STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON AT EAGLE VALLEY, THE	3060 VALLEY FARMS ROAD INDIANAPOLIS, IN 46214

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00391900 and IN00392186. Complaint IN00391900 - Substantiated. State deficiencies related to the allegations are cited at R0045. Complaint IN00392186 - Substantiated. State deficiencies related to the allegations are cited at R0045 and R0383. Survey date: October 17, 18 and 19, 2022. Facility number: 014045 Residential Census: 112 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 28, 2022.	R 0000		
R 0045 Bldg. 00	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Yantiss	Executive Director	11/10/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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.

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	(iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice			

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	specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on record review and interview, the facility	R 0045	**This plan of correction is**	11/07/2022

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	failed to provide a notice of discharge from the facility, as soon as practicable, when a resident was sent to the hospital for behaviors and not permitted to return (Resident B) for 1 of 3 residents reviewed for transfer/discharge. Findings include: On 10/18/22 at 10:00 a.m., the medical record was reviewed for Resident B. The diagnoses included, but were not limited to anxiety disorder, depressive disorder, and dementia. A nurse' note, dated 9/15/22 at 1:12 p.m., indicated Resident B was observed propelling her wheelchair around the secured memory care unit trying to open doors. She went to the nurses' station asking staff to take her home. She had a verbal altercation with staff, "cussing at staff" when they responded to her inquiries. Resident B blocked another resident from progression down the hall with her wheelchair. When unidentified Certified Nurse Assistants (CNAs) attempted to move the resident's wheelchair to allow another unidentified resident to pass, Resident B became combative. She kicked "at" and hit "at" the staff members. The resident called the staff "bitches" and threw newspapers and binders, at the nurses' station. The staff called 911. A nurses' note, dated 9/15/22 at 4:55 p.m. as a late entry, indicated at 1:00 p.m., "Call placed to 911. Resident continues asking staff to let her out. Police and EMT are here to transfer resident to the hospital...ED [Executive Director] contacted resident's daughter to inform her that the resident is not allowed back at the facility. It was explained to the resident's daughter (Name) that resident is danger to self and others...."		**submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of The Harrison as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.** · What corrective action(s) will be accomplished for those residents found to have been	

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	On 9/1/22 at 5:42 p.m., a nurses' note indicated nursing staff reported resident was aggressive and agitated. The resident's daughter was notified staff would be calling 911 for assistance due to the resident striking out at them and throwing things. The resident was transferred to the local hospital by ambulance. The most recent service plan, 6 month (180 day), dated 5/10/22, indicated Resident B was 5 feet 2 inches and 108.2 pounds. The psychosocial assessment indicated she was "frequently disruptive, aggressive, or socially inappropriate behavior, either verbally or physically improper and was able to be redirected." The template trigger indicated, "May require professional consultation or staff training." Anxiety and or depression status indicated, "Resident is under treatment at this time." The template trigger indicated, "(Resident is under treatment PERSONALIZE WHO)" No personalization for consultant or provider was identified in the service plan. The elopement assessment indicated the resident resided on a secure memory care unit due to exit seeking behaviors. She would remain safe within the building. The service plan did not offer any specific interventions for addressing the resident's behaviors, other than redirect. The service plan triggers indicated additional memory care services may be needed. None were identified. On 10/17/22 at 10:33 a.m., during an interview, Resident B's family member indicated on 9/15/22 she had been notified by a regional consultant from the facility Resident B was sent to the hospital for combative behaviors. At the hospital		affected by the deficient practice; · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; · How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? · By the date the systemic changes will be completed. **R045** 1. Resident B is no longer residing in the Community. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The Executive Director and Wellness Director were in-serviced on providing notice of discharge from Community as soon as practicable, when a resident is sent to hospital for behaviors and not permitted to return. 4. The Executive Director, Wellness Director or designee will	

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	she was contacted by phone from the Executive Director and told Resident B would not be able to return to the facility. The resident had been sent out to the hospital a couple weeks before and had returned to the facility. The facility had not given her any notification or mentioned any attempts to update the care plan or approach to her behavior. No written notice was ever received. The resident's belongings were removed from her room on 9/29/22. On 10/18/22 at 2:15 p.m., during an interview, the Executive Director (ED) indicated Resident B was identified as potential harm to others due to her combative behaviors. She had been sent to the hospital twice. The facility was not required to give a written notice to residents who was a potential harm to others. Due to the need for immediate termination the notice had been communicated verbally, over the phone to the daughter. After the first incident (9/1/22) they had a verbal discussion with Resident B's daughter about her behaviors. The facility felt she would be better served elsewhere. Conversations by email had been started on 9/19/22. They had emailed her a list of places to consider for placement. They had been working on getting them sent out. On 10/18/22 at 2:13 p.m., the ED provided a current undated policy from the facility Operations Manual. This document indicated "...Termination by the Community...A transfer or discharge is for Your welfare; Your needs can not be met by thee community; You acquire a condition or engage in conduct that interferes with the health, safety, peaceful lodging, or quiet enjoyment of others..." A second document, titled Involuntary Move Out, from the Operations Manual indicated "...Notice of the possible need for an involuntary move		monitor to ensure notice of discharge from Community is provided as soon as practicable, when a resident is sent to hospital for behaviors and not permitted to return. 5. Corrective Date: November 3, 2022	

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	should be provided verbally, in a meeting with the Resident and/or his/her family significant others, and/or his/her case manager. If it appears that the concerns can be adequately addressed, the resident should be put on a probationary status for 30 days to monitor the situation. This status should be formalized by written notice...If an involuntary move is indicated, follow instructions from your REGIONAL MANAGER in serving the resident and/or family/significant other(s) with an eviction notice...Be sure to follow all guidelines for this process in your State regulations...." This state residential finding relates to Complaints IN00391900 and IN00392186.			
R 0383 Bldg. 00	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on record review and interview, the facility failed to ensure a resident (Resident D) had a comprehensive care plan developed in cooperation with mental health providers for 1 of 3 residents reviewed for transfer/discharge.	R 0383	**This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of**	11/07/2022

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	Findings include: On 3/18/22 at 11:30 a.m., the closed medical record was reviewed for Resident D. The diagnoses included, but was not limited to, bipolar disorder (a major mental illness) and post-traumatic stress related to sexual abuse by a parent. The resident had been admitted to the facility on 9/22/21. A primary care physician's history and physical, dated 6/1/21, indicated Resident D was quick to anger and made impulsive decisions. She was easily overwhelmed. She had been seeing a counselor through her rehab, but it had not seemed to help. The Resident had a developmental delay and a longstanding history of multiple antidepressant medications and mood stabilizers. At that time, she was being seen by (Name with Name of Therapy Clinic). She discharged from the facility on 8/1/22, to an extended stay hotel . The medical record contained notes from the (Name of Therapy Clinic) dated from 2/2/21 through 7/20/21. No psychiatric clinic or physician notes were in the medical record after the admission date, during the resident's stay at the facility. The therapy notes, dated 7/20/21, indicated Resident D had complained of depression, precipitated by home life. The onset was sudden. The progression was worsening with multiple prior occurrences. Severity was described as moderate, worsening with angry outbursts, anxiety, decreased appetite, depression, difficulty falling asleep, difficulty staying asleep, hopelessness, impulsiveness, and irritable. The most recent service plan for Resident D,		**The Harrison as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.** · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · How the facility will identify other residents having the potential to be affected by the	

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	dated 5/16/22, indicated, "Reason of assessment: Initial," with a created date of 10/18/22. Resident Status: Moved out. The section titled, "Psychosocial" indicated Behaviors: "Resident is frequently disruptive, aggressive, or socially inappropriate behavior, either verbally or physically improper. Is able to be redirected. The resident will maintain and or maximize current level of functioning with disruptive/socially inappropriate behavior." A template trigger indicated, "May require professional consultation or staff training." Mood, anxiety, and or depression status indicated "Resident has depression, anxiety or mood disorders. Resident is under treatment at this time." The template trigger indicated " Resident is under treatment (PERSONALIZE WHO)." No physician, counselor or treatment clinic was listed on the service plan. Support systems were listed as "husband, psychiatrist and counselor." The psychiatrist or counselor were not identified in the service plan. The resident did not sign the service plan. A handwritten notation indicated, "Resident refused to sign." On 10/17/22 at 1:25 p.m., during an interview, the Executive Director (ED) indicated Resident D was originally admitted to the facility with her husband, he was her care giver. He passed away. The police had been called to the facility numerous times due to her behaviors and threatening staff. On 10/19/22 at 9:24 a.m., during an interview, the ED indicated Resident D was a Medicaid recipient. She was not aware of requirements for Medicaid residents with mental health disorders to be under		same deficient practice and what corrective action will be taken; · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; · How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? · By the date the systemic changes will be completed. **R383** 1. Resident B is no longer residing in the Community. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The Community is using third-party vendors as a resource for residents. In addition, the third-party vendors are assisting staff with appropriate mental health care plans for residents. 4. The Executive Director, Wellness Director or designee will meet with the designated mental healthcare provider upon initial visit and at least once monthly following for a possible update to the care plan and to discuss any concerns.	

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	the care of a mental health provider or have a care plan developed in cooperation with the mental health provider. Maybe that was something new that had not yet been implemented. She had contacted corporate for further guidance. If the resident refused treatment, that was their right. On 10/19/22 at 12:00 p.m., the ED provided page 47 of the Special Behaviors Manual, dated 8/17. She indicated they did not have a policy related to mental health in the facility but would use the manual for guidance. The manual indicated "...9. The Wellness Director and/or ED, designee should assist Residents, as needed, in coordinating access to appropriate providers for evaluation and/or treatment (e.g., psychologist, psychiatrist, social worker). Document such assistance in the resident's Service Notes. 10. Monitor for any change in a Resident's status and/or his/her service needs/preferences. Notify the Wellness Director, ED and/or other designated Community Team Members of such changes, and document the observations in the Resident's Service Notes, assessment and service plan...." This state residential finding relates to Complaint IN00392186.		5. Corrective Date: November 3, 2022	