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	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00450189 & IN00451278. Complaint IN00451278 - No deficiencies related to the allegations are cited. Complaint: IN00450189 - State deficiencies related to the allegations are cited at R0117 & R0118. Survey dates: January 27 & 28, 2025 Facility number: 014916 Residential Census: 69 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 1/31/2025	R 0000		
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on record review and interview, the facility failed to ensure staff provided care to residents within their scope of practice for 1 of 5 staff members reviewed for employee records. (RA 2) Finding includes: During an interview on 1/28/2025 at 9:00 A.M., the Assistant Administrator indicated RA 2 was a Resident Assistant (RA) and not a Certified Nursing Assistant (CNA). He indicated RA 2 still needed to complete the hands on portion of her training to become a CNA.	R 0117	RA2 was immediately removed from the clinical schedule of providing direct care to residents. RA2 will be scheduled to reflect only services of an RA until such time that RA2 can provide documentation of CNA Certification. CNA Certification will be verified by BOM or designee upon receipt. Upon verification RA2 may be reinstated on the direct care /clinical schedule if available. Ongoing the BOM will	03/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tara Carney		02/21/2025

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	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 1/28/2025 at 9:14 A.M., Resident G indicated RA 2 had placed a callous patch on the bottom of her foot once while providing care to her. During an interview on 1/28/2025 at 9:55 A.M., RA 2 indicated she pushed residents to and from the dining room via their wheelchairs, helped change residents clothing and soiled briefs, provided and assisted residents with bandaid application and had placed a callous patch on a resident's foot. During an interview on 1/28/2025 at 2:40 P.M., the Assistant Administrator indicated RA's were not able to do any type of resident transfers, feed residents or change a resident's brief. He indicated RA's were able to transport residents from place to place and do general housekeeping duties. He indicated RA 2 should not have been doing any hands on care with residents. A review of the facilities job description for Personal Care Aide indicated responsibilities included, but were not limited to: Perform housekeeping duties, such as making residents beds, cleaning resident apartments, common areas and dining room and assisting residents to and from the dining room. On 1/28/2025 at 2:48 P.M., a policy regarding Resident Assistance duties was requested but one was not provided prior to the survey exit. This citation relates to complaint IN00450189.		maintain a tracking log for all new hires that are hired contingent of receipt of CNA Certification. Employees hired under a pending CNA certification may be scheduled to provide only services as identified under the RA job description and within the RA P&P. Business Office Manager or designee will maintain binder for all licensed employees. Licenses will be audited 5 times per week for 4 weeks, then 1 time a week for 4 weeks, then once a month for a minimum of 4 months by Business Office Manager or designee.	
R 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency Based on record review and interview, the facility	R 0118	RA2 was immediately removed	03/28/2025

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	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to ensure staff members became certified within the required time frame and failed to ensure staff members who were on shift maintained an active license for 3 of 5 staff members reviewed for employee records. (RA 2, CNA 3 & CNA 4) Findings include: 1. An employee record review was completed for RA 2 and indicated the employee was hired on 4/9/2024. The record lacked documentation RA 2 had obtained the required CNA certification within 120 days of hire. During an interview on 1/28/2025 at 9:00 A.M., the Assistant Administrator indicated he was under the impression RA 2 was actively working towards her CNA licensure. He indicated the employee should have been certified within 120 days of their hire date. 2. An employee record review was completed for CNA 3 and indicated the employee's CNA certification had expired on 1/4/2025. CNA 3 was not on the weekly schedule viewed for 1/26 - 2/2/2025. The record lacked documentation CNA 3's license had been renewed. 3. An employee record review was completed for CNA 4 and indicated the employee's CNA certification had expired on 8/6/2024. A review of the facilities staffing schedule from 1/26/2025- 2/1/2025 indicated the employee was scheduled to work, as a CNA, on the following dates: - 1/27/2025 - 1/28/2025		from the clinical care schedule as outlined within the response for tag #R117. CNA3 and CNA4 were immediately removed from the clinical schedule of providing direct resident care pending verification of current licensure/certification. The BOM received proof of licensure status for CNA3 and CNA4 on 2/3/2025. CNA3 and CNA4 were reinstated on the clinical direct care schedule following verification of status. Ongoing the BOM or designee will create and maintain a tracking log for licensure/certification expiration dates and request proof of renewal within 30 days prior to expiration for all staff required to have a state issued license or certification R/T their job position. Business Office Manager or designee will maintain binder for all licensed employees. Licenses will be audited 5 times per week for 4 weeks, then 1 time a week for 4 weeks, then once a month for a minimum of 4 months by Business Office Manager or designee.	

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	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- 1/29/2025 - 1/30/2025 - 2/1/2025 The record lacked documentation CNA 4's certification had been renewed. During an interview on 1/28/2025 at 1:28 P.M., the Assistant Administrator indicated CNA 3 currently worked PRN (as needed) and would be taken off the schedule until her certification was renewed. He indicated CNA 4 would be sent home and unable to work until her certification was renewed. He indicated CNA 3 and CNA 4 should not have been working with expired certifications. On 1/28/2025 at 2:22 P.M., the Assistant Administrator provided the policy titled, "Pre-employment Screening to Include Criminal Background Checks", dated 4/2021 and indicated it was the policy currently being used by the facility. The policy indicated, "...3. Obtains a copy of licensing, certification, and registration and verifies the authenticity...." The policy did not address certification renewal procedures. This citation relates to complaint IN00450189.			
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance Based on record review and interview, the facility failed to ensure employee records included specific job orientation documentation for 2 of 5 staff members reviewed for employee records (Housekeeper 8 & RA 2). Findings include: 1. On 1/28/2025 at 1:10 P.M., an employee record	R 0119	Housekeeper 8 and RA2 received job specific orientation as follows: Housekeeper8 was educated by the Maintenance Director on 3/1/2025. RA2 was educated by the Healthcare Director on 3/1/2025. Ongoing the BOM or designee will hold all new hire employee files	03/28/2025

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	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	review was completed for Housekeeper 8. Housekeeper 8 was hired on 9/24/2024. The record lacked documentation Housekeeper 8 had completed a job specific orientation after she was hired. 2. On 1/28/2025 at 1:15 P.M., an employee record review was completed for RA 2. RA 2 was hired on 4/9/2024. The record lacked documentation RA 2 had completed a job specific orientation upon hire. During an interview on 1/28/2025 at 1:28 P.M., the Assistant Administrator indicated he did not have the job specific orientations for Housekeeper 8 and RA 2. On 1/28/2025 at 2:22 P.M., the Assistant Administrator provided the policy titled, "(Name of Facility) Policy/Procedure", dated 4/2021 and indicated it was the policy currently being used by the facility. The policy indicated, "Staff will receive initial orientation to meet state regulations...."		until documentation of job specific training is documented as completed. Job specific training/orientation will be completed within 30 days of employee start date by the relevant department head. Business Office Manager or designee will audit employee files to ensure current staff have completed job specific training/orientation by 3/1/25. Business Office Manager or designee will audit new employee files to ensure completion of job specific orientation 5 times per week for 4 weeks, then 1 time per week for 4 weeks, then 1 time monthly for a minimum of 4 months.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure staff members received training on abuse and dementia annually for 3 of 5 staff members reviewed for in-services. (Maintenance Director, RA 2 & Housekeeper 6) Finding includes: On 1/28/2025 at 1:00 P.M., a review of the	R 0120	Abuse and dementia annual training for RA2, Housekeeper6 and the Maintenance Director will be completed under the direction of the Executive Director no later than 3/14/2025. Ongoing abuse training will be completed at the time of hire/orientation and annually as a topic for the all staff meeting every March. Dementia	03/28/2025

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	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	employee records was completed. The employee records for the Maintenance Director, RA 2 and Housekeeper 6 lacked documentation of yearly dementia and abuse training for each employee. During an interview, on 1/28/2025 at 1:28 P.M., the Assistant Administrator indicated he had not provided staff members with a yearly dementia training or abuse training as required. On 1/28/2025 at 2:22 P.M., the Assistant Administrator provided the policy titled, "(Name of Facility) Services Policy/Procedure," dated 4/2021 and indicated it was the policy currently being used by the facility. The policy indicated, "...Staff will then receive initial and ongoing departmental training, as well as annual refresher training to many initial orientation topics...."		training (6 hours) will be assigned to all new hires in the current online training platform with deadline for completion being within 180 days of the employee start date. Annual dementia specific training will be assigned to each employee annually in March via the current online training platform and have a deadline for completion by the end of the month of March. Ongoing the BOM or designee will monitor completion of assigned training modules in the online platform to ensure completion is timely. BOM or designee will report noncompliance to the pertinent department head(s). Employees out of compliance with training will be removed from the schedule until such time that compliance is obtained. Business Office Manager or Designee will audit required annual training for current and new employees no later than 3.14.25; Business Office Manager or designee will audit training completion for employees 5 times per week for 4 weeks, then 1 time per week for 4 weeks; then 1 time monthly for a minimum of 4 months.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance Based on record review and interview, the facility	R 0121	CNA7 was provided a	03/28/2025

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	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to ensure staff members received tuberculosis (TB) risk assessments annually for 1 of 5 staff members reviewed for employee records (CNA 7). Finding includes: On 1/28/2025 at 1:10 P.M., an employee record review was completed for CNA 7. The record lacked documentation a yearly TB risk assessment had been completed for CNA 7. During an interview on 1/28/2025 at 1:28 P.M., the Assistant Administrator indicated CNA 7 should have received an annual TB risk assessment and had not. On 1/28/2025 at 2:22 P.M., the Assistant Administrator provided the policy titled, "Tuberculosis-Associates," dated 4/2021 and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: All caregivers shall be screened for tuberculosis (TB) infection and disease prior to beginning employment as per state regulations. The need for subsequent evaluations shall be performed annually per state regulations...."		TST/Screening Questionnaire by the Healthcare Director. Screening attestation was completed and filed in the employee personnel file by the BOM/designee. Ongoing the Healthcare Director or designee will provide TST/Screening for all employees annually in March of each calendar year. The Healthcare Director or designee will monitor employee compliance and will communicate noncompliance to the appropriate department heads. Employees outside of compliance will be removed from the schedule until such time that the employee completes the TST/screening. Business Office Manager or designee will audit employee files to ensure employees are in compliance with TB policy by 3.14.25; Business Office Manager or designee will audit employee files to ensure current and new employees are in compliance with the TB policy 5 times per week for 4 weeks, then 1 time per week for 4 weeks, then 1 time monthly for a minimum of 4 months.	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance Based on record review and interview, the facility failed to ensure employee records included signed job descriptions for 2 of 5 staff members reviewed for employee records (Housekeeper 8 & RA 2).	R 0123	Housekeeper8 and RA2 were provided and have signed a job description. The job description has been placed in the employee files.	03/28/2025

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	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: On 1/28/2025 at 1:10 P.M., an employee record review was completed for Housekeeper 8 and RA 2. The records lacked documentation a job description was provided to Housekeeper 8 and RA 2 and was signed by the employees upon their hire. During an interview on 1/28/2025 at 1:28 P.M., the Assistant Administrator indicated he did not have a signed job description for Housekeeper 8 and RA 2 and he should have. On 1/28/2025 at 1:50 P.M., a policy regarding job descriptions was requested but one was not provided prior to the survey exit.		Ongoing job descriptions will be provided to all employees upon hire/orientation. The BOM or designee will hold open all new employee files until required signed job description is completed. The Business Office Manager or designee will audit employee files to ensure each employee has a signed job description no later than 3.14.25; Business Office Manager or designee will audit employee files ensuring each one has a signed job description 5 times per week for 4 weeks, then 1 time per week for 4 weeks, then 1 time monthly for a minimum of 4 months.	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency Based on observation and interview, the facility failed ensure the kitchen was maintained in a clean, litter free manner for 1 of 1 kichens.This deficient practice had the potential to affect all 69 residents who consumed food from the kitchen. Findings include: During a tour of the kitchen, conducted on 1/27/2025 from 9:45 A.M. until 10:31 A.M., with the Dietary Manager (DM) the following was observed: a. The walk-in cooler had dried blood that had dripped from meat onto the floor. b. Food prep area 2 had debris and a lemon under	R 0154	The Dining Service Director will reeducate all staff on proper thawing and storage of meat and all food items including dating and labeling. The ice machine will be scheduled to be cleaned twice a month, the beginning of the month to the end of the month. The Dining Service Director will monitor cleaning schedule monthly for compliance. Ice machine was cleaned on 02/12/2025.	03/15/2025

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	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the shelving on the floor and a dirty paper cup on counter top. c. The ice maker had a large amount of a calcium build up and the front of ice bin was dirty d. There was coffee grounds and coffee spillage on a food prep counter e. The ice tea maker had a thick tea residue around the inside f. There was debris and a greasy substance on the floor behind the stove and under steamer g. There was a greasy build up on the outside of the small deep fiver h. There was wrappers and other food debris on the shelves where plates were stored. i. A multipurpose orange cleaner was stored on a shelf below the steam table next to an opened gallon bottle of maple syrup and there was a bottle of "Grease Express" cleaner on the food prep counter next to the deep fryer. During an interview, on 1/28/2028 at 10:18 A.M., with the Dietary Manager (DM, she indicated the cleaning schedule had not been been followed and when staff were thawing out meat, it should have been placed in a pan so it did not drip onto the floor. In addition, she indicated the cleaning supplies should be stored separately and away from food products and the food prep areas. A current facility policy titled "Kitchen Safety and Sanitation" was provided by the Assistant Administrator on 1/27/2025 at 12:25 P.M. and indicated as the current policy. The policy indicated to "...store all cleaning products and/or other chemicals separately from all food supplies and food preparation equipment..." and "...food preparation and serving areas must be cleaned after each use ..."		Daily and weekly cleaning schedule will be put in place and the food service director will follow it through by end of shift make sure that all the surface and equipment's are clean including the microwave. Food service director will reeducate on Storage labeling and usage of the chemicals, make sure is in original container, labelled and stored at a designated place. The Dining Service Director will monitor weekly to ensure compliance. Kitchen equipment's and floor will be deep cleaned by 3/15/2025. The in-service and the education have already started, and it will be done not later than 3/15/2025. Immediate Steps taken: - Cleaned the greasy floor and walls while survey was still in progress - Cleaned the kitchen equipment including microwave. - Throw away undated and unlabeled stuff - Implementing daily cleaning schedule for cooks, servers, and dishwasher. Dining Service Director or designee will audit kitchen cleaning logs 5 times weekly for 4 weeks, then 1 time weekly for 4	

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	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			weeks, then 1 time monthly for a minimum of 4 months to ensure compliance.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on record review and interview, the facility failed to obtain resident weights every 6 months for 3 of 7 residents reviewed for weight. (Resident 4, E and D) Findings include: 1. A record review for Resident 4 was completed on 1/28/2025 at 9:20 A.M. Diagnoses included, but were not limited to: bipolar I disorder, anxiety disorder, neuropathy, diabetes mellitus type and mania. Resident 4 admitted on 7/31/2024. A review of Resident 4's weights in the clinical record, indicated no weights were documented. A Vital Signs History document, dated 12/2/2024 through 12/23/2024, indicate no weights were documented. During an interview, on 1/28/2025 at 2:59 P.M., the Director of Nursing indicated weights should be completed monthly, unless ordered otherwise. 2. A record review for Resident E was completed on 1/28/2025 at 9:20 A.M. Diagnoses included, but were not limited to: bipolar type I, anxiety disorder and cancer. A review of Resident E's weights in the clinical record, indicated a weight had been last	R 0216	The Healthcare Director (HCD) will complete a 100% review of resident charts for baseline weight on admission (by day 4 of the resident stay). Any resident that is out of compliance will have a weight taken and recorded in the EMR. Ongoing, weights will be obtained and recorded on admission (by day 4 of the resident stay) and monthly by the 5th day of each month. The HCD in collaboration with the dietician will monitor residents for significant change to monthly weights. The dietician will be responsible for making recommendations with regard to weight changes. The HCD will be responsible for communication of dietician recommendations to the attending clinician(s). The HCD will implement any new orders given by the attending clinician(s). The Healthcare Director or designee will audit resident charts for weights by 3.14.25; The Healthcare Director or designee will then audit charts for weight compliance 5 times per day for 4 weeks, then 1 time per week for 4	03/28/2025

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	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documented on 12/8/2023. A Vital Signs History document, dated 9/3/2024 through 12/23/2024, indicate no weights were documented. 3. A record review for Resident D was completed on 1/28/2025 at 10:03 A.M. Diagnoses included, but were not limited to: chronic kidney disease stage 3 and over active bladder. A review of Resident D's weight in the clinical record, indicated a weight had been last documented on 1/20/2024. A Vital Signs History document, dated 1/20/2024 through 1/9/2025, indicated no recorded weights. A Policy was provided, on 1/28/2025 at 2:57 P.M., by the Executive Director. The policy titled, "Nutritional Status/Weight Monitoring", indicated, "...3. A routine cycle will be established for the obtaining of each resident's weight monthly, unless ordered differently by the resident's physician...."		weeks, then 1 time monthly for a minimum of 4 months to ensure compliance.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to have service plans signed by the resident/resident representative for 3 of 7 residents reviewed for service plans. (Resident 4, 3 and C) Findings include: 1. A record review for Resident 4 was completed on 1/28/2025 at 9:20 A.M. Diagnoses included, but were not limited to: bipolar I disorder, anxiety	R 0217	Resident3, Resident4, and ResidentC will have a review of each service plan completed by the Healthcare Director (HCD) and signatures pertaining to goals and interventions will be obtained from the Resident or POA as appropriate. The HCD will complete a 100% audit of all Resident service plans to identify any residents out of	03/28/2025

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	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	disorder, neuropathy, diabetes mellitus type and mania. A service plan, dated 6/3/2024, was not signed by the resident or the resident's representative. 2. A record review for Resident 3 was completed on 1/28/2025 at 9:55 A.M. Diagnoses included, but were not limited to: depression, acute kidney failure, agoraphobia and hypertension. A Service Plan, dated 4/2/2024, was not signed by the resident or the resident's representative. 3. A record review for Resident C was completed on 1/27/2025 at 2:33 P.M. Diagnoses included, but were not limited to: hypertension, malnutrition, dementia, heart failure and arthritis. A Service Plan, dated 4/2/2024, was not signed by the resident or the resident's representative. During an interview, on 1/28/2025 at 2:59 P.M., the Director of Nursing indicated the service plans needed to be signed by the resident and/or their representative. She indicated she could not find any current signed copies of the service plans. A policy was provided, on 1/28/2025 at 2:57 P.M., by the Executive Director. The policy titled, "Individualized Service/Care Plan ISP/ICP [Individual Service Plan/Individual Care Plan]" indicated, "...7. ISP/ICP shall be reviewed and updated at least once every 12 months or upon significant change in the change in the condition of the resident changes, The review and update shell be performed by a staff member that has had the training needed to complete them an on conjunction with the resident, and as appropriate, with the resident's family, legal representative,		compliance with signatures. Residents will be brought into compliance with this initiative. Ongoing Service Plans will be updated in the EMR annually or with any significant change in resident condition. Healthcare Director or designee will audit service plans to ensure proper signatures 5 times per week for 4 weeks, then 1 time per week for 4 weeks, then 1 time monthly for a minimum of 4 months.	

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	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	direct care staff, case manager, health care providers, and qualified mental health professionals or other persons...." 410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency			
R 0273 Bldg. 00	Based on observation and interview, the facility failed to ensure food was stored, served and prepared in a sanitary manner for 1 of 1 kitchens and 1 of 2 dining rooms observed for food service (Memory Care Dining Room). This had the potential to affect all 69 residents who received food from the kitchen and all 25 residents in the Memory Care Dining Room. Findings include: 1. During a tour of the kitchen, on 1/27/2025 from 9:45 A.M. until 10:31 A.M., with the Dietary Manager, the following was observed: a. In the walk-in cooler there was a box of sliced mushrooms not covered, a brown substance in a 1/6th pan not labeled or dated, a brown substance in a 1/3rd pan not labeled or dated, sausage/hot dogs in liquid not labeled or dated, a large container of Yoplait yogurt with a use by date of 1/25/2025. b. In the dry storage area there was an open, unsealed bag of tortilla chips, a bottle of wine vinegar opened and undated, an open, unsealed bag of spaghetti noodles, an open, unsealed bay of macaroni pasta, a yellow cake mix with the use by date of 12/4/2024 and an open bag of croutons, undated and unsealed. c. The back prep area had shelves with plates and bowls not inverted and silverware of spoons,	R 0273	The DSD, HCD, or designee will provide training to all employees that may be providing meal service to the residents. The training will include Infection Control Policies and Procedures, as well as the Personal Hygiene Policy for employees. The DSD, HCD, or designee will ensure that all employees that may be providing meal service to the residents are scheduled to training by 3/31/2025. All employees that may be providing meal service to the residents will receive training on the Infection Control Policies and Procedures, as well as the Personal Hygiene Policy when in General Orientation as a new hire employee. Audits will be completed each mealtime weekly for 4 weeks, bi-weekly for 4 weeks, and once a week for 4 months. If we found deficient upon completion of the full audit the DSD, HCD, or designee will retrain staff on infection control policies and personal hygiene policy and the full 6-month audit will then start over and repeat. This is to	03/31/2025

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	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	knives, and forks not inverted on counter. d. In the back prep area refrigerator there were prepared sandwiches stored together in cellophane wrap not labeled or dated, an open bag of lunch meat undated, five- 1 ounce (oz) relish dishes not labeled or dated, an opened bag of shredded cheddar cheese unsealed and not dated, and 1 gallon container of French dressing with no open date. e. In the Freezer there was a bag of shrimp not sealed or dated. f. In the back prep area 2 there were large bins with bulk items in them with no label or use by date, two open bags of confectioner's sugar with no open dates, two opened quart size bottles of soy sauce with no open date, an opened gallon of rice vinegar with no open date, a gallon bottle of Worcestershire sauce opened with no date, five- 1 gallon bottles of sherry cooking wine open with a manufacturers use by date of 7/29/2023 and a bag of brown sugar on the shelf above sink not sealed or dated. g. In the sandwich cooler there was an unsealed bag of lettuce with brown pieces, unsealed bags of shredded and sliced cheeses, opened bag of chopped garlic not dated, opened container of vegetable base undated, an opened bag of parmesan cheese undated, a container of beef stock undated, and a container of basil pesto undated. h. In the front reach in cooler there was an opened gallon of ranch dressing not dated, an opened bottle of French dressing not dated, an opened jar of mayonnaise not dated, a quart size container of strawberry yogurt undated, a		ensure that the deficiency does not reoccur.	

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	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	container of peaches with a use by date of 1/15/2025, two large containers of pickle spears not sealed or dated, packets of guacamole with use by dates of 12/6/2024, a bag of lettuce opened and not dated, sour cream packets with use by dates of 12/9/2024, a jar of Dijon mustard with a use by date of 1/11/2025, A1 steak sauce with a use by date of 12/7/2024, three individually prepared salads with no dates, and a bag of croutons not sealed or dated. 2. During a second kitchen walk through, conducted on 1/28/2028 at 10:18 with the Dietary Manager (DM) , she indicated when staff opened a product, they should have put an "open by and use by" date on it. She also indicated if the product was not in the original package, staff were to apply a label on the product and include what the product was. 3. During a continuous dining observation, on 1/27/2025 from 12:25 P.M. through 1:02 P.M., staff members were observed to have their thumbs over the edge of the dinner plate, their thumbs inside the side dish bowls, and hands cupping over the rim of drinkware while serving the meal to residents in the Memory Care unit. The observations included the following: - CNA 5 was observed turning glassware from an inverted position to an upright position and moving the glassware by cupping the rim of the glassware to prepare the glassware for meal service. - During an observation, 11 glassware/coffee cups were served by cupping the top of the glassware/coffee cups. - Rolled silverware in clothe napkins were served while held against the server's clothing. - Staff placed their thumbs on the eating surface of the dinner plate while serving 13 times. - Staff placed their thumbs inside bowls of			

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	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	coleslaw four different times During an interview, on 1/28/2025 at 2:53 P.M., CNA 5 indicated glassware should not be cupped and staff should not place their thumb onto the eating surface of plates and bowls. A current facility policy titled "Storage of Products" was provided on 1/27/2025 at 12:25 P.M. by the Assistant Administrator. This policy indicated "label the product with preparation dated as sell as use by dated". It also indicated that "once opened, food that has been stored in dry storage should either be refrigerated or sealed in airtight containers". A Policy was provided, on 1/28/2025 at 3:03 P.M., by the Executive Director. The policy titled, "Dining Room Service", indicated, "...The Dining Service staff be responsible for the effective and efficient management of the meal service area in Assisted Living. [Facility name} meals are plated by Dining Services staff and served by Health Care Staff...."			