total: 94 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

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

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	Quality review completed December 27, 2022.			
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure administered medications were confirmed to have been taken for 1 of 3 randomly observed cognitively intact residents, reviewed for medication administration. (Resident 69) Findings include: On 12/13/22 at 2:43 p.m., Resident 69 was observed resting in bed. On the over the bed table, located next to the resident's bed and within reach of the resident, a white tablet (medication/pill) was observed. The tablet was approximately one-half inch in length, one-quarter inch wide, and one-eight inch thick. Printed on the tablet was the number 93. No staff were visible at that time. During an interview at that time, Resident 69 indicated the white tablet had been on the over the bed table for "the past day or two." Resident 69 indicated he was unsure what the medication was or why it had been prescribed. On 12/13/22 at 3:00 p.m., RN 5 entered Resident 69's room. During an interview at that time, RN 5 indicated she was not sure what the white tablet was or why it had been prescribed. RN 5	F 0658	Preparation or execution of this plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth on this statement of deficiencies. The plan of correction is prepared and executed solely because it's required by the position of federal and state law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during a recertification survey on November 22, 2021. Please accept this plan of correction as the provider's credible allegation of compliance. **F658 D** **Corrective action for the residents found to have been affected by the deficient practice:** Resident 69 was immediately assessed for increased signs and symptoms of infection. Vitals complete with no abnormal findings. MD made aware with no	12/27/2022

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	indicated medications were not to be left in a resident's room. Staff were to administer medications and verify the medication had been consumed by the resident before leaving the resident's room. RN 5 retrieved the white tablet from the over the bed table, exited Resident 69's room and went to the medication cart. RN 5 indicated the white tablet was Resident 69's prescribed Amox-K clav (Augmentin, an antibiotic used for respiratory infections) 875/125 mg (milligram) tablet. RN 5 indicated Resident 69 was prescribed the Augmentin for seven days, starting on 12/8/22, and was to be administered every twelve hours. On 12/15/22 at 2:15 p.m., Resident 69's clinical record was reviewed. The diagnoses included, but were not limited to, pneumonia, acute and chronic respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions), and chronic obstructive pulmonary disease. The Quarterly MDS (Minimum Data Set) assessment, dated 11/1/22, indicated Resident 69 was cognitively intact. A Post-Acute Care Note, signed by the MD/NP (Medical Doctor/Nurse Practitioner) on 12/8/22, indicated Resident 69 had pneumonia and was prescribed "Augmentin 875/125 mg. PO BID [by mouth two times per day] for 7 days." Physician Orders, as identified on the December 2022 Medication Administration Record (MAR) document indicated, "Augmentin oral tablet 875-125 mg, give one tablet by mouth every morning and at bedtime for pneumonia for seven days." The MAR indicated the medication had been administered to Resident 69 at bedtime on		new orders. Medication administration record audited for resident and found to have all doses of ordered ABT medication signed off as administered per MAR. Residents ABT medication cartridge was counted and found to not have any doses over or under amount per length of ABT therapy. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who receive oral medications have the potential to be affected by this alleged deficient practice. A whole house audit was conducted for all residents who receive oral medications to ensure no medications were left at beside. Any deficiencies in correct practice were immediately corrected and MD and RP made aware and appropriate action take per MD order upon notification. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated Licensed Nursing Staff and QMA's on facilities "Medication Administration" policy with emphasis on ensuring medications are administered per MD ordered with licensed nurse	

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	12/8/22; in the morning and at bedtime daily from 12/9/22 to 12/14/22; and in the morning on 12/15/22. During an interview on 12/19/22 at 3:15 p.m., the DNS (Director of Nursing Services) indicated the nursing staff were to ensure prescribed medications were administered as directed by the physician. Medications were not to be left at the resident's bedside. On 12/16/22 at 10:35 a.m., the Director of Nursing Services provided a copy of the Policies and Standard Procedures: Medication Administration policy, dated 2013, and indicated it was the current policy in use by the facility. A review of the policy indicated, " ...Do not leave medication at bedside ..." 3.1-35(g)(1)		staff or QMA present and not leaving medications at bedside at any time. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON and/or Designee will audit 5 resident's daily x's 4 weeks, then 5 resident's weekly x's 4 weeks, then 5 resident's monthly x's 4 months to ensure residents ordered oral medications were not left at bedside and administered per MD order. The DON and/or Designee will audit through observation 1 Licensed nurse or QMA daily for 4 weeks, then 1 Licensed nurse or QMA weekly for 4 weeks, then one Licensed nurse monthly x's 4 months to ensure adherence to "Medication Administration" policy during medication pass and not leaving medication at bedside. The DON and/or Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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F 0814 SS=C Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure the dumpster area was kept clean for 4 of 4 dumpster area observations. Trash bags were not tied, debris was on the ground, the dumpster side panel doors were not closed, and broken furniture was left on the ground. Findings include: 1. On 12/13/22 from 11:10 a.m. to 11:15 a.m., during the initial kitchen tour with the Dietary Manager (DM), the dumpster area, located approximately 30 yards from the kitchen's rear exit door, the following was observed: a. One of the two dumpster sliding side panel doors was observed to not be closed. Inside the dumpster container were multiple filled trash bags. b. One large wooden broken piece of furniture, located on the ground behind the dumpster container, was observed. No staff were visible in the area during that time. During an interview at that time, the DM indicated the sliding side panel door was to be kept closed and the dumpster area was to be kept free from trash and debris. 2. On 12/16/22 from 9:20 a.m. to 9:25 a.m., during a follow up observation of the dumpster area with Dietary Aide 2, the following was observed:	F 0814	Preparation or execution of this plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth on this statement of deficiencies. The plan of correction is prepared and executed solely because it's required by the position of federal and state law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during a recertification survey on November 22, 2021. Please accept this plan of correction as the provider's credible allegation of compliance. **F 814 SS C** Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) **Corrective action for the residents found to have been affected by the deficient practice:** Staff In-serviced on the requirements of refuse, recycle and properly securing all refuse bins. **Corrective actions to be monitored to ensure the deficient practice will not recur:** Maintenance Manager or designee	12/27/2022

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	a. One large 55 gallon wheeled plastic trash can, lined with an interior plastic bag, was observed approximately 10 feet from the dumpster container. The trash can lacked a lid and the interior plastic bag was observed to not be tied. The interior plastic bag was observed to be full of garbage including, but was not limited to, corn and other un-identifiable foods. b. One of the two dumpster sliding side panel doors was observed to not be closed. Inside the dumpster container were multiple filled trash bags. c. One large wooden broken piece of furniture, located on the ground behind the dumpster container, was observed. d. Behind the dumpster and between the broken furniture, one large plastic trash bag filled with opened soda pop cans, used incontinence briefs, and other un-identifiable medical supplies were visible. No staff were visible in the area during that time. During an interview at that time, Dietary Aide 2 indicated all trash was to be put inside the dumpster container; the dumpster lids and doors were to be kept closed; and the wheeled trash can that was filled with food and other garbage "the untied trash bag may have been there since the previous afternoon [12/15/22]." 3. On 12/16/22 from 4:30 p.m. to 4:35 p.m., during a follow up dumpster area observation, the following was observed: a. One large 55 gallon wheeled plastic trash can, lined with an interior plastic bag, was observed approximately 10 feet from the dumpster container.		will check the refuse area daily to ensure compliance with 483.60(i)(4) and Retail Food Establishment Sanitation Requirements - Title 410 IAC 7-24. ED or designee will do weekly audits for 3 months to ensure refuse area is within regulation(s)	

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	The trash can lacked a lid and the interior plastic bag was observed to not be tied. The interior plastic bag was observed to be full of garbage including, but was not limited to, corn and other un-identifiable foods. b. One large wooden broken piece of furniture, located on the ground behind the dumpster container, was observed. No staff were visible in the area during that time. 4. On 12/19/22 from 9:10 a.m. to 9:15 a.m., during a follow up observation of the dumpster area with Dietary Aide 6, the following was observed: a. One of the two the dumpster sliding side panel doors was observed to not be closed. Inside the dumpster container were multiple filled trash bags. b. One large wooden broken piece of furniture, located on the ground behind the dumpster container, was observed. c. Behind the dumpster and between the broken furniture and on two other sides of the dumpster container were multiple large plastic trash bags filled with used incontinence briefs and other un-identifiable medical supplies and foods were visible. d. Two large 55 gallon wheeled plastic trash cans were observed approximately 10 feet from the dumpster container. The trash cans lacked a lid and both cans contained multiple filled plastic bags. Both trash cans had full plastic trash bags hanging over and outside of the container. The closed plastic bags contained trash, debris and unidentifiable medical supplies and foods products.			

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	e. On the ground surrounding the dumpster container the following was observed: multiple plastic gloves, lids and utensils; a large metal lid; one cinnamon roll; an opened quart jug of milk; and noodles and other unidentifiable foods. No staff were visible in the area during that time. During an interview at that time, Dietary Aide 6 indicated the dumpster area was to be kept clean and free of trash and debris. During an interview on 12/16/22 at 3:09 p.m., the ADM indicated the facility did not have a specific trash dumpster policy. The facility followed the local, state, and federal requirements. The trash dumpster area was to be kept free of debris, trash bags were to be tied and all trash was to be placed into the dumpster container. The ADM indicated the untied trash bag that contained food and other garbage may have been at the dumpster area "since earlier in the day [12/16/22]." On 12/16/22 at 3:17 p.m., a review of the Retail Food Establishment Sanitation Requirements - Title 410 IAC 7-24, effective November 13, 2004, indicated, "...receptacles and waste handling units for refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside..." 3.1-21(i)(2) 3.1-21(i)(5)			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must			

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	develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's			

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	representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on interview and record review, the facility failed to follow vaccination guidelines for the administration of the influenza vaccination for 3 of 7 residents reviewed for vaccinations. The influenza vaccine consent form was not offered at admission and the vaccinations were not administered. (Resident 8, Resident 11, and Resident 27) Findings include: 1. On 12/13/22 at 12:17 p.m., Resident 27's clinical record was reviewed. Resident 27's immunization record indicated "immunization requested" under the influenza section. The record lacked a current influenza vaccination. Resident 27 had an admission date of 8/30/22. 2. On 12/13/22 at 1:15 p.m., Resident 11's clinical record was reviewed. Resident 11's immunization record indicated "immunization requested" under the influenza section. The record lacked a current influenza vaccination. Resident 11 had an admission date of 10/1/22. 3. On 12/13/22 at 1:30 p.m., Resident 8's clinical record was reviewed. Resident 8's immunization	F 0883	Preparation or execution of this plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth on this statement of deficiencies. The plan of correction is prepared and executed solely because it's required by the position of federal and state law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during a recertification survey on November 22, 2021. Please accept this plan of correction as the provider's credible allegation of compliance. **F883D** **Corrective action for the residents found to have been affected by the deficient practice:** Residents 8, 11, 27 were immediately offered flu vaccination	12/27/2022

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	record indicated "immunization requested" under the influenza section. The record lacked a current influenza vaccination. Resident 8 had an admission date of 11/4/22. On 12/15/22 at 2:15 p.m., the DON (Director of Nursing) provided influenza consent forms for Resident 8, Resident 11, and Resident 27. The three forms indicated that the resident or their representative had each provided verbal consent to receive the influenza vaccination and were each dated for 12/14/20. On each form, the month and day were handwritten, and the year was a part of the typed form. During an interview on 12/19/22 at 1:15 p.m., the DON indicated that the three provided influenza forms for Resident 8, Resident 11, and Resident 27 were each supposed to be dated for 12/14/22. She indicated that the forms had a typing error and that the consents were obtained on December 14 of the current year (2022). During an interview on 12/20/22 at 10:00 a.m., the DON indicated that the influenza consent forms for Resident 8, Resident 11, and Resident 27 should have been offered upon admission and that they should have received their influenza vaccinations. On 12/16/22 at 10:35 a.m., the DON provided a copy of the facility policy titled, "Resident Influenza Vaccine", dated as revised for 1/14/21, and indicated it was the policy currently in use. A review of the policy indicated under the influenza season heading, "The CDC [Center for Disease Control and Prevention] notes that influenza virus is with peak activity in the United States between December and March. For the purpose of this policy, the Influenza Season is considered		upon discovery of alleged deficient practice. Each resident that consented had vaccination consent form signed and were administered flu shot per MD order and medical record updated to reflected administration. Any resident that declined had vaccination declination form signed and medical record updated to reflect declination. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who are eligible to receive the influenza vaccine upon admission have the potential to be affected by this alleged deficient practice. An audit was conducted for the last 30 days on all recent admissions to ensure influenza vaccinations were offered upon admission. Those found to be out of compliance had vaccination offered, and based on consent had vaccine administered per MD order and medical record update to reflect administration. Those offered and declined had medical record updated to reflect declination. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated Licensed Nursing Staff on facilities policy	

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	October 1 through March 31." The policy also indicated, "1. New admission residents will be offered the education and influenza vaccine upon admission in the event admission occurs during the influenza season, October 1 through March 31." 3.1-13(a)		"Resident Influenza Vaccine" with emphasis on offering of influenza vaccine upon admission to facility. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON and/or Designee will audit 5 new admissions daily x 4 weeks, then 5 new admissions weekly x 4 weeks, then 5 new admissions monthly x 4 months to ensure residents were offered influenza vaccination upon admission. The DON and/or Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	