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	04/13/2021

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 12 and 13, 2021. Facility number: 014045 Residential Census: 81 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 26, 2021.	R 0000	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 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. This plan of correction is submitted as required under State and Federal law. The submission	

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

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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			of this Plan of Correction does not constitute an admission on the part of [Insert Name of Community] 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.	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual			

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	occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports			

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	available for inspection to any member of the public upon request Based on observation, interview, and record review, the facility failed to ensure a resident's falls with major injuries were reported to the state board of health for 1 of 7 residents reviewed (Resident 49). Findings include: On 4/12/21 at 9:57 a.m., Resident 49 was observed in her room. She was sitting on her couch, and there was a black supportive brace beside her. She indicated the brace was for her wrist, which had been broken during a fall, several months ago. On 4/12/21 at 12:20 p.m., Resident 49's medical record was reviewed. Resident 49 was admitted with diagnoses to include but were not limited to chronic Afib (Atrial fibrillation, an irregular heartbeat that can lead to blood clots, stroke, heart failure and other heart-related complications), and a history of stroke (damage to the brain from interrupted blood supply). A nursing progress note, dated 11/18/20 at 10:45 a.m., indicated Resident 49 was found on the floor at the foot of her bed complaining of pain in her left wrist, and an abnormal formation was observed on her left wrist/forearm. Resident 49 was sent to the hospital. A nursing progress note, dated 11/19/20 at 1:00 p.m., indicated Resident 49 had been admitted to a local hospital with a fractured left wrist. A nursing progress note, dated 1/7/21 at 10:00 p.m., indicated Resident 49 returned to the facility after completing rehabilitation at a local nursing home.	R 0090	The Community submitted a late report to the state board of health for Resident 49's fall on (May 29, 2021. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. All employees, management and staff, will be in-serviced on the Indiana Department of Health's on "Reportable Incident Policy and ISDH Reportable Unusual Occurrence Policy dated July 15, 2015 or before May 29, 2021. In addition, the community will be providing all staff with a procedure outlining the communication steps to be taken to inform all required individuals of reportable incidents. 4. The Executive Director, Wellness Director or designee will monitor incidents to ensure all major injuries, including falls, are reported to the state board of health. 5. Systemic change date May 29, 2021	05/29/2021

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	A nursing progress note, dated 2/8/21 at 5:20 a.m., indicated Resident 49 was found on the floor by her bed, and was complaining of left hip and lower back pain. She was sent to the hospital. A nursing progress note, dated 2/8/21 at 1:50 p.m., indicated Resident 49 was admitted to a local hospital with a L-3 (lumbar spine) fracture. A nursing progress note, dated 3/11/21 at 9:10 p.m., indicated Resident 49 returned to the facility after completing rehabilitation at a different local nursing home. On 4/12/21 at 3:00 p.m., the Executive Director (ED) provided copies of all state reportable incident forms from November 2020, until April 2021. Resident 49's falls with fractures were not included. During an interview, on 4/12/21 at 3:40 p.m., the ED indicated there were no additional reportable incident forms. Resident 49's two falls with fractures had not been reported and should have been. At this time, he provided a copy of current facility policy titled, "Indiana State Department of Health Division of Long Term Care Reportable Incident Policy," dated 7/15/15. The policy indicated, "...Residential Care Facilities, informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Unusual occurrences include, but are not limited to: (A) Epidemic outbreaks (B) Poisonings (C) Fires, or (D) Major Accidents ...Major Accidents- unexpected or unintentional events resulting in any fractures or other outcomes that require medical treatment beyond basic first aid or ER/physician evaluation...."			

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R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on interview, and record review, the facility failed to ensure the Memory Care (MC) Director had the correct number of educational hours, within three months of hire. This deficiency had the potential to effect 14 of 14 residents residing in the memory care unit. Findings include: During an interview, on 4/14/21 at 1:14 p.m., the	R 0095	1. The Executive Director will complete the 12 hours of dementia training on or before May 29, 2021. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The Business Manager or	05/29/2021

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	Executive Director (ED) indicated he was the memory care director but went to the Wellness Director (WD) for clinical questions. He indicated he had no educational transcript, for the last 7 months, to document any dementia education since he was hired on 9/14/21 but believed he had accomplished about 6 of the required 12 hours. A document, titled, "Job Description and Profile," dated 12/11/19, was provided by the ED on 4/14/21 at 3:07 p.m. A review of the document indicated, " ...Job Position Title: Memory Care Director...Skill/knowledge requirements ...Meet continuing education requirements and certifications on job classification and position, including state requirements...." A State of Indiana document, titled, "Indiana State Department of Health, Division of Long-Term Care, Residential Regulations," dated 2008, indicated for MC Directors to, " ...have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia...."		designee will audit employees' files to ensure staff receive the correct number of education hours within three months of hire. 4. The Business Manager or designee will monitor to ensure staff receive the correct number of education hours within three months of hire. 5. Systemic change date May 29, 2021	
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			

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	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. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on interview and record review, the facility failed to ensure all staff received the State required orientation and annual education for 2 of 5 staff reviewed for education. Findings include: During 5 random employee record reviews, on 4/13/21 at 1:00 p.m., the findings were as follows: The facility could not provide educational records	R 0120	Staff ED and QMA will receive the state required orientation and annual education on or before May 29, 2021. 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 utilizes Relias, learning management programing	05/29/2021

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	for the Executive Director (ED) having resident rights and dementia training within the first 6 months of his employee. His start date was 9/14/20. The facility could not provide educational records for Qualified Medical Aid (QMA) 16 having annual resident rights, abuse, and dementia training. Her start date was 8/2/18. During an interview with the ED, on 4/13/21 at 3:07 p.m., he indicated the corporate office told him all the staff education was loaded into computerized educational software and all the employees had access. A current in-service document, titled, "Annual In-House In-Service Calendar," with no date, was provided by the Regional Nurse Specialist, on 4/13/21 at 3:10 p.m. A review of this document indicated, " ...In-Service Topic... February Abuse, Neglect, Misappropriation...May Resident Service Agreements / Resident Rights Advanced Directives...October Physical/Mental Special Care Needs...."		system. Relias creates and offers a variety of continued educational modules that are assigned upon hire, monthly and annually. In-service trainings include: Resident Rights, Dementia Training, Prevention and Infection Control, Fire Prevention, Safety, Accident Prevention, Medication Administration and Nursing Care. Upon completion, certificates are awarded, and Relias tracks and saves all modules completed. In addition, the community will review the in-service training records of all employees and make sure that all of the required in-service courses have been assigned correctly to each employee. 4. The Business Manager or designee will monitor to ensure staff receive the state required orientation and annual education. 5. Systemic change date May 29, 2021.	
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 interview and record review, the facility failed to ensure a resident did not receive an antipsychotic medication which had previously been discontinued by the physician for 1 of 2 closed records reviewed (Resident 96).	R 0247	Resident 96 is no longer in the Community. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient	05/29/2021

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	Findings include: On 4/12/21 at 2:30 p.m., the closed medical record was reviewed for Resident 96. The diagnoses included but were not limited to dementia. The record indicated, on 12/18/20, Resident 96 was sent out to the hospital. The resident returned on 1/6/21 with a change in physician orders. Resident 96's medical transfer and orders indicated he was no longer to receive Risperdal (antipsychotic medication). On 2/18/21, a physician's follow up note at the facility, indicated Resident 96 had an order for Risperdal started on 11/12/20, for behaviors, before he was sent to the hospital. When the resident returned to the facility, he no longer had orders for Risperdal, but was taking Haldol (antipsychotic medication) and amitriptyline (antidepressant medication). On 2/13/21 the resident's son brought in a refill of Risperdal and, "nurse wrote an order for the Risperdal. The patient had been on three agents for the past week. Provider called hospice, DON [Director of Nursing] and Nsg [nursing] staff was notified to report the medicine error." On 2/18/21 at 3:30 p.m., a nurse's note indicated Resident 96 was seen by the Nurse Practitioner (NP). He had been receiving Risperdal 0.25 mg in error. Orders were received to discontinue the medication. On 4/13/21 at 10:55 a.m., the Wellness Director provided a printed copy of Resident 96's February Medication Administration Record (MAR) for review. The record indicated Risperidone 0.25 mg, take one tablet by mouth, twice daily. The order date was listed as 2/13/21 and discontinued on		practice. 3. On April 15, 20021, all nurses and QMA's were in-serviced on a) ensuring that medications received from family or pharmacy must have a current physician order in the resident's chart before accepting any medication. b) when receiving discharge orders from the hospital, all orders must be verified via phone with the primary care physician and the verification must be written on the discharge orders by the nurse with whom contacted the primary care physician. The nurse will initial and date of verification. The nurse will then document in the resident's chart. Once the order is verified by primary care physician the pharmacy will be notified. In addition, only the pharmacy can enter medications into ACCUflo. 4. The Executive Director, Wellness Director or designee will. 5. Systemic change date May 29, 2021	

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	2/18/21. On 4/13/21 at 2:10 p.m., during an interview, the Wellness Director indicated Resident 96's son had been contacted by (name of pharmacy) to pick up a refill (auto refill) of Risperidone. The son had brought the refilled medication to the facility and gave it to an unidentified nurse. The nurse should have looked in the chart for the last physician's orders to verify an order for the medication before adding it to the administration record. In this case the medication had been discontinued and should have not been restarted. The facility followed State regulations for medication administration and the facility's corporate guidelines.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure staff followed appropriate dish washing procedures for 2 of 2 observations of dish washing. The facility failed to ensure staff wore hair nets to cover all hair when serving food and delivering meals to residents, and transported food uncovered down the hallways for 4 of 4 residents observed for hall trays (Residents 76, 71, 67, and 82). Findings include: 1. On 4/12/21 from 9:17 a.m. until 9:30 a.m., an initial kitchen tour was conducted with the Kitchen Manager. At 9:25 a.m., Kitchen Aid 12 was observed as he	R 0273	1. Staff assigned to Residents 76, 71, 67 and 82 are wearing hairnets that cover all hair when serving food and delivering meals and are transporting food covered down the hallways. Kitchen Aid 12 is no longer employed with Community. CNA's 9 and 10 were covering all hair with hair restraints. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. On or before May 29, 2021, all dietary staff will be required to attend in-service trainings on	05/29/2021

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	completed a dish wash cycle. He used a dish towel that had been draped over his shoulder to wipe out and dry the inside of a mixing bowl. At this time, the Kitchen Manager indicated dishes should not be dried with a towel but left to air dry. At 9:37 a.m., Kitchen Aid 12 opened the dish washer door, and a rack of clean dishes was observed. He slid a second rack of dirty dishes to the dish washer door, directly beside the rack of clean dishes. He pulled the sink sprayer over and began to spray the dirty dishes to rinse them before wash. The spicket sprayed and back splashed onto the clean dishes. At this time the Kitchen Manager indicated, Kitchen Aid 12 should have moved the clean rack out of the way, so back splash from the dirty dishes did not contaminate the clean dishes. On 4/12/21 at 3:40 p.m., the Administrator provided a copy of current, but undated facility policy titled, "Washing and Sanitizing Dishes/Utensils." The policy indicated, "Sanitation is a process by which an agent or substance is applied to a clean surface to destroy any germs that may cause an illness. Washing and sanitizing dishes and utensils are important procedures in order to prevent the spread of disease. This process may be accomplished either by machine washing or hand washing. All guidelines in the Food Sanitation rules published by the Health Department must be followed... air dry dishes and utensils (do NOT use towels for drying dishes/utensils as this could spread contamination) ...." 2. On 4/12/21, during a continuous dining observation, from 11:30 a.m. to 12:30 p.m., Certified Nursing Assistants (CNA) 9 and 10 were observed serving the lunch meal from a countertop steam table, in the Memory Care		proper dish washing, sanitizing and drying procedures. In addition, all dietary staff and Nursing staff will be required to attend in-service trainings wearing hairnets that cover all hair when serving food and delivering meals and are transporting food covered down the hallways. 4. The Dietary Manager or designee will randomly audit staff to ensure proper dish washing procedures and proper usage of hair restraints. 5. Systemic change date May 29, 2021	

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		A. BUILDING 00 B. WING	04/13/2021

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	Dining Room. CNA 10 had long hair reaching down her mid back and falling forward of her shoulders onto her chest. She wore a hair net on the crown of her head, it did not exceed below her ears. CNA 9 had above the shoulder length hair. She wore a hair net with several strands of hair on the sides and back of her head not contained inside the net. At 11:39 a.m., CNA 10 plated 2 meals and placed the meals on an open 3 tier cart. CNA 9 then transported the cart to the unit pantry where she added thickener to the drinks on the cart. She exited the pantry to her left and took the 3 tiered cart, with uncovered plates of food and bowls of soup down the hallway to Resident 76, leaving the cart in the hall while taking the meal into the resident's room. CNA 9 then pushed the 3 tiered cart down the hall, past the dining room, with an uncovered plate of food and soup, to deliver a meal to Resident 71. She returned the cart to the dining area. At 11:52 a.m., CNA 10 took a handful of gloves from a glove box and stuffed them in her jacket pocket. She then placed a meal on the 3 tiered cart and proceeded down the hall to deliver a meal to Resident 67. At 11:56 a.m., CNA 10 returned to the dining room and changed gloves. She used the gloves from her pocket. She left the dining room with an uncovered meal on the 3 tiered open cart. She stopped in the common area and interacted with Resident 67 and addressed 2 other unidentified			

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	residents in the common area. She then escorted Resident 67 back to his room and CNA 9 took the 3 tiered cart, which was sitting in the common area, to Resident 82's room to deliver the uncovered plate of food and soup. On 4/13/21 at 11:02 a.m., during an interview the Wellness Director indicated hair nets "must" be worn when serving food. Food should have been covered before taking it out of the dining room, for room service. On 4/13/21 at 8:45 a.m., the Wellness Director provided an undated policy, titled "Hair Restraint Policy." This policy indicated, "It is the policy of this Community that all dietary staff shall wear hair restraints (hairnets), including beard restraints if applicable, while in the kitchen and preparing meals ...." A second, undated policy provided on 4/13/21 at 8:45 a.m., titled, "Delivered Meal Service," indicated, "...Cover hot food with a plastic cover to keep food warm...."			
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation and interview, the facility failed to ensure an expired vial of multidose PPD (purified protein derivative, tuberculosis testing medication) was discarded and unavailable for use, and refrigerated medications were properly stored for one resident (Resident 36) for 2 of 3	R 0297	The Community removed and discarded the opened multidose vial of PPD from the refrigerator. The refrigerator on the 2nd floor medication storage room that contained medications for	05/29/2021

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	random medication storage rooms observed for medication storage. Findings included: On 4/13/21 at 8:40 a.m., the 3rd floor medication storage room was observed with Licensed Practical Nurse (LPN) 7. An opened multidose vial of PPD was observed in the refrigerator. The bottle had an open date of 2/28/21. On 4/13/21 at 8:45 a.m., LPN 7 indicated she did not administer PPD tests, but she believed all opened bottles or vials should have been discarded after 30 days. She removed the bottle from the refrigerator. On 4/13/21 at 8:55 a.m., the 2nd floor medication storage room was observed with LPN 7. The refrigerator contained medications for Resident 36 including suppositories, 10 Bisacodyl (laxative) 10 mg, and 30 acetaminophen (for pain or fever) 650 mg. No other medications were in the refrigerator. The refrigerator was not locked. No signage was observed on the refrigerator. Inside the refrigerator a blue package sign indicated "Specimen." On 4/13/21 at 9:00 a.m., during an interview, LPN 7 indicated the refrigerator was not for medication storage. It was a specimen refrigerator. They stored laboratory specimens there for the lab to pick up. Resident 36's medications should have not been stored in that refrigerator. The staff were all aware it was only for specimens, not medications. On 4/13/21 at 10:55 a.m., the Wellness Director provided a current undated policy, titled "Storage of Medications." This policy indicated "...Only		Resident 36 were removed. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. On April 15, 2021, all medication rooms were relabeled with proper signage. The 2nd floor medication room was marked as "Lab Specimens Only". In addition, on April 15, 2021, all nurses and QMA's were in-serviced on a) the Community's medication storage policy, b) utilizing the correct refrigerator for lab specimens and c) on dating opened medications and removing expired and destroyed per pharmacy guidelines. In addition, a new monitoring log was initiated for the Nurse's and QMA's on 6:00 a.m. -2:00 p.m. shift to check the refrigerator weekly for 4 weeks then monthly. Nurse's and QMA's will turn in monitoring log sheets to Wellness Director or designee for monitoring weekly then monthly. 4. Nurse's and QMA's will turn in monitoring log sheets to Wellness Director or designee for monitoring weekly then monthly. 5. Systemic change date May 29, 2021.	

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	medications and medication supplies should be kept in the medication room ...The medication must also be dated with the date opened ...The refrigerator should not be used for any non-medical items...."			