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	11/13/2024

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: Novermber 12, and 13, 2024. Facility number: 014959 Residential Census: 58 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 26, 2024.	R 0000	Harmony at Avon respectfully request a desk review and compliance in this matter. Thank you for your consideration.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance Based on interview and record review, the facility failed to ensure fire drills were completed according to facility policy for 3 of 4 quarters reviewed for fire drills. This deficiency had the potential to affect 58 of 58 residents residing in the facility. Findings include: During an interview, on 11/12/24 at 10:25 a.m., the Maintenance Director (MM) indicated he had been working at the building since 10/14/24 and "everything" was about 3 months behind. The facility had not done fire drills since July. He provided documentation of the fire drill he had completed since he started at the facility. It was dated 10/20/24 on second shift. A current policy, titled, Fire and Emergency Evacuations Drills," dated 4/2021, was provided	R 0092	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The TELS report was reviewed and it was identified that timely fire drills were executed for the months of October and November, 2024. **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:** Fire Drills will be conducted each month in a timely manner. At least every six (6) months a fire and disaster drill will be held in	01/17/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scheree Eads	Executive Director	12/12/2024

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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	by the Executive Director (ED), on 11/12/24 at 12:35 p.m. A review of the policy indicated, " ...Fire Safety Procedures Plan shall include ...Community Staff shall conduct fire drills: Each work shift per quarter with one (1) sleeping shift. Provide written documentation with action plan for deficiencies. Maintain records for 3 years ...."		conjunction with the local fire department. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Maintenance Director will be educated to the Fire Drill Policy by the Executive Director. The TELS report will be monitored monthly for fire drill compliance by the Maintenance Director. The TELS report identifies the date and time of the fire drill. **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 Maintenance Director will report the outcome of the fire drill audits to the QAPI Committee on a monthly basis for review and recommendations. If it is determined that a fire drill was not conducted in a timely manner, then an action plan will be implemented. Any recommendation made by the committee will be followed up by the Maintenance Director and the results will be brought to the next scheduled QAPI Committee.	
R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance	R 0095		01/17/2025

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	Based on interview and record review the facility failed to ensure the annual Alzheimer's / Dementia Special Care Unit form was completed for 1 of 1 year reviewed, and failed to ensure the specialized dementia care unit had a Director who met the minimum qualifications of an earned degree which had the potential to affect 17 of 58 residents of the facility who resided on the secured memory care unit. Findings include: 1. On 11/12/24, upon entry to the facility, the Alzheimer's / Dementia Special Care Unit form was requested. During an interview, on 11/13/24 at 10:33 a.m., the Executive Director (ED) indicated the facility had an Alzheimer's unit (Harmony Square), but did not complete the Special Unit disclosure form. She thought the requirement to complete the form went away about 5 years ago. A review of the Alzheimer's / Dementia Special Care Unit form indicated, "Please complete on or before December 31st. Data must be current as of December 1st. A current policy, titled, "Harmony Square and Harmony Reflections Program Special Care Neighborhood Disclosure," dated 3/2022, was provided by the ED, on 11/12/24 at 12:05 p.m. A review of the document indicated, " ...The Harmony Square philosophy enables memory impaired residents to reach their highest potential and optimal self-care and independence ...." 2. During the survey entrance conference on 11/12/24 at 9:40 a.m., copies of the Memory Care Director's (MCD) qualifications and ongoing		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Special Unit Disclosure Form was completed by the Executive Director and will be submitted to ISDH on 12/13/24. The Executive Director has been designated as the Director for the Alzheimer's and dementia special care unit. **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 Special Unit Disclosure Form will be completed by the Executive Director each year between the dates of 12/1/24 and 12/31/24. The Executive Director meets the requirement of an earned degree and will have twelve (12) hours of dementia-specific training within three (3) months of employment as the Director. The Executive Director holds a Bachelor of Science in Business and a Master of Health Administration from Indiana University. **What measures 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/Designee will monitor the timely completion of the Special Unit Disclosure	

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	trainings were requested. On 11/12/24 at 2:00 p.m., the Executive Director (ED) provided a copy of the MCD's active Practical Nurse (LPN) licenses and 5.25 hours of dementia-specific training. During an interview on 11/13/24 at 1:40 p.m., the MCD indicated she did not have an earned degree, but her LPN license was active. During an interview on 11/13/24 at 2:00 p.m., the ED indicated she did not know the MCD was required to have an earned degree. The ED indicated she could not find a policy, but the facility followed the Residential rules.		Form on an annual basis. The Executive Director will complete six (6) hours of dementia-specific training on an annual basis. **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 Special Unit Disclosure Form and the dementia-specific training documentation will be presented to the QAPI Committee. If it is determined that the Special Unit Disclosure Form or the required dementia-specific hours were not completed in a timely manner, then an action plan will be implemented. Any recommendation made by the committee will be followed up by the Executive Director and the results will be brought to the next scheduled QAPI Committee.	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance Based on interview and record review, the facility failed to ensure a thorough and complete pre-employment screening was conducted for 2 of 5 employee records reviewed. Findings include: On 11/13/24 at 10:00 a.m., five randomly selected employee files were reviewed.	R 0116	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Regional HR Business Partner reviewed background check on CNA #9 and determined that the employee meets the Harmony guidelines for	01/17/2025

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HARMONY AT AVON	2141 NORTH DAN JONES ROAD AVON, IN 46123

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	Licensed Practical Nurse (LPN) 12 was hired on 9/12/24. Her file lacked documentation of a completed background check. Certified Nursing Assistant (CNA) 9 was hired on 12/9/22. A background check had been conducted and completed, however it indicated, an assault charge which resulted in bodily injury was found. There was no evidence or documentation to indicated the charge had been acknowledged by administrative staff and/or a decision on why she was allowed to continue her employment process. During an interview on 11/13/24 at 2:15 p.m. the Director of Nursing (DON) indicated, she did not know about those two employees as they were hired before she had been, but it would be her expectation moving forward, that a background check must be completed before staff work on the floor, and if there were concerning results from the screen, it would need to be discussed and approved with corporate oversight. During an interview on 11/13/24 at 3:00 p.m., the Executive Director (ED) indicated she could not locate any additional documentation for the required items from the employee records review. On 11/13/24 at 3:25 p.m., the ED provided a copy of current facility policy titled, "Pre-Employment Screening to Include Criminal Background Checks," dated 4/2021. The policy indicated, " ...manager extends job offer to candidate both verbally and in writing contingent upon criminal background and drug test results ... the criminal background and drug testing must be completed for all new hire. Both must be completed and the results received prior to the start date- no exceptions ...."		employment. **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:** 100% of current employee files were audited by the Regional HR Business Partner for documentation of background checks. Deficient items will be brought to current. Background checks have been completed and reviewed for all employees. This information will be maintained in the employee files. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Regional HR Business Partner will educate the Business Office Manager to the New Hire Checklist that includes the requirement of a background check prior to employment. The BOM will complete the checklist that includes the background check for all new employees. The background check will be completed prior to General Orientation. **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:**	

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		A. BUILDING 00 B. WING	11/13/2024

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			The Business Office Manager/Designee will audit the new employee files monthly for 3 months to ensure the timely completion of the background check. **Additionally, the Regional HR Business Partner will conduct a quarterly new employee file audit. All findings will be reported to the monthly QAPI Committee for review and follow-up. If the QAPI Committee determines that substantial compliance has not been accomplished, then an action plan will be implemented. Any recommendation made by the committee will be followed up by the Business Office Manager and the results will be brought to the next scheduled QAPI Committee.**	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance Based on interview and record review, the facility failed to ensure employees received job-specific orientation as a part of the new hire onboarding process for 5 of 5 employees reviewed for orientation. Findings include: On 11/13/24 at 10:00 a.m., five randomly selected employee files were reviewed. Licensed Practical Nurse (LPN) 12 was hired on	R 0119	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Employees without documented job specific orientation will be re-oriented to their job specific roles by the appropriate department head/designee utilizing the corresponding Onboarding Completion Checklist.	01/17/2025

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		A. BUILDING 00 B. WING	11/13/2024

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	9/12/24. Their file lacked documentation of job-specific orientation. Certified Nursing Assistant (CNA) 9 was hired on 12/9/22. Their file lacked documentation of job-specific orientation. Qualified Medication Aide (QMA) 8 was hired on 8/18/23. Their file lacked documentation of job-specific orientation. Housekeeper (HK) 10 was hired on 10/18/23. Their file lacked documentation of job-specific orientation. Dietary Aide (DA) 11 was hired on 8/10/22. Their file lacked documentation of job-specific orientation. During an interview on 11/13/24 at 3:00 p.m., the Executive Director (ED) indicated she could not locate any additional documentation for the required items from the employee records review. During an interview on 11/13/24 at 3:25 p.m., the ED indicated she could not located a policy related to new hire procedures, but the facility followed the Residential Rules.		The employees will sign the job specific orientation checklist to attest to the training/orientation. The job specific orientation checklists will be placed in the employee file by the BOM/designee for retention. LPN #12, CNA #9, QMA #8, HK #10, DA #11 will be included in the re-orientation outlined above. **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:** 100% of current employee files were audited by the Regional HR Business Partner for documentation of job specific orientation. Deficient files will be brought to current expectations. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Employee orientation will consist of a General Orientation for all employees, regardless of job duties, and encompass material related to; special populations, policy and procedures, first aid, emergency procedures, fire safety, confidentiality, etc. Personalized job specific orientation will be completed for all new employees by the respective department head or designee (i.e., Clinical by the	

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		A. BUILDING 00 B. WING	11/13/2024

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HARMONY AT AVON	2141 NORTH DAN JONES ROAD AVON, IN 46123

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			Healthcare Director/designee) prior to the employee working a shift independently. Job specific orientation will be documented on the corresponding Onboarding Completion Checklist and retained in the employee file (i.e., CNA/Certified Nursing Assistant Onboarding Completion Checklist for all new CNAs). **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 Business Office Manager/Designee will audit the employee files monthly for 3 months to ensure the timely completion of the job specific orientation. Additionally, the Regional HR Business Partner will conduct a quarterly employee file audit. All findings will be reported to the monthly QAPI Committee for review and follow-up. If the QAPI Committee determines that substantial compliance has not been accomplished, then an action plan will be implemented. Any recommendation made by the committee will be followed up by the Business Office Manager and the results will be brought to the next scheduled QAPI Committee.	

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		A. BUILDING 00 B. WING	11/13/2024

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HARMONY AT AVON	2141 NORTH DAN JONES ROAD AVON, IN 46123

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R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on interview and record review, the facility failed to ensure employees received the minimum required dementia-specific training upon hire and annually thereafter for 5 of 5 employees reviewed for training. Findings include: On 11/13/24 at 10:00 a.m., five randomly selected employee files were reviewed. Licensed Practical Nurse (LPN) 12 was hired on 9/12/24. Their file lacked documentation of dementia-specific orientation upon hire. Certified Nursing Assistant (CNA) 9 was hired on 12/9/22. Their file lacked documentation of dementia-specific orientation upon hire and annually thereafter. Qualified Medication Aide (QMA) 8 was hired on 8/18/23. Their file lacked documentation of dementia-specific orientation upon hire and annually thereafter. Housekeeper (HK) 10 was hired on 10/18/23. Their file lacked documentation of dementia-specific orientation upon hire and annually thereafter. Dietary Aide (DA) 11 was hired on 8/10/22. Their file lacked documentation of dementia-specific orientation upon hire and annually thereafter. During an interview on 11/13/24 at 3:00 p.m., the Executive Director (ED) indicated, she could not locate any additional documentation for the required items from the employee records review.	R 0120	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Dementia specific training will be completed with the Healthcare Director (HCD), Harmony Square Director (HSD) and Executive Director (ED) on 12/18/24 by Cathleen O'Brien, CDP, Vice President of Memory Care & Programming for Harmony Senior Services. The HCD, HSD and ED will then facilitate training of other staff. LPN #12, CNA #9, QMA #8, HK #10, DA #11 will be included in those staff trained as indicated above. **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:** An audit of 100% of employee files was conducted by the Regional HR Business Partner. Employees identified as not meeting the dementia training criteria will be retrained as indicated above. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**	01/17/2025

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		A. BUILDING 00 B. WING	11/13/2024

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HARMONY AT AVON	2141 NORTH DAN JONES ROAD AVON, IN 46123

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	During an interview on 11/13/24 at 3:25 p.m., the ED indicated, she could not located a policy related to new hire and/or ongoing training for dementia-specific topics, but the facility followed the Residential Rules.		Six hours of dementia specific training for all staff having resident contact will be completed within 6 months of the employee hire date. Annual dementia training for these employees will consist of an additional 3 hours each year. Documentation of the employee completion of the trainings will be retained in each employee file. **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 Business Office Manager/Designee will audit the employee files monthly for 3 months to ensure the timely completion of the dementia-specific training upon hire and annually thereafter. Additionally, the Regional HR Business Partner will conduct a quarterly employee file audit. All findings will be reported to the monthly QAPI Committee for review and follow-up. If the QAPI Committee determines that substantial compliance has not been accomplished, then an action plan will be implemented. Any recommendation made by the committee will be followed up by the Business Office Manager and the results will be brought to the next scheduled QAPI Committee.	

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		A. BUILDING 00 B. WING	11/13/2024

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HARMONY AT AVON	2141 NORTH DAN JONES ROAD AVON, IN 46123

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R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance Based on interviews and record reviews, the facility failed to ensure employees received the minimum pre-employment health screening for tuberculosis (TB) for 5 of 5 employees reviewed. Findings include: On 11/13/24 at 10:00 a.m., five randomly selected employee files were reviewed. Licensed Practical Nurse (LPN) 12 was hired on 9/12/24. Their file lacked documentation of an initial TB pre-employment screen via skin/blood testing. Certified Nursing Assistant (CNA) 9 was hired on 12/9/22. Their file lacked documentation of an annual risk assessment for TB screening. Qualified Medication Aide (QMA) 8 was hired on 8/18/23. Their file lacked documentation of an annual risk assessment for TB screening. Housekeeper (HK) 10 was hired on 10/18/23. Their file lacked documentation of an annual risk assessment for TB screening. Dietary Aide (DA) 11 was hired on 8/10/22. Their file lacked documentation of an annual risk assessment for TB screening. During an interview on 11/13/24 at 3:00 p.m., the Executive Director (ED) indicated, she could not locate any additional documentation for the required items from the employee records review. On 11/13/24 at 2:04 p.m., the DON provided a copy	R 0121	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Employees without documented health screening for Tuberculosis will be administered a two-step Tuberculin skin test utilizing Mantoux method. Positive results will result in the employee being required to have a chest x-ray and potentially other testing to determine appropriate diagnosis. **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:** An audit of 100% of current employee files was completed by the Regional HR Business Partner to identify employees out of compliance. Employees identified will have testing as indicated above. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** As a component of the new hire process, all new employees will be screened for tuberculosis as part of the pre-employment	01/17/2025

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	of current facility policy titled, "Tuberculosis-Associates," dated 4/2021. The policy indicated, " ...all associated shall be screened for tuberculosis (TB) infection and disease prior to beginning employment as per state regulations. The needs for subsequent TB evaluations shall be performed if warranted per state regulations and the facility's TB Control Program ... The community's Executive Director and/or Healthcare Director or designee will complete an initial Risk Assessment for the prevention of tuberculosis and develop a TB Control Plan. The Plan and Risk Assessment will be reviewed annually ...."		process. Potential employees will either provide documentation within the one month prior to employment of a negative TB test or documentation of a positive TB test with further documentation of a negative chest x-ray/additional testing, or be subject to the two-step tuberculin skin test administered by facility staff. The employee will not be permitted to work until the first administered step has been read as negative or additional testing following a positive reaction has been completed and is negative. Annual TB screening for employees will consist of a screening questionnaire pertaining to s/s of tuberculosis, tuberculin skin test, or chest x-ray as appropriate. TB screening results will be retained in an employee health file within the business office. **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 Business Office Manager/Designee will audit the employee files monthly for 3 months to ensure the timely completion of the minimum pre-employment health screening for tuberculosis (TB). Additionally, the Regional HR Business Partner	

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		A. BUILDING 00 B. WING	11/13/2024

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

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			will conduct a quarterly employee file audit. All findings will be reported to the monthly QAPI Committee for review and follow-up. If the QAPI Committee determines that substantial compliance has not been accomplished, then an action plan will be implemented. Any recommendation made by the committee will be followed up by the Business Office Manager and the results will be brought to the next scheduled QAPI Committee.	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency Based on observation, interview, and record review, the facility failed to ensure the walk-in freezer was maintained in good repair after a leak in the air conditioning and exhaust unit was found for 1 of 1 observation of the freezer. This deficient practice had the potential to affect 58 of 58 residents who were served out of the kitchen. Findings include: On 11/12/24 at 9:45 a.m., an initial kitchen tour was conducted with the Regional Culinary Specialist (RCS). The walk-in freezer was observed. There were thick clouds of dense vapor as the ceiling exhaust fan struggled to move the air. Ice was noted coated to the refrigeration ceiling unit pipes, and several cardboard boxes, which stored food items, were observed to be coated with layers of ice. There was ice built up on the floor under the	R 0154	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The compressor motor in the walk-in freezer was repaired and is working properly. **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:** A kitchen audit will be completed by the Regional Culinary Specialist related to ensure that the kitchen equipment is working properly. If any equipment is not working properly, a work order will be completed and submitted to	01/17/2025

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	11/13/2024

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	storage racks, and a large area of ice was noted on the floor of the walk-in unit at the seat of the door. The RCD indicated, the unit had been repaired a few months ago, but the problem had not been totally fixed as the freezer continued to leak water which would melt and re-freeze. The RCD indicated, if more ice accumulated at the seal, it could prevent the door from closing and the unit would not be able to maintain temperature. On 11/13/24 at 2:04 p.m., the Director of Nursing (DON) provided a copy of current facility policy titled, "Equipment Maintenance & Safety," dated 4.2021. The policy indicated, " ...Dining Services staff shall maintain all kitchen equipment in a safe and sanitary condition and in compliance with applicable regulations ... freezers, refrigerators and ice machines have coils that should be cleaned every two to three months by the Maintenance department or by a local refrigeration repair vendor ...."		the Maintenance Director. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Regional Culinary Specialist will educate the Dining Service Director on monitoring kitchen equipment to ensure that the equipment is working properly. The Dining Service Director/Designee will conduct a monthly kitchen equipment audit to ensure proper that the equipment is working properly. **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 Dining Service Director/Designee will complete the kitchen equipment audit monthly and will report the findings to the monthly QAPI Committee for review and follow-up. If it is determined that substantial compliance has not been accomplished, then an action plan will be implemented. Any recommendation made by the committee will be followed up by the Dining Service Director and the results will be brought to the next scheduled QAPI Committee.	

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R 0239 Bldg. 00	410 IAC 16.2-5-4(c) Health Services - Nonconformance Based on interview and record review, the facility failed to ensure medications were given within an appropriate timeframe to 1 of 7 residents reviewed for medication administration. Findings include: On 11/13/2024 at 9:45 a.m., Resident 23's medical record was reviewed. Her electronic medication administration record (eMAR) was reviewed and revealed the majority of medication administrations were late. Some of those medications included but were not limited to: a. On 10/1/24, Acetaminophen (Tylenol) 500 milligram (mg) capsule was due at 9:00 a.m., but not administered until 11:47 a.m. b. On 10/1/24, Baclofen (muscle relaxant) 10 mg tablet was due at 9:00 a.m., but not administered until 11:47 a.m. c. On 10/2/24, Calmoseptine ointment (skin protectant) was due at 12:00 a.m., but not administered until 5:27 a.m. d. On 10/5/24, Aspirin 81 mg chewable tablet (anticoagulant) was due at 9:00 a.m., but not administered until 11:43 a.m. e. On 10/5/24, Escitalopram (antidepressant) 5 mg tablet was due at 9:00 a.m., but not administered until 11:43 a.m. During an interview, on 11/13/2024 at 2:04 p.m., the Health Care Director (HCD) indicated she would try to locate a policy related to medication administration times, but it was her expectation and nursing best practice for nurses to administer medication no sooner or later than 1 hour before	R 0239	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Medical record/MAR/TAR and/or any appropriate medication report(s) for resident #23 will be reviewed related to late medication administration. The attending clinician will be notified of the episodes and of any documented ill effects noted for the resident as a result of the late administrations. **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 HCD and HSD will review MAR/TARs, reports for current residents for the months of November and December (through current at time of the review) for any medications administered outside acceptable timeframe of an hour before or an hour after scheduled medication administration time. Attending clinicians will be notified of late medications identified and any documented ill affects resulting from the late administration. **What measures will be put into**	01/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	or after the medication was due to be given. On 11/13/2024 at 3:00 p.m., the HCD indicated they could not find a policy related to appropriate time parameters for medication administration.		**place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Employees designated to administer medications will be educated on the company Medication Oversight Program elements pertaining to medication administration times by the HCD and/or designee(s). HCD and HSD or designee will review 5 residents MAR/TAR, reports monthly for 3 months, then quarterly to ensure medication administration compliance is maintained. Re-education related to the components of the Medication Oversight Program pertaining to timeliness of medication administration will be provided to individual employees as needed based on audit results. **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 HCD and HSD or designee will complete the MAR/TAR audit monthly for 3 months and then quarterly. The findings from the audits will be reported to the monthly QAPI Committee for review and follow-up. If it is determined that substantial compliance has not been accomplished, then an action plan	

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			will be implemented. Any recommendation made by the committee will be followed up by the HCD/HSD and the results will be brought to the next scheduled QAPI Committee.	
R 0271 Bldg. 00	410 IAC 16.2-5-5.1(d) Food and Nutritional Services - Deficiency Based on observation and interview, the facility failed to provide a resident with the physician prescribed diet for 1 of 1 resident reviewed for dietary orders (Resident 2). Findings include: On 11/12/24 at 11:40 a.m., Resident 2 was observed sitting in a high back padded chair in the dining room. He had 2 bowls of pureed food sitting in front of him. Qualified Medication Aide (QMA) 7 indicated she did not know what the contents of the bowls were. It was later inquired about with the kitchen staff, and it was green beans and sausage. He did not get a fruit cup like the other residents had. He was being assisted with eating by Certified Nursing Assistant (CNA) 13. On 11/12/24 at 1:30 p.m., a review of Resident 2's Medication Administration Record (MAR) revealed he was ordered to have a regular mechanical soft diet. On 11/13/24 at 10:12 a.m., a nursing note, dated 8/29/24, indicated Resident 2 needed to have his diet changed to pureed but no orders followed the progress note.	R 0271	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Clinician diet order for resident #2 was reviewed and clarified with the dietary department. **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:** An audit of 100% of resident diet orders was completed by the HCD and HSD. Resident diet orders were reviewed with the dietary department and discrepancies from the clinician order corrected as applicable. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The HCD will verify diet orders are	01/17/2025

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	On 11/13/24 at 10:15 a.m., Resident 2's paper medical record was reviewed, and no orders could be found regarding a pureed diet and there was no identified follow up by a dietician or nutritionist. During an interview, on 11/13/24 at 1:15 p.m., the Health Care Director (HCD) indicated she was unaware of his diet being pureed. A policy was provided by the Health Care Director (HCD) on 11/12/24 at 1:58 p.m., it indicated, "...All residents that have been placed on a specialized diet by the physician, in either therapy or consistency, will have an on-site oversight of special diets by a dietician or nutritionist, each of whom much meet the State requirements and Regulations Governing Standards for Dietician and Nutritionists...."		present on admission to the community for all new residents. Changes to any diet will be made via a clinician order. Orders will be entered in the resident medical record. Changes to diet orders will be communicated in morning standup to the dietary department by the HCD. Dietary department will update the diet communication board with changes as they occur. **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 HCD and Dietary Manager will complete quarterly audits of diet of record for all residents in the community at the time of the audit. The findings from the audit will be reported to the monthly QAPI Committee for review and follow-up. If it is determined that substantial compliance has not been accomplished, then an action plan will be implemented. Any recommendation made by the committee will be followed up by the HCD/Dining Service Director and the results will be brought to the next scheduled QAPI Committee.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency			

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	Based on observation, interview, and record review, the facility failed to ensure food items in the storage areas were labeled and dated for easy identification and to prevent serving potentially spoiled foods for 1 of 1 observation. This deficient practice had the potential to effect 58 of 58 residents who were served out of the kitchen. Findings include: On 11/12/24 at 9:45 a.m., an initial kitchen tour was conducted with the Regional Culinary Specialist (RCS). In the walk-in refrigerator, the following was observed. A large Tupperware container with no label or date which the RCS identified as pasta salad. A large Tupperware container with no label or date which the RCS identified as broccoli cheddar soup. A large Tupperware container with no label or date which the RCS identified as raw chicken marinating in seasoned liquid. A large roll of ground hamburger which had been opened was also observed without a label or date. During an interview on 11/12/24 at 9:55 a.m., the RCS indicated, all items should be labeled with a sticker to identify what the item was, and dated for when it was opened/prepared and when to use or dispose of it by. On 11/13/24 at 2:04 p.m., the Director of Nursing (DON) provided a copy of current facility policy titled, "Storage of Products," dated 4/2021. The	R 0273	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The unlabeled food items were immediately discarded. **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:** A kitchen audit will be completed by the Regional Culinary Specialist related to proper storage and dating opened food items and any findings will be immediately corrected. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Regional Culinary Specialist will educate the culinary staff on food storage and labeling opened items. The Dining Service Director will conduct a weekly kitchen sanitation audit to ensure proper storage and dating. **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 Dining Service Director/designee will complete the Sanitation Audit Tool weekly	01/17/2025

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	policy indicated, " ...wrap, cover or seal all refrigerated foods and label the product with the preparation dated as well as use by date ...."		for 3 months and then quarterly thereafter. The Dining Service Director/designee will report the findings to the monthly QAPI Committee for review and follow-up. If the QAPI Committee determines that substantial compliance has not been accomplished, then an action plan will be implemented. Any recommendation made by the committee will be followed up by the Dining Service Director and the results will be brought to the next scheduled QAPI Committee.	
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency Based on record review and interview, the facility failed to ensure residents' physician orders were reviewed by the pharmacist at least every 60 days in order to ensure appropriate dose/use and make recommendations as needed. This deficient practice had the potential to effect 7 of 58 residents reviewed during the annual survey. Findings include: During the annual survey from 11/12/24 through 11/13/24, the medical records for Residents 2, 29, 59, 49, 23, 9 and 7 were reviewed. Their records lacked documentation of pharmacy reviews and or recommendations. During an interview on 11/13/24 at 2:05 p.m., the Director of Nursing (DON) indicated she could	R 0298	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents #2, 29 ,59, 49, 23, 9, 7 - current medications list were printed and submitted to the attending clinicians for review and validation. The pharmacy representative has been contacted to establish a process to obtain pharmacist reviews and recommendations routinely. **How the facility will identify other residents having the potential to be affected by the same deficient practice and**	01/17/2025

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		A. BUILDING 00 B. WING	11/13/2024

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	not locate any pharmacy reviews. She asked another floor nurse to help her look, but that floor nurse also could not locate any reviews or recommendations. The DON indicated she could not locate a policy but the facility followed the Residential rules.		**what corrective action will be taken:** The HCD will complete an audit of resident charts for pharmacy recommendations. The HCD will contact the pharmacy representative to complete a review internally and provide any recommendations for current residents found to be out of compliance. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** A process for pharmacy to send reviews/recommendations will be developed in conjunction with the HCD to ensure a pharmacist completes these at a minimum of every 60 days. The process when reviews/recommendations are received with be that the HCD/designee forwards a copy via fax or other means to the attending clinician to address/accept/decline with signature required and return to the community to process and retain in the resident chart. **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 HCD will monitor that	

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			reviews/recommendations are received within the timeframes established by the pharmacy process. Frequency will be at minimum every 60 days. The HCD will report the findings to the monthly QAPI Committee for review and follow-up. If the QAPI Committee determines that substantial compliance has not been accomplished, then an action plan will be implemented. Any recommendation made by the committee will be followed up by the HCD and the results will be brought to the next scheduled QAPI Committee.	
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency Based on observation and interview, one medication cart contained medications that were undated or expired for 1 of 2 medication carts reviewed (Harmony Square). Findings include: On 11/12/24 at 10:06 a.m., Harmony Square's medication cart was observed. The following were observed on the cart and was either missing a date to indicate when opened or had expired. a. Resident 55 had fluticasone spray (used for sinusitis) on the cart with no date to indicate when it was opened. She had a bottle of polymyxin B-TMP eye drops (an antibiotic) on the cart with no date to indicate when they were opened. b. Resident 53 had dorzolamide-timolol eye drops (used to treat glaucoma) on the cart with no date	R 0304	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Contracted pharmacy will perform medication cart audits in the month of December 2024. Medications for resident # 55, 53, 48, 50, 52 will be included in these cart audits. Expired medications will be removed and replaced as needed. On 12/11/24 Kristen Dimitch, VP of Clinical Practice and Education provided the HCD and HSD education on the Harmony Medication Oversight Program which contains processes	01/17/2025

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	to indicate when they were opened. c, Resident 48 had insulin glargine on the cart with no date to indicate when the pen was opened. She had Humalog on the cart with no date to indicate when it was opened. She had insulin Lantus on the cart with a date opened of 8/23/24, which had expired. d, Resident 50 had an insulin pen of lispro on the cart with a date opened of 8/17/24. She had a second insulin pen of lispro with a date opened of 10/8/24. e. Resident 52 had a tube of erythromycin 0.5% eye ointment (an antibiotic) on the cart with no date to indicate when it was opened. During an interview, on 11/12/24 at 10:30 a.m., Qualified Medication Assistant (QMA) 7 indicated she floated around and today was her first day on this cart. A policy titled, "Medication Storage," was provided by the Health Care Director (HCD), on 11/12/24 at 1:58 p.m. It indicated, " ...all medications must be stored in accordance with label instructions...."		associated with medication cart management, medication cart audits, medication storage. **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:** Medication cart audits will be completed for all medication carts currently in use within the community. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The Harmony Medication Oversight Program will be implemented within the community. HCD, HSD or designee(s) will provide all staff responsible for medication administration, who have access to the medication carts, with training on the Program. The Program contains weekly and monthly audits of medication carts that will be implemented to mitigate these deficient practices. **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:**	

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			Weekly and Monthly Medication cart audits will be retained within the community. For a period of 3 months, the weekly and monthly audits will be forwarded to the Regional Director of Resident Care to ensure the process is be followed. Regional Clinical Team members may wish to complete random audits when in the community to ensure compliance but is not required at this time. The HCD/HSD will report the findings to the monthly QAPI Committee for review and follow-up. If the QAPI Committee determines that substantial compliance has not been accomplished, then an action plan will be implemented. Any recommendation made by the committee will be followed up by the HCD/HSD and the results will be brought to the next scheduled QAPI Committee.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance Based on observation and interview, the facility failed to implement and ensure an ongoing process of an infection control program which had the potential to affect 58 of 58 residents residing in the facility. Findings include: During an interview, on 11/13/24 at 2:00 p.m., the Health Care Director (HCD) provided an Infection	R 0407	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** On December 3, 2024 – Jacqualyn Hickman, Senior Healthcare Director, provided the HCD education related to the Infection Control Program currently in place	01/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Control (IC) binder. A review of the IC binder showed months of the years and each month listed resident names. She indicated that she recently started her position and there was no IC program that consisted of a system to analyze patterns of known infection symptoms nor a plan that included ongoing analysis of surveillance data and review of data and documentation of follow-up activity A current policy titled, "All Infection Control Program," dated 3/2022, was requested upon entry and provided soon after. A review of the policy indicated, "...Monitoring performance of infection control practices by staff and volunteers: The safety committee will meet monthly and as needed, addrress current and past month's infection incidents and will review the steps of prevention implemented, as well as the outcomes. The HCD [Health Care Director] will be the designated on-site Infection Control Officer that is knowledgeabe about the Federal CDC guidleines in control and prevention of infections...."		on that date. **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:** Survey identified that all residents of the community had the potential to be affected by deficient practice. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Ongoing, education related to the Infection Control Program will be provided to the HCD and other relevant employees as part of the Onboarding Job Specific Orientation and Monthly All Staff Meetings. **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:** Evidence of employee training will be documented and retained in the employee file. The BOM or designee will complete an initial employee file audit following employee orientation to ensure training documentation is completed and will conduct quarterly audits as described in this POC under Job Specific Orientation/Training deficiencies.	

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		A. BUILDING 00 B. WING	11/13/2024

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			Ongoing Infection Control education will be provided by the HCD/Designee during the Monthly All Staff Meetings. The BOM and HCD will report the findings to the monthly QAPI Committee for review and follow-up. If the QAPI Committee determines that substantial compliance has not been accomplished, then an action plan will be implemented. Any recommendation made by the committee will be followed up by the HCD and the results will be brought to the next scheduled QAPI Committee.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on record review and interview, the facility failed to ensure an annual health statement was obtained for residents annually after an initial statement upon admission. This deficient practice had the potential to affect 7 of 58 residents reviewed during the annual survey. Findings include: During the annual survey from 11/12/24 through 11/13/24, medical records for Residents 2, 29, 59, 49, 23, 9 and 7 were reviewed. Their records lacked documentation of an annual health statement. During an interview on 11/13/24 at 2:05 p.m., the Health Care Director (HCD) indicated she did not know residents needed a health statement every	R 0409	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Clinical chart audit for residents # 2, 29, 59, 49, 23, 9, 7 – were completed. Residents indicated will be screened for tuberculosis via TB skin test, chest x-ray or s/s questionnaire as appropriate based on prior test/screening results. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	01/17/2025

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	year after admission as she thought the statement at the time of admission was the only thing required. She could not locate a policy but indicated the facility followed the Residential rules.		**taken:** An audit of 100% of current/active resident charts was completed by the HCD and designee(s) for compliance with an annual health statement. Residents identified as out of compliance will receive a screening for tuberculosis via TB skin test, Chest x-ray or s/s questionnaire as appropriate. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Residents will be screened annually and attending clinicians will be requested to document any evidence of resident infectious disease. **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 HCD will schedule annual resident assessments in the EHR and will prompt attending clinicians for completion of an annual health statement/assessment. The HCD will keep a tracker log for resident anniversary dates and will contact attending clinicians approximately one month prior to the resident anniversary date related to the annual statement. The HCD will	

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			review the tracking log monthly for communication to the attending clinician. The HCD will report the findings to the monthly QAPI Committee for review and follow-up. If the QAPI Committee determines that substantial compliance has not been accomplished, then an action plan will be implemented. Any recommendation made by the committee will be followed up by the HCD and the results will be brought to the next scheduled QAPI Committee.	