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

FORM APPROVED
OMB NO. 0938-039

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	10/04/2023

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00417879. Complaint IN00417879 - State deficiencies related to the allegations are cited at R0052 and R0117. Survey dates: October 3 and 4, 2023 Facility number: 014959 Residential Census: 67 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 19, 2023.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. A. Based on observation, interview, and record review, the facility failed to ensure residents were free from neglect when a new admission resident (Resident B) was not adequately supervised on the secured memory care unit after already falling with injury from wandering which resulted in actual harm when Resident B wandered into another resident's room, sustained a fall and was sent to the Emergency Room (ER) where he was diagnosed with two subdural hemorrhages with	R 0052	R. 052 Residents' Rights-Offense Action Plan: a. Immediate: The HCD, BOM or designee audited employee files for Abuse and Neglect training to ensure all employees have completed in person orientation with the employee singed acknowledgement. b. Immediate: All employees	11/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lorena Glover	Executive Director	11/04/2023

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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	poor prognosis and was placed on palliative care and ultimately passed away shortly after the fall for 1 of 5 residents reviewed for accidents (Resident B). B. Based on observation, interview, and record review, the facility failed to ensure residents were free from neglect when a new admission resident sustained a fall alone, while in her apartment in isolation on the secured memory care unit, the facility failed to immediately send her out to the ER causing a delay in treatment until her family member was able to come and privately transport her to the ER where she was treated for a displaced radial fracture of her left arm for 1 of 5 residents reviewed for accidents (Resident M). C. Based on observation, interview, and record review, the facility failed to ensure residents were free from neglect when a memory care resident, with a known history of intrusive wandering, was not adequately supervised to prevent the potential for accidents which resulted in a resident-to-resident altercation when Resident T was found in Resident G's apartment with a cut and bleeding to her right ear and her shoulder for 2 of 5 residents reviewed for accidents (Residents T and G). D. Based on observation, interview, and record review, the facility failed to ensure residents were free from neglect when a memory care resident, with a history of repeated falls, continued to experience unwitnessed falls and the physician was not notified, neurological assessments were not completed, and interventions were not put in place to prevent the potential for future accidents for 1 of 5 residents reviewed for accidents (Resident N).		will be provided education and training on Indiana Residential Care Resident Rights regarding Abuse and Neglect. Training will include our Policy & Procedure on Resident Rights & Abuse & Neglect. c. Long Term: The community will provide annual education and training on Indiana Residential Care Resident Rights and training our policy and procedure on Abuse & Neglect. Employee files will be audited weekly for 8 weeks, bi-weekly for 8 weeks and monthly for 2 months. Completion Date: November 15, 2023 Responsible Party(ies)-HCD, BOM or designee, ED for review	

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Findings include:

A. During a confidential interview, Resident B's family member indicated they had been reluctant to send him to a facility, but with his recent overall decline and worsening memory, he needed more supervision and assistance. He had recently been hospitalized because of his decline and when they decided to transfer him to the facility. They were told to wait until a weekday to admit because there was not enough staff on the weekends. So Resident B admitted on Wednesday, August 16th. A family member came to visit him at least once, every day. During the visits they had concerns with staffing because there would only be one or two aids and there were lots of wandering residents. On Sunday the 20th, a family member went to visit, and was surprised to find him seated in the dining room with fresh red blood trickling down his face. When they inquired about what happened, no one seemed to know, but that he had been found in another resident's room the night before. The family member indicated they had not been contacted about his entering another resident's room or sustaining any head injury, because he did not admit with any skin issues. On Monday the 21st, the family got a call and were informed Resident B had wandered into another resident's room and fallen and they sent him to the local hospital, but he needed to be transferred to a trauma hospital. By the time the family member arrived to the hospital and saw Resident B, they indicated, "it was shocking, he was nearly unrecognizable." His eye was swollen shut and bloody, there was a large hematoma on the back of his skull, bruises across his chest and thighs. After running tests, it was determined he had two separate brain bleeds and would likely not survive. The family decided to place him on comfort/palliative care, and he passed away a few

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days later. The family member indicated they felt betrayed they were assured and promised that only the best care and supervision would be provided, but less than a week after his admission he sustained a life-ending accident.

During an interview on 10/2/23 at 2:45 p.m., CNA 7 indicated she had been the aide that found Resident B the morning of his fall. Usually, she worked on the AL side, but there was a call off, so she was sent to help cover in Memory Care. She was not familiar with the residents in Memory Care and had not been told about Resident B being a new admission. She had been going to see if residents were ready for breakfast and saw the name on the door. She thought the resident in the room was the resident whose name was on the door, but later found out it had been Resident B. She indicated he had been bleeding from his head and his eye was swollen. She indicated he was the only person in the room and found him sitting on the edge of the bed holding his head.

During an interview on 10/2/23 at 3:57 p.m., the Executive Director (ED) indicated at the time Resident B fell and was sent to the hospital, she was notified by the previous DON and made the incident a state reportable but there had not been an investigation. When asked what intervention had been put in place after Resident B was found with an injury in another resident's room the first time, the ED indicated there had not been an investigation and if any intervention had been put in place it would have been done so by the DON and clinical staff. The ED indicated Resident B was a "wanderer," and that "just happened" in Memory Care as a normal occurrence. Although the nursing staff were supposed to provide increase monitoring and supervision within the first 72 hours of a resident's admission, and all

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	residents were rounded on every 2 hours as a standard precaution, it was not the facility's responsibility or requirement to provide one-on-one supervision but that families were welcome to pay for a private sitter. On 10/2/23 at 1:17 p.m., Resident B's medical record was reviewed. He was admitted to the facility on 8/16/23 with diagnoses which included, but were not limited to, dementia (a degenerative and irreversible neurocognitive disorder which affects short and long term memory) and insomnia (a condition in which sleep patterns are disrupted and often result in inability to sleep at night). Resident B had been admitted to the facility after a recent hospitalization. The corresponding hospital summary, dated 7/18/23, indicated Resident B was brought for a hospital follow up and his families concerns for possible dementia requesting a referral for home care or memory care facility. Resident B did have progressing dementia and increased difficulties with confusion. He was recently hospitalized after which he went to extended care, unfortunately since his discharge it had been more difficult for the family to help or provide care. He had a component of Sundowner's (a state of confusion which occurs in the late afternoon and lasts into the night which can cause different behaviors, such as confusion, anxiety, aggression or ignoring directions, pacing or wandering) which caused him to have significant difficulty sleeping. His admission Service Plan and Nursing Assessment, dated 8/16/23, indicated he had "minimal wandering issues," and "may have behavior management plan in place, anytime during shifts and as needed," but lacked documentation of interventions/goals and/or what			

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behavior management strategies should be utilized.

The admission Service Plan and Nursing Assessment also indicated, Resident B was at high risk for falls, and in parenthesis, "(PERSONALIZE interventions)," was left unrevised, therefore lacked documentation of interventions/goals to prevent the potential for falls.

A nursing progress note, dated 8/16/23 at 2:53 p.m., indicated Resident B admitted to the facility. He was alert to his name but confused about the time and place. He used a rolling walker with a shuffled gait.

A nursing progress note, dated 8/19/2023 at 2:56 p.m., indicated Resident B was found in another resident's room. The nurse was called to come assess him because there was a new skin tear and bleeding from his forehead. The skin tear measured 3 centimeters (cm) long by 2 cm wide and first aid was provided.

The record lacked documentation the physician was notified of the new skin tear.

The record lacked documentation of a neurological assessment associated with the new head injury.

The record lacked documentation of an investigation into what caused the injury.

The record lacked documentation of any intervention put in place to help prevent the possibility of a reoccurrence.

A nursing progress note, dated 8/21/23 at 9:23

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a.m., indicated Resident B had been found in another resident's room with another head wound, a wound on his cheek, and a skin tear on his elbow. He was sent to the ER.

A follow up nursing progress note, dated 8/23/23 at 5:42 p.m., indicated Resident B had been unable to say what had happened, but it was noted the thermostat was off the wall, and there was a smear of blood on the wall next to where the thermostat was.

A corresponding State Reportable Incident #15 was created on 8/23/23 and the preventative measure put in place at that time was, "Resident will be placed on 2-hour checks during bedtime hours."

The local hospital ER summary, dated 8/21/23 at 8:42 a.m., indicated, " ...[Resident B] presents to the emergency department via EMS from his facility for complaints of fall. Patient is a poor historian and EMS gave report. They state that he was found in another resident's room on the floor this morning. Unsure of how long he has been there. He was last checked on last night. They report injuries to his left upper arm, head, and bruising to his face ..." an initial head CT was conducted on 8/21/23 at 10:00 a.m. and revealed the following injuries:
a. approximate 1.4 cm deep left and 1 cm deep right hemisphere acute subdural hemorrhage (bleeding in the brain).
b. approximately 7 mm deep acute left parafalcine subdural hemorrhage.
c. the mass effect results in sulcal and ventricular effacement with mild rightward midline shift.
(a midline shift refers to the displacement of brain tissue across the center line of the brain, which may occur following traumatic brain injury in

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association with raised intracranial pressure or an intracranial hematoma which can push the brain towards one side causing midline shift).

Due to the bleeding in his brain, Resident B was lifeline transferred to a second local trauma hospital.

A second head CT was performed at the trauma hospital on 8/21/23 at 5:26 p.m. and revealed his condition had worsened.
a. redemonstrated bilateral cerebral convexity acute on chronic subdural hematomas with evidence of continued interval hemorrhage on the left.
b. right convexity and left parafalcine subdural hematomas were similar to prior.
c. worsening of left hemispheric mass effect with minimal increase in rightward midline shift.

A trauma attending physician note, dated 8/22/23 at 12:47 p.m., indicated, Resident B presented to a local hospital for an ER workup which revealed subdural hematomas and he was transferred to the local trauma hospital. He also had a notable skin tear and hematoma above his left eyebrow, along with several areas of ecchymosis (discoloration of the skin) and skin tears scattered throughout his head, thorax, and legs ...."

Due to his poor prognosis, his family opted for palliative Hospice care and Resident B passed away on 8/26/23 at 5:25 a.m. Resident B's death was referred to the coroner as it met the criteria for further investigation due to "death stemming from any wound or injury. This will include any trauma whether homicidal, suicidal or accidental in nature."

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During an interview on 10/2/23 at 11:05 a.m., the Memory Care Coordinator (MCC) indicated it was difficult to manage the memory care unit with one Qualified Medication Aide (QMA) and two Certified Nursing Aides (CNA), especially now that the unit was full. She remembered Resident B and indicated staffing was a factor in his accident especially since the second fall happened around shift change, and things "tend to get busy and distracting around that time."

During an interview on 10/2/23 at 12:54 p.m., CNA 5 indicated she did not remember Resident B, but there were a lot of residents who fell so it was hard to remember everyone.

During a follow up interview on 10/2/23 at 1:40 p.m., the MCC indicated with only two CNAs and the way the unit was set up, it was impossible to watch everyone 100% of the time. Having a third CNA would be helpful because then there could be one set of eyes on each hall. Unfortunately, at the time Resident B fell, it was right around shift change and the aides must have been busy with other residents. If the nurse or QMA were at the nurses' station going over report, they could not see down any of the halls from behind the desk which also made it hard to supervise residents that pace or wander.

During an interview on 10/2/23 at 2:20 p.m., with the DON and MCC present, the DON indicated the set-up of the unit was a poor design for memory care. If anyone was at the nurses station it was impossible to see down the hallways. It was also hard to determine if residents wandered accidently into the wrong rooms because all the doors to the apartments were kept shut. So as staff walked down the halls during round, without opening every single door, they would not be able

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to quickly visualize each room. Staffing was also a contributing factor related to falls and residents wandering into the wrong rooms. With only 2 CNAs for more than 30 residents, many of whom had behaviors, it had become harder to manage than when the building first opened. As the resident census increased in memory care unit, so did the number of falls, but the facility had not provided additional staff with the increased resident census to help monitor or supervise.

Cross reference R0117.

B. On 10/3/23 at 11:43 a.m., Resident M's medical record was reviewed. Resident M admitted on 5/25/23 and had a diagnosis which included but was not limited to, dementia.

Her admission Service Plan and Nursing Assessment, dated 5/22/23, indicated Resident M was at "low risk" for falls and in parenthesis, "(PERSONALIZE interventions)," was left unrevised, therefore lacked documentation of interventions/goals to prevent the potential for falls.

A current CNA assignment sheet lacked documentation of Resident M's preference to pace/wander the halls and/or that she was at risk for fall or had a history of falls and lacked revision to include whether or not she required close monitoring.

An admission nursing progress note, dated 5/25/23 at 4:08 p.m., indicated, "resident arrived to new apartment. alert with some confusion/forgetfulness noted. resident will remain in apartment throughout remainder of day due to being at end of covid isolation from previous facility."

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A nursing progress note, dated 5/26/23 at 4:11 p.m., indicated Resident M reported she had fallen in her apartment but could not give a description of when or what happened, only that she had gotten herself back up. She complained of pain in her left wrist, and although there was no bruise noted, "wrist does not present straight," and Resident M complained of pain upon flexion. An order for a STAT (immediate) x-ray was placed.

The record lacked documentation of any intervention put in place to prevent the potential for additional falls.

A nursing progress note, dated 5/26/23 at 7:21 p.m., indicated, the results of Resident M's x-ray had been received and revealed a displaced radial fracture with tissue swelling of her left arm/wrist. The nurse contacted Resident M's family member and informed them of her broken wrist, and that she needed to go to the ER. The family was not able to provide private transportation at that time, " ...resident needs to be seen by a doctor and needs to be taken to the ER due to the result of the x-ray of her arm and he stated that he cannot make it tonight that he will come by tomorrow to take resident to the ER. Resident is unable to be transported to the ER by ambulance due to resident being unsafe and resident cannot be alone ...." Until transportation could be arranged, a new order was received for Tylenol as needed and the nurse applied ice. Eventually, Resident M's family member was able to come and took her to the ER.

The record lacked documentation of what time Resident M left the facility.

The record lacked documentation of when

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Resident M returned to the facility.

A nursing progress note, dated 5/28/23 at 9:01 p.m., indicated new and/or increased swelling and puffiness was noted to the back of Resident M's left hand. The nurse contacted Resident M's family member and indicated she needed to go back to the ER, as the swelling could be an indication of "compartment syndrome," (a painful and dangerous condition caused by pressure buildup from internal bleeding or swelling of tissues which required immediate medical attention). Again, the family member was unavailable to come and take her to the ER. "...Resident is unable to be transported to ER alone due to confusion/dementia and concerns about resident safety ... family stated that they cannot come and take the resident to the ER tonight and that they will come tomorrow ...."

The note lacked documentation the physician was notified of suspected compartment syndrome.

The note lacked documentation if she was sent back to the ER at all.

C. On 10/4/23 at 9:00 a.m., Resident T's medical record was reviewed. She admitted on 6/27/22 with diagnoses which included, but were not limited to dementia and hypertension, (high blood pressure).

Her most recent Service Plan and Nursing Assessment, dated 3/24/23, and indicated she had "minimal wandering issues," and "may have behavior management plan in place, anytime during shifts and as needed," and "current wandering within the residence or facility, but does not jeopardize health or safety of self or others." The record lacked revision of wandering

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	history which had resulted in a head injury and lacked documentation of interventions/goals and/or what behavior management strategies should be utilized to prevent future intrusive wandering accidents. A current CNA assignment sheet lacked documentation of Resident T's preference to pace/wander the halls and/or that she was at risk for intrusive wandering and lacked revision to include whether or not she required close monitoring. A nursing progress note, dated 5/28/23 at 12:57 a.m., indicated Resident T was found in Resident G's room "...nurse received call from [Memory Care] stating that [Resident T] entered another resident's [Resident G] apartment and was hit by the other resident resulting in bleeding ..." Resident T was found sitting on the floor of Resident G's room. Resident T was assisted off the floor and back to her apartment. Resident G was found to have some purple discoloration to her right ear and a small cut which was bleeding. In addition to the new injury on her ear, an already open area on her should appeared aggravated and was also bleeding. Resident G was sent to the ER. The record lacked documentation of an investigation or intervention to prevent further accidents, and lacked documentation vital signs, neurological check and/or range of motion. On 10/4/23 from 9:18 a.m., until 9:55 a.m., the following was observed on the secured Memory Care unit. Upon entrance at 9:18 a.m., three staff members were observed at the end of the hall, huddled together, and talking.			

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At 9:20 a.m., Resident T was not in her room upon entry to observe for mobility bars.

At 9:43 a.m., Resident T remained out of her room.

At 9:45 a.m., when the QMA at the nurses' station was asked about Resident T's whereabouts, she stood up to look into the T.V. lounge. Resident T was not there, and she indicated she must be in her room.

At 9:46 a.m., the QMA entered Resident T's room and confirmed she was not in her room.

At 9:50 a.m., the QMA asked the two aides to help her look, and they began to go door by door to look for Resident T.

At 9:55 a.m., the MCC found Resident T in another resident's room and indicated she liked to go into that room to look out the window. Fortunately, the resident who lived in that room was out to the hospital or she would have been upset.

During an interview on 10/4/23 at 9:56 a.m., QMA 11, CNA 5 and CAN 8 indicated they had not seen Resident T leave her room, in the hallway, or entering the other resident's room. QMA 11 indicated she had not checked the room where Resident T was found, because that resident was out at the hospital and her door was supposed to be locked.

D. On 10/3/23 at 1:53 p.m., Resident N's medical record was reviewed. She admitted to the facility on 8/24/22 with diagnoses which included, but were not limited to, dementia and diabetes (a condition that effects the body's ability to

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maintain/control blood sugar levels).

Her most recent Service Plan and Nursing Assessment was dated 6/3/23, and indicated, she had severe memory impairment, was at "high risk" for falls and in parenthesis, "(PERSONALIZE interventions)," was left unrevised, therefore lacked documentation of interventions/goals to prevent the potential for falls.

A current CNA assignment sheet lacked documentation of Resident N's pattern of repeated falls and/or interventions in place to address her being a high fall risk and lacked revision to include whether or not she required close monitoring.

Sine her admission, Resident N experienced repeated falls as follows documented in the nursing progress notes which lacked documentation a post fall assessment, vital signs and/or a neurological assessment, physician was notification, and interventions put in place to prevent further falls.

1. On 8/25/22 at 2:13 p.m., (less than 24 hours after her admission) the nursing progress notes from the QMA indicated Resident N had a fall last night.

2. On 8/26/2022 at 4:52 p.m., nursing progress notes indicated Resident N was found on the floor in the hallways without her walker. She was sitting on her bottom after her unwitnessed fall.

3. On 9/4/2022 at 9:14 p.m., nursing progress notes indicated Resident N fell inside the door of her apartment. No injuries were noted, and vital signs were within normal limits.

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	4. On 9/26/22 at 4:17 p.m., nursing progress notes indicated Resident N was witnessed as she bent over to pick something up off the floor. She fell forward but did not hit her head. No other injuries were visible at that time, but a few hours later, a small bruise was noted on her left hand 3rd finger. 5. On 10/1/22 at 6:26 p.m., nursing progress notes indicated Resident N was found "scooting" on the floor on her bottom. 6. A nursing progress note, dated 11/1/22 at 11:17 p.m., indicated Resident N was found sitting on the floor when nurse conducted her rounds. Resident N indicated she slid off her couch when she tried to sit down. 7. On 11/13/22 at 5:26 p.m., nursing progress notes indicated Resident N had a fall in her bathroom and scooted herself out to her chair. 8. On 11/15/22 at 12:33 p.m., nursing progress notes indicated Resident N had two falls that day and sustained a small scrape on her knee. 9. On 12/3/22 at 10:53 a.m., nursing progress notes indicated Resident N fell that morning around 7:30 a.m., when she tried to clean herself up. She fell and hit her head on the floor. She sustained a bruise to the left side of her forehead. Resident N fell again around 10:00 a.m., as she attempted to clean her room. At that time, she complained of pain in her hip and was given ibuprofen. 10. On 12/6/22 at 2:49 p.m., nursing progress notes indicated Resident N was found in the hallway outside of her apartment on the floor and hung onto the handrail. She did not have pants on at the time and her brief was down around her knees.			

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	11. On 12/13/22 at 3:24 p.m., nursing progress notes indicated Resident N was found sitting on her buttock on the floor in the doorway of her apartment. 12. On 12/18/22 at 6:44 p.m., Resident N was found on the floor in the middle of the hallway. She sustained a skin tear to her right knee. 13. On 12/21/22 at 2:00 p.m., Resident N was found on the floor on top of a pillow in front of her couch. 14. On 1/1/23 at 2:47 p.m., Resident N had a fall around 2:30 p.m. when she slid from her chair as she tried to remove a blanket form her chair. 15. On 1/11/23 at 6:16 a.m., Resident N had an unwitnessed fall in her bathroom and "scooted" herself outside of her apartment. 16. On 1/12/23 at 7:30 a.m., Resident N was found sitting in front of her couch on the floor with her back against the couch and indicated she slid off the couch. 17. On 1/18/23 at 5:48 p.m., Resident N was found on the floor, laying on her back, in the common area living room. She had last been seen by staff standing in the common area. 18. On 1/23/23 at 3:38 p.m., Resident N was found on the floor in front of her couch. No injuries noted. 19. On 2/3/23 at 3:33 p.m., Resident N was found sitting on the floor of her apartment. 20. On 3/18/23 at 8:33 p.m., Resident N was found by her family member after an unwitnessed fall.			

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She was sitting on the floor. The family member and a CNA assisted Resident N off the floor (before a nursing assessment was completed), then called the nurse. Resident N complained of pain on her lower right arm. An order for an x-ray was received, but the family insisted on sending her to the hospital.

The record lacked documentation of hospital outcome.

The record lacked documentation of interventions put in place at that time.

21. On 5/8/23 at 8:54 p.m., Resident N had an unwitnessed fall and was found outside of her apartment by her door with a new skin tear on her right hand which was bleeding. Resident N also complained of pain in her right shoulder on a scale of 8 out of 10. Her family took her to the ER.

On 5/9/23 at 1:03 p.m., Resident N returned from the hospital and has sustained a shoulder fracture.

No interventions were documented upon her return to prevent the potential for future falls/accidents.

22. On 5/30/23 at 2:29 p.m., Resident N fell and hit her head, she was bleeding from her eyebrow. She was sent 911 to the ER where the laceration was glued shut. She returned with some swelling and discoloration on the bridge of her nose.

23. On 6/5/23 at 6:46 p.m., "Resident had an unwitnessed fall."

24. 6/6/23 at 6:45 p.m., Resident N had an unwitnessed fall and was found on the floor. "

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...no discomfort except from right arm that is already in a sling from previous fall ....." She sustained a new skin tear on her right palm.

25. On 6/30/23 at 2:30 p.m., Resident N was found on the floor in front of her couch on her knees. She indicated she was trying to get off the floor after she slipped getting up from her couch.

26. On 7/18/23 at 7:00 p.m., Resident N had a witnessed fall in front of the nurses' station. She turned too fast with her walker and fell on the floor where she hit her cheek and chin. An x-ray was ordered for her jaw and cheek bone.

27. On 8/2/23 at 6:00 p.m., Resident N fell while ambulating with her walker. She fell near the door of her apartment. All parties were notified and an intervention to monitor her for the following 72 hours was place.

However, less than 24 hours later, on 8/3/23 at 9:48 a.m., Resident N was found on the floor again. The nurse assessed her with no noted injuries but failed to notify the physician.

28. On 9/5/23 at 2:48 p.m., the nurse was notified Resident N had fallen. She had already been assisted off the floor and back into her chair but had been found on one knee.

29. On 9/9/23 at 8:16 p.m., Resident N was coming out of her room when she lost her balance and fell to her right hitting her head on the floor. She was sent to the ER. She returned later that evening with no new interventions documented.

30. On 9/10/23 at 11:52 a.m., Resident N was walking to her room with her walker and turned into her apartment, swung the walker which

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caused her to lose her balance. She landed on her left knee but got herself up without assistance.

31. On 9/10/23 at 8:01 p.m., Resident N had an unwitnessed fall.

32. On 9/11/23 at 1:58 p.m., Resident N was walking towards her room, when she turned into her room, she did not turn her walker, lost her balance and fell to the floor.

33. On 9/11/23 at 9:28 p.m., Resident N was coming out of her room when she lost her balance ad fell.

34. On 9/18/23 at 11:57 a.m., the Nurse was notified that Resident N had a fall that morning (but did not specify when) and that Resident N had gotten herself up and was back in the dining room. Per facility protocol, she was sent to the ER where she was diagnosed with a urinary tract infection.

During the exit conference on 10/4/23 at 2:20 p.m., the Executive Director (ED) requested clarification of identified concerns related to falls and indicated as an Assisted Living facility, they were not required to report/investigate and/or implement interventions for every resident after every fall or provide one-on-one supervision for residents at all times. The ED indicated, "residents have the right to fall."

On 10/3/23 at 1:00 p.m., the DON provided a copy of current facility policy titled, "Fall Prevention Program," revised 3/2022. The policy indicated, "The goal of the Fall Prevention Program includes the appropriate screening for, and assessment of, the resident, so that a pro-active ISP/ICP can be developed to reduce fall; prevent injuries; and ultimately improve quality of life for our residents ... A fall is defined as an occurrence characterized

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	by the failure to maintain an appropriate lying, sitting or standing position, resulting in an abruptly undesired relocation, usually to the ground ... the key to the best Fall Prevention Program is in the identification of those residents that are most likely to fall (observation skills) and in the creativity of the Resident Care Team to identify individualized approached and the execution of those approaches while providing care. the development of a library of approaches that are specific to your community is essential to your community success ... Some approaches that you many want to add to your own resource library are ... [37 bulleted items were listed for reference/suggestions] ...." During an interview on 10/3/23 at 1:20 p.m., the DON indicated, there was not policy that addressed/outline the procedure for what staff were expected to do when a resident experienced a fall. Instead, she offered a verbal policy which included, but was not limited to her expectation for staff to: 1. Immediately call for assistance if needed and ensure the nurse comes immediately. 2. Apply first aid as needed and complete a full set of vital sings and if the fall was unwitnessed, the nurse should conduct an initial neurological assessment. It was the facilities practice that if a resident had a diagnosis of dementia and had experienced an unwitnessed fall, they were to be sent out to the ER, no questions asked. The DON indicated, even though she had only been there a couple months, she believed that had been the procedure before she started as well. On 10/4/23 at 12:15 p.m., the DON provided a copy of current facility policy titled, "Wandering or Walking About," dated 4/1/22. The policy indicated, " ...admitted residents will be closely monitored for changes and care strategies and			

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	approaches will be initiated when necessary ... the Memory Care staff will monitor each resident's whereabouts routinely and maximum physical freedom within a safe environment. Staff will further ensure resident safety and encourage program participation ... Wandering behaviors typically occur with severe memory loss and often inadvertently place residents at risk for accident or injury ... resident monitoring, staff shift assignments will designate residents at risk who require close monitoring, staff will mental note assigned residents whereabouts every 30 minutes, the Harmony Square Coordinator will assign a staff member to physically make safety checks throughout Memory Care Community each hour ...." This citation relates to complaint IN00417879.			
R 0058 Bldg. 00	410 IAC 16.2-5-1.2(bb)(1-9) Residents' Rights - Deficiency (bb) Residents have the right and the facility must provide immediate access to any resident by: (1) individuals representing state or federal agencies; (2) any authorized representative of the state; (3) the resident ' s individual physician; (4) the state and area long term care ombudsman; (5) the agency responsible for the protection and advocacy system for developmentally disabled individuals; (6) the agency responsible for the protection and advocacy system for mentally ill individuals; (7) immediate family or other relatives of the resident, subject to the resident ' s right to deny or withdraw consent at any time;			

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	(8) the resident ' s legal representative or spiritual advisor subject to the resident ' s right to deny or withdraw consent at any time; and (9) others who are visiting with the consent of the resident subject to reasonable restrictions and the resident ' s right to deny or withdraw consent at any time. Based on observation and interview, the facility failed to provide immediate access to state and federal agencies, representatives of the state, including the Ombudsman for 67 of 67 residents residing in the assisted living facility. Findings include: During an interview, on 10/2/23 at 2:30 p.m., the Executive Director (ED) indicated the signage with agency contacts were in the activity rooms. On 10/4/23 at 11:00 a.m., during an observation of the Wabash activity room, there was no signage present with agency contacts. On 10/4/23 at 1:00 p.m., during an observation of the Wabash activity room, there was signage on white 8 by 11 paper typed in size 12 font, taped to the inside wall of the activity room. During an interview, on 10/4/23 at 2:30 p.m., the ED indicated the signage was added in the activity rooms. She indicated there was signage at the side entrance of the building that led to the assisted living and dementia care unit. On 10/4/23 at 2:39 p.m., the Healthcare Director pointed out the signage on the assisted living unit. The signage was pinned to cork board. It was in a nursing area at the nurse's station. There was a scale in front of the signage. The HD	R 0058	R. 058 Residents' Rights-Deficiency Action Plan: a. Immediate: The HCD, ED or designee have audited the community to ensure the Resident Rights, State and Federal agencies, representatives of the state including the Ombudsman are posted. b. Immediate: The Resident Rights, State and Federal agencies, representatives of the state including the Ombudsman information will be posted in a visible manner. c. Long Term: The community will monitor placement annually to ensure the Resident Rights, State and Federal agencies, representatives of the state including the Ombudsman information is update and visible. Completion Date: November 15, 2023 Responsible Party(ies)-HCD or designee, ED for review	11/15/2023

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	indicated the area was a nursing area and not within the site of visitors or residents. She indicated she would post at the main entrance and the side entrance of the assisted living. A policy was not provided during the survey or at exit.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (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 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.			
	Based on observation, interview, and record review, the facility failed to ensure an adequate number of staff was available in the secured Memory Care unit to provide adequate	R 0117	R.117 Personnel-Deficiency Action Plan: a. Immediate: The HCD or designee will audit residents' charts to identify residents with	12/03/2023

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	supervision and monitoring of residents to prevent several residents from intrusive wandering which resulted in a resident-to-resident altercation with injury, between Resident T and Resident G. This deficient practice had the potential to effect 33 of 33 residents who resided on the Memory Care Unit (Residents B, M, T, N, and L) Findings include: On 10/2/23 from 10:25 a.m. until 11:25 a.m., a general observation of the secured memory care unit was conducted. The Memory Care Coordinator (MCC) was working on the floor as the Qualified Medication Aide (QMA) conducting morning medication administrations. There were two Certified Nursing Aides (CNAs), and several unidentified residents wandering/pacing through the halls. During an interview on 10/2/23 at 11:05 a.m., the MCC indicated it was difficult to manage the memory care unit with one QMA and 2 CNAs, especially now that the unit was full. She remembered Resident B and indicated staffing was a factor in his accident especially since the second fall happened around shift change, and things tend to get busy and distracting around that time. Cross reference R0052 On 10/2/23 at 12:49 p.m., 12 unsupervised residents were observed in the common area T.V lounge. CNA 5 was observed as she assisted an unidentified resident, who walked slowly with her walker up the main entrance hallway. Another unidentified resident, who was walking with a walker, was approached by one of her peers who		intrusive behaviors. b. Immediate: The HCD or designee will monitor daily staffing ratios to ensure appropriate staff to resident ratio per resident's needs. c. Long Term: The HCD or designee will review residents progress notes weekly for behavioral changes of condition and will adjust staffing ratios as needed to provide adequate supervision and monitoring of residents in secured memory care neighborhood. The community will monitor behavior notes for compliance each week for 8 weeks, bi-weekly for 8 weeks, and monthly for 2 months. Completion Date: December 3, 2023 Responsible Party(ies)- HCD or designee, ED for review	

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took hold of her walker. The first resident pulled her walker away and continued to walk away, but the second resident took hold of the back her shirt and trailed behind her. The first resident swatted the second resident's hand off her shirt and sternly indicated to the second resident, "I'm not going that way!"

During an interview on 10/2/23 at 12:54 p.m., CNA 5 indicated there were only 2 CNAs that worked on Memory Care, sometimes only 1 if there was a call off. On the assisted living (AL) side, it was not so bad because most of those residents were much more independent, but for Memory Care they needed three to be able to supervise and assist the residents' need. She indicated if there were only two aides and one when on break that left more than 30 residents for one aide. Also, after meals when residents needed to be toileted, both aides were in resident rooms to assist them leaving many residents unsupervised in the common area.

During an interview on 10/2/23 at 12:58 p.m., CNA 6 indicated as long as she had worked there they needed three aides but had only ever had two. The staff made it work as best as they could.

On 10/2/23 at 12:59 p.m., CNA 5 gave an inflated beach ball to one of the residents in the T.V lounge and told her to start a toss game, then assisted another resident back to her room to change her brief. At the same time, CNA 6 assisted a second resident back to his room for a restroom break, which left nine residents in the T.V. lounge unsupervised and the following was observed.

At 1:03 p.m., Resident H, who had previously been observed pacing up and down the halls

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	independently and without an assistive device, approached the visitor silently from behind and rested her head on the visitor's shoulder. The visitor was started, but the resident was pleasant, smiled, and then gave the visitor a hug. At 1:04 p.m., Resident L, stood up from the chair she was seated in and attempted to exit the common area. As she approached Resident G, who was seated on her rollator walker, Resident G told her to, "go sit back down." When Resident L did not sit back down, Resident G stood from her walker, grasped Resident L by the shoulders, pushed her backwards several feet and firmly pressed her back down into her chair. Resident G sternly indicated, "sit down and stay down!" At 1:06 p.m., Resident M was observed at the entrance door to the unit as she attempted to push it open and touched the key-fob receiver box to open the door. At 1:13 p.m., Resident H quickly rushed up on Resident G and bend over to give her a hug. Resident G startled and pushed Resident H away, as Resident H giggled and indicated nonsensical words. During a follow up interview on 10/2/23 at 1:40 p.m., the MCC indicated with only two CNAs and the way the unit was set it was impossible to watch everyone 100% of the time. Having a third CNA would be helpful because then there could be one set of eyes on each hall. Unfortunately, at the time Resident B fell, it was right around shift change and the aides must have been busy with other residents. If the nurse or QMA were at the nurses' station going over report, they could not see down any of the halls from behind the desk which also made it hard to supervise residents that pace or wander. On 10/2/23 at 1:50 p.m., Resident M was observed			

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as she entered Resident H's apartment. Resident H walked up the hall and went into her room. Upon finding Resident M in her apartment, Resident H became upset, agitated, and tearful. The MCC assisted Resident M out of the apartment, but Resident H remained upset and followed the MCC and Resident M to her room.

During an observation on 10/3/23 at 9:15 a.m., Resident L attempted to enter another resident's apartment. The other resident was sitting in a wheelchair in the doorway of her apartment when Resident L attempted to squeeze behind her and go into the room. The other resident pushed at Resident L and yelled, "get out! Get out!" QMA 11 was at the nurses' station and got up to assist Resident L into the TV lounge.

During an interview on 10/3/23 at 10:25 a.m., the Director of Nursing (DON) and MCC indicated there had never been more than two CNAs for memory care. When the building first opened up until several months ago, the census was lower and with two aides it had been more manageable. But now that the Memory Care unit was full, staff desperately needed more help for supervision.

On 10/4/23 from 9:18 a.m. until 9:55 a.m., the following was observed on the secured Memory Care unit:

Upon entrance at 9:18 a.m., three staff members were observed at the end of the hall, huddled together, and talking.

At 9:20 a.m., Resident M and H were observed pacing through the hallways. Resident T was not in her room.

At 9:43 a.m., Resident T remained out of her room.

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At 9:45 a.m., when the QMA at the nurses' station was asked about Resident T's whereabouts, she stood up to look into the T.V. lounge. Resident T was not there, and she indicated she must be in her room.

At 9:46 a.m., the QMA entered Resident T's room and confirmed she was not in her room.

At 9:50 a.m., the QMA asked the two aides to help her look, and they began to go door by door to look for Resident T.

At 9:55 a.m., the MCC found Resident T in another resident's room and indicated she liked to go into that room to look out the window. Fortunately, the resident who lived in that room was out to the hospital or she would have been upset.

On 10/4/23 at 9:00 a.m., the DON provided a resident census summary which averaged the Memory Care population on a monthly basis since January of 2023. The average census in January was 22 residents. At the time of the survey, the average resident census was 33 (a 50% increase).

A Fall Incident Report (reported falls only) in Memory Care revealed the following:
a. no reported fall from January-June 2023
b. only one fall in June
c. only one fall in July
d. four reported falls in August
e. seven reported falls in September

During the exit conference on 10/4/23 at 2:20 p.m., the Executive Director (ED) indicated as an Assisted Living facility they were not required to maintain a certain staffing ratio and that the

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	Memory Care unit was over-staffed. This citation relates to complaint IN00417879.			
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants.			

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	(E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on observation and interviews, the facility failed to ensure employees were educated upon hire in required dementia training, resident rights and resident abuse prevention for 2 of 5 employees (Bookkeeping Office Manager 11 and Licensed Practical Nurse 9). Findings include: On 10/4/23 at 12:30 p.m., Bookkeeping Office Manager (BOM) 11's employee file was reviewed. The file contained a document signed by the employee indicating she had received general orientation. The list contained multiple education topics to include Resident Rights and Abuse training. The employee file lacked any documentation indicating the education occurred. On 10/4/23 at 12:32 p.m., Licensed Practical Nurse (LPN) 9's employee file was reviewed. The file contained a document signed by the employee indicating she had received general orientation. The list contained multiple education topics to include Resident Rights and Abuse training. The employee file lacked any documentation indicating the education occurred. On 10/4/23 at 1:32 p.m., during an interview with the BOM and Healthcare Director (HCD), the BOM indicated they did not have any documentation that included the instruction date or time, location, instructor who provided the training. The HCD indicated employees receive 16 hours of orientation. During the orientation, the person training the new employee trained them on the topics on the general orientation topics. The BOM and HCD indicated they were working on a	R 0120	R. 120 Personnel-Noncompliance Action Plan: a. Immediate: The HCD or designee, BOM, ED will audit each employee file to identify employees not in compliance. b. Immediate: Employees identified not in compliance will receive the required Dementia training, resident rights, and resident abuse prevention training. c. Long Term: The ED or BOM will complete audits of every file of each newly hired employee within 30 days of hire to ensure required trainings are completed. New employee files will be audited for compliance each month for 6 months. Completion Date: December 3, 2023 Responsible Party(ies)-ED, BOM or Designee	12/03/2023

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	training program. A policy was not provided during the survey or at exit.			
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.			
	Based on observation, interview, and record review, the facility failed to ensure residents' environments remained free from the potential for accidents when bedrails/mobility bars were installed but not assessed, monitored, or maintained in a safe operating condition for 4 of 4 residents reviewed for bedrails (Residents K, T, V and W). Findings include: On 10/2/23 at 10:42 a.m., Resident V's room was observed. Her bed was against the wall, and there was a quarter mobility bar/rail installed to the open side of her bed. The device was secured	R 0148	R. 148 Sanitation and Safety Standards-Deficiency Action Plan: a. Immediate: The HCD or designee audited each apartment to identify residents that have side rails. b. Immediate: Residents identified with having side rails will be evaluated by contracted therapy company or hospice to ensure safe use of side rails. HCD will assess residents, update service and obtain physician orders.	11/15/2023

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	under the mattress and wobbled with a gentle touch. On 10/2/23 at 10:44 a.m., Resident K's room was observed. He laid in bed diagonally, with his feet off the side of the mattress. His hips were pushed back and rested against a quarter mobility rail which was installed at the head of the bed. The rail legs went to the floor, and a slat went under the mattress, but it appeared that his position in bed had pushed the rail outward. A triangular gap was observed between the rail and the mattress. On 10/3/23 at 2:12 p.m., the Memory Care Coordinator (MCC) indicated she did not know how many residents had side rails or mobility bars installed on their bed. On 10/4/23 at 9:07 a.m., the MCC indicated there were only four residents in Memory Care with devices installed on their beds, Residents K, T, V, and W. At that time the MCC indicated she did not know if there were initial or ongoing assessments for the safety and/or appropriateness of the devices. On 10/4/23 at 9:43 a.m., Resident T's empty bed was observed. There were bilateral half side rails installed. While there was no gap between the rail and the mattress, the rails were able to be wobbled easily. On 10/4/23 at 9:57 a.m., Resident W's empty bed was observed. There was a collapsible half side rail, in the downward position at that time. On 10/4/23 at 12:15 p.m., Residents K, T, V and W's medical records were reviewed. The records lacked a physician's order for the		c. Long Term: HCD or designee will perform apartment audits to monitor safe use of side rails. Audits will be completed weekly for 8 weeks, bi-weekly for 8 weeks and monthly for 2 months. Completion Date: November 15, 2023 Responsible Party(ies)- HCD or Designee, ED for Review	

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	installed devices. The records lacked documentation of an initial assessment for the appropriate and necessary need for the device. The records lacked ongoing assessment routine or as needed to determine the appropriate of the device. The records lacked documentation of routine safety evaluations of the installed devices. On 10/4/23 at 1:24 p.m., the Director of Nursing (DON) indicated there was no policy to address the use of bedrails and/or mobility, but she indicated devices were not permitted without appropriate physician's order and therapy screening. At that time the DON provided a copy of current facility policy titled, "Restraint - Free Environment," revised 3/2022. The policy indicated, " ...the community shall provide alternative ways in which to maximize residents' safety and mobility ...."			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.			
	Based on record review and interview, the facility failed to complete semiannual evaluations for 2 of 4 residents reviewed and failed to obtain signatures on service plans for 2 of 4 residents reviewed (Resident C and E).	R 0214	R. 214 Evaluation-Deficiency Action Plan: a. Immediate: The HCD or designee will audit each resident chart for compliance of	12/03/2023

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	Findings include: 1. On 10/3/23 at 10:12 a.m., a comprehensive record review was completed for Resident C. She had diagnoses which included but not limited to heart disease, HLD (hyperlipidemia), hypertension and pacemaker. Resident C's semiannual assessment was completed on 5/10/23. This assessment was overdue. Resident C did not sign her service plan. 2. On 10/3/23 at 11:10 a.m., a comprehensive record review was completed for Resident E. She had diagnoses which included but were not limited to GERD (gastroesophageal reflux disease), heart disease, HLD (hyperlipidemia), hypertension and osteoporosis. Resident E's semiannual assessment was completed on 3/10/23. This assessment was overdue. Resident E did not sign her service plan. On 10/3/23 at 2:30 p.m., The Healthcare Director indicated she had been with the facility in her role for 6 weeks. She acknowledged some assessments were overdue and she was doing her best to get them completed.		semiannual evaluations. b. Immediate: Residents identified to not have a semiannual evaluation will be evaluated by a licensed nurse and service plans will be formed. Care plan meetings with the residents and/or POA will be scheduled to obtain required signatures for compliance. c. Long Term: HCD or designee will perform monthly audits to ensure compliance annual, semiannual evaluations and signatures of care plans. Audits will be completed weekly for 8 weeks, bi-weekly for 8 weeks and monthly for 2 months. Completion Date: December 3, 2023 Responsible Party(ies)-HCD or Designee, ED for Review	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, interview, and record review, the facility failed to ensure timely follow up was conducted with a hospice provider to ensure appropriate treatments were available and in place for a resident (Resident T) who had an	R 0240	R. 240 Health Services-Deficiency Action Plan: a. Immediate: The HCD or designee will audit resident charts for treatments that are provided by	12/03/2023

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	open wounds for 1 of 1 resident reviewed for Hospice services. Findings include: On 10/4/23 at 9:43 a.m., Resident T's empty bed was observed. There was a folded gauze pad, entirely saturated with green and black drainage. The sheets were observed to have a large, dried stain. There was a 4 by (x) 4 adhesive bandage on the bedside table dated 9/28/23. On 10/4/23 at 9:57 a.m., with Resident T's permission, the wound on her upper right shoulder was observed. There was an outward growth, approximately the size of a golf ball which was lumpy and bumpy. There was active bleeding and serosanguineous drainage noted. The bleeding and draining had saturated through Resident T's thick sweatshirt. No dressing was in place. During an interview on 10/4/23 at 10:00 a.m., the Memory Care Coordinator (MCC) indicated the growth on Resident T's shoulder was cancerous and hospice provided all the wound treatments and had been in the day before to change her treatment. The MCC indicated the aide who got her dressed and up for the day should have notified the nurse that the treatment had come off. On 10/4/23 at 10:15 a.m., Resident T's medical record was reviewed. She resided on the Memory Care Unit and received hospice services. She had a current physician's order in her hospice binder, dated 9/19/23, which indicated wound care to her upper right shoulder two times a week and		outside providers. b. Immediate: Residents identified to have treatment orders will be monitored each shift by a clinical team member to ensure placement of treatment. c. Long Term: HCD or designee will monitor treatment orders for all residents each week during the course of the treatment. Orders will be monitored weekly for 8 weeks, bi-weekly for 8 weeks, and monthly for 2 months. Completion Date: December 3, 2023 Responsible Party(ies)-HCD or Designee	

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as needed if dislodged or soiled. Cleanse wound with wound cleanser and gauze, allow to dry, apply 4 layers of Xerofoam and cover with self-adhesive dressing. "To be completed by facility nurse if hospice nurse is absent."

Resident T's current October physician's orders were reconciled with her hospice order and lacked documentation that the above order had been transcribed to the facility nurse Medication/Treatment Administration Record.

Resident T's hospice provider failed to follow their order when the previous three treatments were reviewed and revealed they had only been completed on a weekly basis instead of bi-weekly. She had been seen for wound care after the order changed on 9/21/23, 9/28/23, and 10/3/23.

During an interview on 10/4/23 at 1:25 p.m., the Director of Nursing (DON) indicated the facility did not provide wound care, all wound care treatments should be provided through the resident's contracted services. It appeared that when hospice wrote the new order, the facility failed to follow up with the hospice provider to clarify the order.

On 10/4/23 at 12:15 p.m., the DON provided a copy of current facility policy titled, "Hospice Service and Agreement," revised 3/2022. The policy indicated, "Residents with a terminal illness may receive care coordinated with a hospice agency ... the community shall maintain in the resident's record a copy of the resident's current hospice care plan approved by the community, the hospice agency, and the resident or the resident's Health Care Surrogate Decision Maker ... Care staff will be trained on all functions so they may provide per regulation and community policy ...."

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R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation, interview, and record review, the facility failed to ensure that a licensed nurse was trained in the proper administration technique of insulin for 1 of 1 resident observed during a medication pass (Resident O). Findings include: On 10/3/23 at 2:15 p.m., a comprehensive record review was completed for Resident O. He had diagnoses that included but not limited to COPD (chronic obstructive pulmonary disease), CAD (coronary artery disease), bladder cancer, CHF (congestive heart failure), diabetes mellitus, HLD (hyperlipidemia) and hypertension. On 10/3/23 at 12:09 p.m., Resident O was observed sitting in his apartment. LPN 9 entered the apartment to obtain Resident O's blood sugar. He had a free style libre to his right arm. LPN 9 cleansed the free style libre site with an alcohol prep, then fanned the site with her hand. She cleaned Resident O's cell phone with an alcohol prep, then fanned the phone. Resident's blood sugar was 168. LPN 9 reviewed Resident O's medication orders. He had orders for lispro insulin administer per sliding scale: if blood sugar was 151 to (-) 200 administer 4 units, if blood sugar was 201-250 administer 8 units, if blood sugar was 251-300 administer 12 units, if blood sugar was 301-350	R 0247	R. 247 Health Services-Deficiency Action Plan: a. Immediate: The HCD or designee audited employees' files to identify the employees that are qualified to perform insulin administration. b. Immediate: All identified employees will be provided education and training on insulin administration and medication management policies and procedures. c. Long Term: The community will ensure implementation medication management policy and procedure with medication aides and LPN/RN during new hire orientation and signed acknowledgement of receiving and reviewal or policy and procedure. Employee files will be audited bi-weekly for 12 weeks and monthly for 3 months. Completion Date: December 3, 2023 Responsible Party(ies)-HCD or designee	12/03/2023

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	administer 16 units, if blood sugar was 351-400 administer 20 units, if blood sugar was greater than 400 units notify the physician, and hold if he does not eat. Resident O required 4 units of lispro per order. LPN 9 took the lispro insulin pen, attached a needle, and dialed in 4 units of insulin. LPN 9 did not prime the insulin pen with 2 units of insulin prior to dialing in the 4 units. LPN 9 indicated she was unaware she was supposed to prime the insulin pen prior to dialing in the ordered units. LPN 9 cleansed Resident O's left upper arm with alcohol then proceeded to fan the injection site with her hand. LPN 9 injected the insulin into his arm and pulled the needle out without holding for 5 seconds. The policy provided did not include how to administer insulin via an insulin pen. Per the manufacturer's instructions, it indicated to prime the insulin pen with 2 units of insulin and hold the needle in the skin for 5 seconds after administering.			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation and interview, the facility failed to ensure a resident who self-administered her medications secured controlled substances for 1 of 3 residents reviewed for medication self-administration (Resident C).	R 0295	R. 295 Pharmaceutical Services-Noncompliance Action Plan: a. Immediate: The HCD or designee will each resident file to identify the residents	11/15/2023

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	10/04/2023

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

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	Findings include: On 10/3/23 at 10:12 a.m., a comprehensive record review was completed for Resident C. She had diagnoses which included but not limited to heart disease, HLD (hyperlipidemia), hypertension and pacemaker. On 10/3/23 at 2:15 p.m., observed resident sitting in her chair. She had her medications in her bedroom. The medications were observed on a table. Her medication bottles sitting on the table included three controlled substances. The controlled substances were pregabalin (Lyrica) 75mg, zolpidem (Ambien) 5mg, and tramadol 50mg. Resident C indicated she does not lock her medications in a secured area of the apartment. On 10/3/23 at 2:30 p.m., the HD (Healthcare Director was notified of Resident C's controlled substances being unsecured. On 10/4/23 at 1:03 p.m., observed resident sitting in her recliner. She indicated her medications were locked up now. A policy title "Storage of Medications and Resident Self-Management dated 04/2021 was provided by the HD on 10/3/23 at 9:00 a.m. It 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 ....".		self-administer. b. Immediate: The HCD or designee will educate the residents who self-administer on the requirement to keep medications behind a double lock. a. Long Term: The HCD or designee will perform apartment audits to monitor for compliance of keeping medications behind a double lock. Audits will be completed weekly for 8 weeks, bi-weekly for 8 weeks and monthly for 2 months. Completion Date: November 15, 2023 Responsible Party(ies)- HCD or Designee, ED for Review	
R 0407	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance			

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		A. BUILDING 00 B. WING	10/04/2023

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Bldg. 00	(b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.			
	Based on an interview and record review, the facility failed to implement and maintain an infection control plan to monitor and track infections throughout the facility. This deficient practice had the potential to effect 67 of 67 residents who resided in the facility. Findings include: During an interview with the HCD (Healthcare Director), on 10/3/23 at 10:10 a.m., the HD indicatd there was no infection control system in place to monitor and track infections. She indicated she had been with the facility for 6 weeks and would get one in place. She had started a binder. A policy titled, "All Infection Control Program," was provided by the HD on 10/2/23 at 2:15 p.m. It indicated " ...The ED (Executive Director) or HCD (Healthcare Director)will be the designated on-site infection control officer that is knowledgeable about the Federal CDC (Center for Disease Control and Prevention) and prevention guidelines on infection control and who will control the community infection control practices and ensure that all of the team is trained in the infection control practices ....".	R 0407	R. 407 Infection Control-Noncompliance Action Plan: a. Immediate: The HCD, BOM or designee will audit employees' files for Infection Control training. b. Immediate: The HCD implemented policies and procedures which includes monitoring and tracking infections throughout the community. Training will be provided to the clinical department regarding infection control and documentation. c. Long Term: HCD is deemed as the onsite infection control officer. Employee files will be audited weekly for 8 weeks, bi-weekly for 8 weeks and monthly for 2 months. Completion Date: November 15, 2023 Responsible Party(ies)-HCD or Designee	11/15/2023

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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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