

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/11/2022

FORM APPROVED

OMB NO. 0938-039

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>08/11/2022 |
|--|---|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>HARMONY AT AVON | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2141 NORTH DAN JONES ROAD<br>AVON, IN 46123 |
|---|--|

| (X4) ID PREFIX TAG     | SUMMARY STATEMENT OF DEFICIENCY (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 |
|------------------------|---|---------------|---|----------------------|
| R 0000<br><br>Bldg. 00 | <p>This visit was for an Initial State Residential Licensure Survey.</p> <p>Survey dates: August 10 and 11, 2022.</p> <p>Facility number: 014959</p> <p>Residential Census: 29</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on August 24, 2022.</p>   | R 0000        |   |                      |
| R 0117<br><br>Bldg. 00 | <p>410 IAC 16.2-5-1.4(b)<br/>Personnel - Deficiency</p> <p>(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for</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 other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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.

|   |   |   |  |                      |   |
|---|---|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION    |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br>08/11/2022 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARMONY AT AVON |   |   | STREET ADDRESS, CITY, STATE, ZIP COD<br>2141 NORTH DAN JONES ROAD<br>AVON, IN 46123  |                      |   |
| (X4) ID PREFIX TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES (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 |   |
|   | <p>every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on record review, and interview, the facility failed to ensure at least one staff member with First Aid certifications were on every shift for 15 of 21 work shifts reviewed and failed to ensure documentation of certifications were on site at all times. This deficient practice had the potential to effect 29 of 29 residents who resided at the facility.</p> <p>Findings include:</p> <p>On 8/11/22 at 10:00 a.m., the Executive Director (ED) provided copies of the employee CPR (cardiopulmonary resuscitation) and first aid certifications for review.</p> <p>A review of the work week schedule, dated 7/24/22 through 7/30/22, indicated 15 shifts did not have an employee who was certified in first aid assigned.</p> <p>On Sunday 7/24/22 an employee, who was certified in first aid, was not assigned to any shift that day (days, evenings or nights).</p> <p>On Monday 7/25/26 an employee, who was certified in first aid, was not assigned to evening or night shift that day.</p> <p>On Tuesday 7/26/26 an employee, who was certified in first aid, was not assigned to evening or night shift that day.</p> <p>On Wednesday 7/27/26 an employee, who was certified in first aid, was not assigned to evening</p> | R 0117  | The BOM and/or designee will audit employee files and develop tracking system to ensure facility staff obtain and maintain CPR & First Aid certifications. The facility will schedule a CPR and First Aid training for all clinical associates and other associates that are found to need a current CPR and First Aid certification. The Healthcare Director or designee will monitor the clinical staffing schedule to ensure that there are sufficient number of certified associates on the schedule per the regulation guidelines. This monitoring will be ongoing for one year to ensure compliance. This corrective action will be completed by September 30, 2022. | 09/30/2022           |   |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>08/11/2022 |
|--|---|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>HARMONY AT AVON | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2141 NORTH DAN JONES ROAD<br>AVON, IN 46123 |
|---|--|

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCY<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |
|--------------------------|---|---------------------|--|----------------------------|
| R 0216<br><br>Bldg. 00   | <p>or night shift that day.</p> <p>On Thursday 7/25/26 an employee, who was certified in first aid, was not assigned to evening or night shift that day.</p> <p>On Friday 7/25/26 an employee, who was certified in first aid, was not assigned to evening or night shift that day.</p> <p>On Saturday 7/25/26 an employee, who was certified in first aid, was not assigned to evening or night shift that day.</p> <p>On 8/11/22 at 2:00 p.m., during an interview, the ED indicated she was unable to find first aid cards for the employees who worked the shifts identified as uncovered by a first aid trained person. She believed there were more cards for staff members, but she had not found them.</p> <p>On 8/11/22 at 3:20 p.m., the Director of Nursing (DON) provided a current policy, dated 2/22, titled, "First Aid and Cardiopulmonary Resuscitation (CPR)." This policy indicated, " ...In each building of the Community, there shall be at least one staff person at all times with current certification in First Aid and Cardiopulmonary Resuscitation...Each direct care staff member shall maintain current certification in First Aid...A current listing of all staff who have current certification in first aid and CPR shall be maintained in the Community at all times...."</p> <p>410 IAC 16.2-5-2(c)(1-4)(d)<br/>Evaluation - Noncompliance<br/>(c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the</p> |                     |  |                            |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>08/11/2022 |
|--|---|---|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>HARMONY AT AVON | STREET ADDRESS, CITY, STATE, ZIP COD<br>2141 NORTH DAN JONES ROAD<br>AVON, IN 46123 |
|---|---|

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE |
|--------------------------|---|---------------------|--|----------------------------|
|                          | <p>following:</p> <p>(1) The resident ' s physical, cognitive, and mental status.</p> <p>(2) The resident ' s independence in the activities of daily living.</p> <p>(3) The resident ' s weight taken on admission and semiannually thereafter.</p> <p>(4) If applicable, the resident ' s ability to self-administer medications.</p> <p>(d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on observation, interview, and record review, the facility failed to assess a resident for medication self-administration or obtain a physician order for self-administration of a nasal spray (Resident 8) for 1 of 1 residents reviewed for self-administration of medications.</p> <p>Findings include:</p> <p>On 8/11/22 at 8:57 a.m., during a medication administration observation, and interview, Qualified Medication Aid (QMA) 4 was observed as she prepared medications for Resident 8 at the medication cart. She indicated the resident's fluticasone nasal spray was not in the medication cart because the resident kept it in her room. She indicated she did not know if Resident 8 had a self-administration order for her nasal spray.</p> <p>On 8/11/22 at 9:00 a.m., QMA 4 took the prepared cup of medications to Resident 8 in her apartment. Resident 8 was seated in a chair. The QMA assisted her to take her oral medications the got her nasal spray from a table in the apartment and sat it in front of her. She reminded her to use her nasal spray.</p> <p>On 8/11/22 at 11:00 a.m., Resident 8's medical records were reviewed. The diagnoses included,</p> | R 0216              | The Healthcare Director or designee will audit the clinical chart to identify the residents that are self-administering medications. The facility will train the associates on the policy "Storage of Medications and Resident Self-Management." The Healthcare Director or designee will monitor resident rooms to ensure compliance to community policy and procedures. This monitoring will be ongoing for one year to ensure compliance. This corrective action will be completed by September 30, 2022. | 09/30/2022                 |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>08/11/2022 |
|--|---|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>HARMONY AT AVON | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2141 NORTH DAN JONES ROAD<br>AVON, IN 46123 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCY (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 |
|--------------------|--|---------------|---|----------------------|
| R 0240<br>Bldg. 00 | <p>but were not limited to arthritis of the shoulder, chronic pain and major depression.</p> <p>A physician's order indicated instill 1 spray of fluticasone prop 50 microgram (mcg) spray in each nostril twice daily at 8:00 a.m. and 8:00 p.m.</p> <p>There was no physician order to self-administer. There was no self-administer assessment on the record.</p> <p>On 8/11/22 at 2:40 p.m., during an interview, the Director of Nursing indicated Resident 8 did not have an order to self-administer her nasal spray. She would call the doctor.</p> <p>On 8/11/22 at 3:20 p.m., the DON provided a current policy, dated 4/21, titled "Storage of Medications and Resident Self-Management." This policy indicated "...A resident may be permitted to keep his own medications in a secure place in their locked apartment if the assessment has indicated that the resident is capable of self-administering medication and has been assessed by a licensed nurse employed by the facility who has assessed that the resident is capable of self-administration of medications to include; identification of each medication, the reason for use, dosing instructions, frequency of dose, ability to reorder medications independent of another person, ability to open and close all original containers, read the labels on medication containers, instill any eye drops independently if ordered, apply any patches independently if ordered and apply any topical if ordered ...."</p> <p>410 IAC 16.2-5-4(d)<br/>Health Services - Deficiency<br/>(d) Personal care, and assistance with activities of daily living, shall be provided</p> |               |   |                      |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>08/11/2022 |
|--|---|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>HARMONY AT AVON | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2141 NORTH DAN JONES ROAD<br>AVON, IN 46123 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCY (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 |
|--------------------|---|---------------|---|----------------------|
|                    | <p>based upon individual needs and preferences. Based on observation, interview, and record review, the facility failed to assess and obtain specific physician treatment orders for 1 of 1 residents reviewed for wound care (Resident 12).</p> <p>Findings include:</p> <p>On 8/11/22 at 9:26 a.m., during a medication pass observation, with Qualified Medication Aid (QMA) 4, the medications were prepared from the medication cart for Resident 12.</p> <p>The Medication Administration Record (MAR) indicated Resident 12 received gentamicin cream to her left lower extremity daily. QMA 4 asked Licensed Practical Nurse (LPN) 3 about the order. LPN 3 indicated the resident had a wound on her left lower leg. She had been going to the wound center for treatment. If there was no dressing on the resident's leg apply the cream around the perimeter of the wound, on the dry skin, not on the wound itself. But if the leg was bandaged do not apply the cream. Do not unwrap the bandage.</p> <p>On 8/11/22 at 9:30 a.m., Resident 12 was observed in her apartment seated in a chair. QMA 4 asked about her left leg and pulled up the resident's pant leg to view the area. A kerlix (gauze) wrap covered the leg from ankle to knee. The resident indicated it had been wrapped at the doctor's office last week and she thought her next appointment was in a week or two. She had the papers on her table somewhere.</p> <p>QMA 12 did not unwrap the resident's bandages or apply the treatment to the wound. She put the cream back into the medication cart.</p> <p>On 8/11/22 at 11:02 a.m., during an interview, the</p> | R 0240        | The Healthcare Director or designee will audit the residents Medication Administration Records to identify any residents who may have treatment orders. The Healthcare Director (Director of Nursing/DON) will train the associates that pass medications on the policy "Change of Medication Treatment Orders." The Healthcare Director or designee will monitor treatment orders for residents and ensure compliance to the physician orders and the community policy and procedures by reviewing the MAR weekly. This will be monitored for one year to ensure compliance. This corrective action will be completed by September 30, 2022. | 09/30/2022           |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>08/11/2022 |
|--|---|---|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>HARMONY AT AVON | STREET ADDRESS, CITY, STATE, ZIP COD<br>2141 NORTH DAN JONES ROAD<br>AVON, IN 46123 |
|---|---|

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |
|--------------------------|--|---------------------|--|----------------------------|
|                          | <p>Director of Nursing (DON) indicated Resident 12's leg wounds were managed by the wound clinic. The facility did not unwrap her legs to assess the wounds or apply any treatments. The wound care clinic did that themselves. The order for gentamicin cream had been on the resident's profile when she was admitted on 8/3. It was not something they applied and should have been discontinued from the medication list. She had not seen the wounds. They did not remove the bandages. Wound Clinic notes and documentation was requested, for review, at that time.</p> <p>On 8/11/22 at 11:30 a.m., the medical record was reviewed for Resident 12. The diagnoses included but were not limited to edema and lymphedema in both lower legs, hypertension, and heart disease.</p> <p>The Admission Assessment, dated 8/3/22, indicated "...leg wraps on from doctor, unable to assess...."</p> <p>The Physician's orders indicated gentamicin 0.1% cream apply cream to left lower extremity topically daily, 8 AM.</p> <p>On 8/11/22 at 3:20 p.m., the DON provided a visit note from a physician visit, dated 7/8/22, from the general practitioner. This note indicated "...Patient and daughter here for 1 month follow-up visit. Also, moving into assisted from independent living, has paperwork to complete, needs CXR [chest x-ray] order, due for pneumovax as well...having more edema, lymphedema in both her lower extremities, she has no weight gain. She was seen yesterday by a video visit by her infectious disease doctor. She underwent total hip arthroplasty which got infected...Patient has had a decline she has more edema in her lower</p> |                     |  |                            |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>08/11/2022 |
|--|---|---|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>HARMONY AT AVON | STREET ADDRESS, CITY, STATE, ZIP COD<br>2141 NORTH DAN JONES ROAD<br>AVON, IN 46123 |
|---|---|

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |
|--------------------------|--|---------------------|--|----------------------------|
|                          | <p>extremities and she had a melanoma removed from her left leg which had opened up and now has been draining with open wound now with extensive discharge needing dressing changes, Wound measurements are 3.5 to 4 cm circular wound with good granulation with pus and slough being drained patient has areas of minimal erthema around it...Patient is currently living in independent living [Name of facility] and daughter is interested in moving her to assisted living. Patient's daughter has been giving her medications and dressing changes, wound care has been ordered with physical therapy in [Name of Hospital]... Assessment Plan: Patient has been having drainage from her wound, has been declining overall with some redness in her lower extremities. I have cultured her wound and I have sent her to wound care to physical therapy...."</p> <p>On 8/11/22 at 3:20 p.m., during an interview, the DON indicated the facility did not have any of the Wound Care Clinics documentation or progress notes. There were no orders to treat, or not treat the wound. She had tried to contact them and physical therapy (on 8/11/22) but had not received any calls back from them.</p> <p>On 8/11/22 at 3:20 p.m., the DON provided a current policy, dated 4/21, titled "Change of Medication Treatment Orders." This policy indicated "At times a physician may order a change in a resident's current medication/treatment order. In such case fax the order to pharmacy. The Healthcare Director or designee may enter and should verify the order in the resident's order medication record in the electronic system...when the discontinued order is a medication, remove all the remaining medication containers..."</p> |                     |  |                            |

|   |   |   |   |   |  |   |  |
|---|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION    |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____                 |  | X3) DATE SURVEY COMPLETED<br>08/11/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARMONY AT AVON |   |   |   | STREET ADDRESS, CITY, STATE, ZIP COD<br>2141 NORTH DAN JONES ROAD<br>AVON, IN 46123 |  |   |  |
| (X4) ID PREFIX TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES (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  |  |   |  |
| R 0297<br><br>Bldg. 00                              | <p>410 IAC 16.2-5-6(c)(1)<br/>Pharmaceutical Services - Noncompliance<br/>(c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident:<br/>(1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, record review, and interview, the facility failed to ensure prescription and over-the-counter medications were available for administration according to physician's orders, for 1 of 4 residents observed for medication administration (Resident 14).</p> <p>Findings include:</p> <p>On 8/11/22 at 8:25 a.m., during an interview, at the nurses' station, Licensed Practical Nurse (LPN) 3 indicated when she notified pharmacy, to reorder a medication it would usually arrive that evening or the next day. They had had some problems with pharmacy because it was a new pharmacy and a new facility. The pharmacy wanted them to submit actual prescriptions for every medication on every resident. She had been accustomed to pharmacy accepting the resident's current reconciled medication lists, in the past.</p> <p>On 8/11/22 at 9:44 a.m., during a medication pass observation, Qualified Medication Aid (QMA) 4 was observed as she prepared morning medications for Resident 14 at the medication cart. She indicated the resident did not have any metoprolol (blood pressure medication) in the cart and she had to reorder it.</p> <p>On 8/11/22 at 9:50 a.m., QMA 4 entered Resident 14's apartment with her morning medications.</p> | R 0297  | The Healthcare Director or designee will audit the medication cart for medications that require reordering. The Healthcare Director or designee will train the associates on the policy "Re-Ordering/Refill for all Routine Medications." The Healthcare Director or designee will audit medication carts weekly and audits will be used to facilitate monitoring for medication availability and/or need to reorder medications. This will be monitored for one year to ensure compliance. This corrective action will be completed by September 30, 2022. | 09/30/2022  |  |   |  |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>08/11/2022 |
|--|---|---|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>HARMONY AT AVON | STREET ADDRESS, CITY, STATE, ZIP COD<br>2141 NORTH DAN JONES ROAD<br>AVON, IN 46123 |
|---|---|

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |
|--------------------------|--|---------------------|--|----------------------------|
|                          | <p>Resident 14 asked about her "other pill." QMA 4 told her blood pressure medication was still on order from the pharmacy. "They would deliver it soon."</p> <p>On 8/11/22 at 1:30 p.m., the Director of Nursing provided a copy of Resident 14's Medication Administration Record (MAR), for the month of August. The record indicated Resident 14 had not received her metoprolol 50 mg tab on 8/9/22 or 8/10/22, the record indicated "waiting on pharmacy." Resident 14 also had not received her physician ordered multivitamin on 8/1, 8/2, 8/3, 8/4, 8/6, 8/7, and 8/9. The various notations indicated "out of med until 8/4, not available to give, out of medication, no supply on hand, out of medication, out of medication, and waiting on pharmacy."</p> <p>On 8/11/22 at 1:30 p.m., the DON indicated she had spoken to LPN 3, and she had pulled Resident 14's blood pressure medication from the EDK (stored emergency supply box). She did not know why it was not administered from the EDK the 2 previous days. It had been reordered from pharmacy. She was unable to provide blood pressure readings (v/s- vital sign documentation) for the week for Resident 14. The metoprolol order did not contain any parameters, so her blood pressure had not been checked.</p> <p>On 8/11/22 at 3:20 p.m., the DON provided a current policy, dated 4/21/22, titled "Re-Ordering/Refill for all Routine Medications." This policy indicated "...all routine medications should be ordered prior to the blister card running out. 'On Demand' refills may be faxed 24 hours a day. Please allow 5 days for refills...."</p> |                     |  |                            |