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	05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00452214 and IN00457425. Complaint IN00452214 - No deficiencies related to the allegations are cited. Complaint IN00457425 - State deficiencies related to the allegations are cited at R241. Survey dates: April 29, 30, and May 1, 2025. Facility number: 014045 Residential Census: 95 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 14, 2025.	R 0000	This Plan of Correction is submitted as required under State 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. The submission of this Plan of Correction 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 judicial and/or administrative proceeding on that basis. The Community also 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 0120	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carmen Bowling	Executive Director	05/28/2025

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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Bldg. 00	Based on record review and interview, the facility failed to follow up with contract providers to ensure and/or obtain required pre-employment documentation for 2 of 5 employee records reviewed. Findings include: On 4/29/25 at 10:00 a.m., five employee records were reviewed. The Interim Director of Nursing (IDON) was hired via a contract provider on 4/18/25. Her record lacked documentation for 6 hours of dementia-specific training within 6 months of hire and lacked documentation related to general and job-specific orientation had been provided upon her hire at the facility. The Activity Director was hired via a contract provider (contract date 12/14/2020). His record lacked documentation for 6 hours of dementia-specific training within 6 months of hire and lacked documentation related to general and job-specific orientation had been provided upon her hire at the facility and his record did not include a copy of the job description with his acknowledgement of responsibilities. On 5/1/25 at 12:00 p.m., the Executive Director (ED) indicated, the facility followed Residential Rules pertaining to employee hiring process employee records. Cross reference R123.	R 0120	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Interim Director of Nursing (IDON) record will be updated to reflect documentation of 6 hours of dementia-specific training and related to general and job-specific orientation. The Activity Director (AD) record will be updated to reflect documentation of 6 hours of dementia-specific training, general and job-specific orientation, and a copy of the job description with his acknowledgement of responsibilities. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The Community reviewed each resident's record to determine which residents, if any, could have been affected by the alleged deficient practice. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** An audit of contracted employees was completed by the Business Director and Executive Director. The Executive Director or	05/28/2025

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			designee will meet with each contracted employee whose record may be missing documentation to ensure all required documentation and training(s) are in the record. In addition, the Executive Director or designee will audit all newly hired contracted employee files to ensure that all required documentation is present and up to date. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director or designee will audit 3 employee records weekly for 4 weeks, then monthly for 3 months, then quarterly thereafter to ensure employees' records are up to date. **5. By what date will the systemic changes be completed?** May 28, 2025	
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 employees completed a general and job-specific orientation for 4 of 5 employee records reviewed.	R 0123	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	05/28/2025

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	Findings include: On 4/29/25 at 10:00 a.m., five employee records were reviewed. The Interim Director of Nursing (IDON) was hired via a contract provider on 4/18/25. Her record lacked documentation that general and job-specific orientation had been provided. The Memory Care Coordinator (MCC) was hired on 9/26/22. Her record lacked documentation that a job-specific orientation had been provided. The Activity Director was hired via a contract provider (contract date 12/14/2020). The AD's record lacked documentation that general and job-specific orientation had been provided. Licensed Practical Nurse (LPN) 6 was hired on 9/16/25. Her record lacked documentation that job-specific orientation had been provided. On 5/1/25 at 12:00 p.m., the Executive Director (ED) indicated, the facility followed Residential Rules pertaining to employee hiring process employee records.		Employee's IDON, Memory Care Coordinator (MCC), AD, and Licensed Practical Nurse (LPN) records will be updated to include documented general and job-specific orientation. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The Community reviewed each resident's record to determine which residents, if any, could have been affected by the alleged deficient practice. An audit of all employee files was completed by Business Director and Executive Director. Executive Director/designee will meet with each employee to complete all required documentation and training(s). **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Executive Director or designee will audit all new employee files to ensure that all required documentation is present and up to date. All employee files have been audited to ensure compliance with pre-employment documentation requirements. **4. How the corrective action(s)**	

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Executive Director/designee will audit 5 employee records weekly x 4 weeks, then monthly for 3 months then quarterly thereafter to ensure employees records are up to date. **5. By what date will the systemic changes be completed?** May 28, 2025	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency Based on observation, interview, and record reviews, the facility failed to ensure dry goods were properly labeled and dated. This deficient practice had the potential to affect 95 of 95 residents who resided in the facility. Findings include: On 4/29/25 at 9:43 a.m., the kitchen was observed with the Certified Dietary Manager (CDM). When observing the dry goods area, it was found that all dry goods had one date on them. The CDM indicated this date was the open date. She indicated there should be the date the item was received, the open date and the expiration date written on each item. There was a bin labeled "bow-tie pasta" dated 11-8-24, but the CDM indicated it was actually rice not pasta and the label was incorrect. When observing the prep station, it was found that there were bulk	R 0154	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All food items noted in the survey were discarded. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The Community reviewed each resident's record to determine which residents, if any, could have been affected by the alleged deficient practice. **3. What measure will be put**	05/28/2025

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	seasonings that the CDM indicated they regularly use, a jug of lime juice that the CDM indicated was only used to clean the grill and a sanitation bucket together underneath the worktable. The CDM indicated the sanitation bucket and the lime juice should not have been stored together with the seasonings. On 5/1/25 at 10:45 a.m., the Executive Director (ED) provided a copy of the current facility operations manual titled "Health Related Services Operations Manual", dated 08/2023. This manual indicated, " ...All items should have a label indicating the item name, date produced, use by date, and expiration, and employee name on label ...Dry ingredients or products , once opened, must be stored in an airtight container, with ingredient/item name, expiration date, and employee name clearly labeled ...Check labels daily and discard outdated food ...."		**into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** The Dining Services Director conducted a walk-through to ensure all items are appropriately dated and labeled. All items not labeled appropriately were immediately discarded. The Executive Director will in-service the Dining Services Director on properly labeling and dating goods. On April 29, 2025, the Dining Services Director in-serviced all kitchen staff on labeling and dating. A walk-through of the kitchen will be conducted to ensure all items are properly labeled and dated. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director/designee will conduct a weekly walk-through for 4 weeks to check labeling and dating of products. **5. By what date will the systemic changes be completed?** May 28, 2025	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense Based on observation, interview, and record review, the facility failed to ensure Residents	R 0241	**1. What corrective action(s) will be accomplished for those**	05/28/2025

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	medications were properly overseen by a licensed nurse for 1 of 4 Residents (Resident B) reviewed for medication discrepancies. Findings include: On 4/29/25 at 12:00 p.m., the Executive Director (ED) provided copies of Resident B's Medication Administration Records (MAR), from September 2024 to April 2025. The MAR from September 2024 indicated the Resident was given Duloxetine (an antidepressant) from 11/1/24 to 11/7/24. From 11/8/24 to 11/30/24 the MAR indicated Resident B was in the hospital. Resident B's December MAR indicated she was not given Duloxetine this month. Resident B's January MAR indicated she was given Duloxetine starting 1/11/25 and ending 3/31/25. Resident B's April MAR indicated she was given Duloxetine once a day for 14 days starting 4/1/25 and ending 4/15/25. On 4/29/25 at 12:00 p.m., the ED provided copies of NP notes from February, March, and April of 2025. An NP note, dated 2/13/25, indicated Duloxetine was not on Resident B's reviewed medications list. The note indicated Resident B was now off of Duloxetine. An NP note, dated 3/13/25, indicated, Duloxetine was not on Resident B's reviewed medications list. The note indicated Resident B was now off Duloxetine. An NP note, dated 4/10/25, indicated Duloxetine was prescribed on 3/31/25 to be started 4/1/25 and end after 14 days. The note indicated, when the NP was reconciling medications with the facility, it was found that Duloxetine was back on Resident B's medication list. The note indicated the NP put in a new order to tapper the Duloxetine so that it could be discontinued again. During a phone call on 4/30/25 at 11:25 a.m.		**residents found to have been affected by the deficient practice:** Resident B is no longer in the Community. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The Community will review each resident's medication record to determine which residents, if any, could have been affected by the alleged deficient practice. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Executive Director will in-service the Wellness Director and nurses to ensure that residents' medications are properly overseen by a licensed nurse. In addition, the Executive Director will work with the Wellness Director and nurses to implement an improved tracking system for new, changing, and discontinued orders to ensure orders are updated in the Electronic Health Record System (EHR) timely. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	Resident B's daughter indicated the Resident went to the hospital in September and came back to the facility in October. She indicated Resident B had been on Duloxetine before her hospital stay, but it was not on her medication list after returning to the facility. Resident B's daughter indicated in February she noticed her mom had become more lethargic and was spending more time than usual in bed, so she requested the Nurse Practitioner (NP) go through her mom's medication list to ensure there were no unnecessary medications being given. The NP discovered that Duloxetine was back on the Residents medication list and had been given from January to March. Resident B's daughter indicated at that time the NP put in a weening dose of Duloxetine and then discontinued the medication. During an interview on 5/1/25 at 10:45 a.m. the NP overseeing Resident B's care indicated Resident B was in the hospital in September and upon her return to the facility it was found that the hospital discontinued the resident's Duloxetine order, and she did not resume the order. The NP indicated in March the facility contacted her about multiple residents with medication discrepancies, this was when it was discovered that the Duloxetine order was back on Resident B's MAR, She was unable to explain how the order could have gotten back on Resident B's MAR. This citation relates to Complaint IN00457425.		**recur, i.e., what quality assurance program will be put into place:** The Executive Director/designee will audit the EHR for signed/current physician orders weekly for 4 weeks, then monthly thereafter to ensure physicians are regularly and consistently reviewing medication lists for discrepancies and that the Community and pharmacy have accurate medication orders for each resident. **5. By what date will the systemic changes be completed?** May 28, 2025	
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure medications were labeled, dated, and stored properly for 1 of 4 medication carts and 2 of 3 medication	R 0304	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	05/28/2025

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	administration observations. Findings include: On 4/30/25 at 11:45 a.m., medication cart 2 was reviewed with Qualified Medication Aide (QMA) 7, the medications that were reviewed were as follows: 1. Neomycin eye ointment (an antibiotic eye ointment) with an open date of 2/4/25, had no pharmacy label and was loose in the medication cart. 2. Prednisolone eye drops (a steroidal eye drop) had no open date and no expiration date. 3. Erythromycin eye ointment (an antibiotic eye ointment) had no open date and no expiration date. 4. Calcitonin nasal spray (a nose spray used to treat osteoporosis) had a label saying "refrigerate" on the bottle. 5. PreserVision vitamin (a multivitamin to help prevent vision loss) did not have a pharmacy label, only the resident's name. On 4/30/25 at 12:00 p.m., QMA 7 indicated the Calcitonin nasal spray should have been in the refrigerator. She indicated she administered it during the morning medication pass and should have put it back in the refrigerator, but she forgot. On 4/30/25 at 12:15 p.m., QMA 7 was observed during a medication pass. During this medication pass QMA 7 did not lock the medication cart 2 of 3 times when it was left unattended. On 5/1/25 at 10:45 a.m., the Executive Director (ED) provided a copy of the current facility operations manual titled, "Health Related Services Operations Manual," dated 08/2023. This manual indicated, "		**practice:** Medication carts will be audited for medications labeled, dated, and stored properly. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The Community reviewed each resident's record to determine which residents, if any, could have been affected by the alleged deficient practice. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Executive Director and Wellness Director will implement weekly cart audits with qualified staff. Qualified staff will be in-serviced on how to audit the medication cart and the storage of medications. All medication carts will be audited to ensure medications are labeled, dated, and stored properly. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director or designee will complete medication	

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	...Follow all state licensing regulation requirements on the storage of medications and any required documentation ...Insulin and other medications requiring refrigeration should be stored separately in the medication room refrigerator ...If a Resident has his/her Over the Counter (OTC) medications stored in the medication room, each OTC medication must be labeled with the Residents name, apartment number and date the medication was opened. Follow the state licensing regulation requirements for OTC labeling ...All routine OTC medications (that which is taken on a regular basis) which community team members are assisting Residents must be provided in a community approved packaging system ...Carts should not be left unattended and must be locked if the care partner is leaving it for any reason ...Secure the MAR binder and /or the EMAR system when unattended ...2. Staff must perform hand hygiene: ...e. before and after assisting with medications ...." 410 IAC 16.2-5-11.1(f) Mental Health Screening - Noncompliance		cart audits weekly for 4 weeks, then monthly for three months. **5. By what date will the systemic changes be completed?** May 28, 2025	
R 0382 Bldg. 00	Based on interview and record review, the facility failed to ensure residents who were recipients of Medicaid funding, and had diagnoses of a major mental illness, (MMI) had a comprehensive care plan developed in collaboration with their mental health provider to address their MMI, potential needs and services with measurable goals and interventions to monitor for worsening symptoms for 2 of 2 residents reviewed for MMI. Findings include: 1. On 4/29/25 at 11:45 a.m., Resident 6's medical record was reviewed. He had a diagnosis which	R 0382	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 6 and 7's comprehensive care plan will be developed in collaboration with their mental health provider. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	05/28/2025

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	included but was not limited to paranoid schizophrenia and received Medicaid funds via a Medicaid waiver. An initial encounter summary from a Behavioral & Mental Health Provider, dated 11/11/22, indicated, " ...paranoia is noted, as the patient initially thought this clinician was someone who was going to 'kick him out' of the facility ... the staff says that the patient has the tendency to behave in a Jekyll/Hyde manner where he has [name] 1 and [name] 2. The patient said that he doesn't want [name] 2 to come out ...." Resident 6's most recent service plan was, dated 2/17/25, indicated he did have hallucinations/delusions, depression, anxiety and mood disorders and required minimum assistance related to his disposition and behaviors, but did not specifically apply goals and/or interventions. The record lacked documentation of a comprehensive care plan to address his mental health needs and goals. 2. On 4/29/25 at 11:00 a.m., Resident 7's medical record was reviewed. He had a diagnosis which included but was not limited to bipolar disorder and received Medicaid funds via a Medicaid waiver. A Behavioral & Mental Health provider summary, dated 9/17/24, indicated, " ...his past psychiatric history is significant for bipolar disorder, dementia and insomnia ... he says he was given a diagnosis of bipolar about five years ago ...." He had a mental health service care plan dated from 2023, but the record lacked documentation of any updates, revisions, and current plan of care.		**taken:** The Community reviewed each resident's record to determine which residents, if any, could have been affected by the alleged deficient practice. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Executive Director will in-service the Wellness Director on when to conduct a major mental illness care plan. In addition, an audit was conducted to ensure that residents who receive Medicaid funding with a major mental illness are identified to ensure a comprehensive care plan is developed in collaboration with their mental health provider. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director or designee will audit the EHR for updated comprehensive care plans on residents identified weekly for 4 weeks, then monthly for three months. **5. By what date will the systemic changes be completed?**	

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HARRISON AT EAGLE VALLEY, THE	3060 VALLEY FARMS ROAD INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 5/1/25 at 12:00 p.m., the Executive Director (ED) indicated the facility followed Residential Rules pertaining to mental health screening and care planning for residents who were recipients of Medicaid funds.		May 28, 2025	