

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 155717	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/01/2020
NAME OF PROVIDER OF SUPPLIER ALPHA HOME - A WATERS COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP 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 0558 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident had access to their call light for 1 of 3 residents reviewed for accommodation of needs (Resident B). Findings include: On 5/29/20 at 12:44 p.m., Resident B was observed lying in bed. The call light was not within her reach. The call light was observed, plugged into the wall, across the room from the bed, and not able to reach the bed. Resident B's record was reviewed on 5/29/20 at 12:14 p.m. The resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. A nursing admission assessment, dated 3/21/20, indicated the resident verbalized and demonstrated the ability to use the call light. An admission Minimum Data Set (MDS) assessment, dated 3/31/20, indicated the resident had a severe cognitive impairment and required extensive assistance with activities of daily living (ADL's). During an interview, on 5/29/20 at 12:45 p.m., Certified Nursing Assistant (CNA) 6 indicated Resident B's bed had been moved across the room, to be in view of the window. She was not sure when the bed was moved. The call light had not reached the bed since it was moved. She was not sure if a touch pad call light had been tried with the resident. An extension for the call light cord was not provided. The call light should have reached the resident's bed. During an interview, on 6/1/20 at 10:57 a.m., the Administrator indicated the resident's bed was moved to the window area on 4/30/20. Prior to the bed being moved, the call light was within the resident's reach. On 6/1/20 at 10:58 a.m., the Administrator provided a document titled, CALL LIGHTS, and indicated it was the policy currently being used by the facility. The policy indicated, Policy: .The call system will be available in the resident's room as well as in the resident's bathroom. Procedure: .9. Always be sure that the resident has a functioning call light that is the easiest type for them to use. Always place the call light in an accessible location to where the resident is located in their room. Tell the resident where it is. Be sure they know how to use it This Federal tag relates to Complaints IN 879 and IN 929.</p> <p>3.1-3(v)(1)</p>		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE		(X6) DATE

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.