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	02/15/2023

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 an Initial State Residential Licensure Survey. Survey dates: February 13, 14 and 15, 2023 Facility number: 014916 Residential Census: 36 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/27/23.	R 0000		
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to ensure a criminal history inquiry was completed timely for 1 of 5 employee personal files reviewed. (Employee 6) Findings include: During the review of personnel files, conducted on 2/13/2023 at 2:00 P.M., the personnel file for Employee 6, with a start date of 1/24/2023, did not contain documentation of a criminal history inquiry.	R 0116	a.) Immediate: BOM or designee will audit of all associate files to ensure compliance with regulation and company policies and procedures. b.) Immediate: BOM or designee will acquire criminal history screenings that may not have been completed prior to employment. c.) Immediate: Train Business Office Manager on company policies and procedures required	03/31/2023

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	On 2/15/2023 at 11:30 A.M., the Administrator provided documentation of a criminal history inquiry for Employee 6 completed on 2/14/2023, a day after the concern was brought to the facility's attention. Review of the facility policy and procedure, regarding personnel files, indicated the following: "...Confidential Personnel File Confidential Information should be filed in a separate file and should not be accessible to anyone other than Human Resources. The following should be filed in he team member's confidential file....Criminal background results...." There was no specific time frame regarding the completion of the criminal background results. During an interview with the Administrator,, conducted on 2/15/2023 at 2:45 P.M., she indicated the policies and procedures presented in the manual on 2/13/2023 in the A.M. were the only policies and procedures utilized by the facility Corporation.		before associates can begin their employment. d.) Long Term: BOM will use a check list to monitor all required steps are completed before an associate can begin their employment. Once all items are completed the employee will then be scheduled for orientation and begin employment. Responsible Party(ies): BOM or designee, ED for review Corrective Action Plan Completion: 3/31/23	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at			

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	least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.			
	Based on record review and interview, the facility failed to ensure there were CPR (cardiopulmonary rescuitation) certified staff working at all times on 7 of 7 days reviewed. Finding includes: The licenses and certificates for all staff were reviewed on 2/15/2023 at 3:30 P.M. The facility provided two current CPR certifications, one for the Administrator and one for the Director of Nursing Services. During an interview with the Corporate Nurse Consultant, Employee 4 on 2/15/2023 at 4:00 P.M., she indicated the facility needed to schedule a class (CPR class) to fix the situation. During an interview with the Administrator, conducted on 2/15/2023 at 4:05 P.M., she confirmed while she and the Director of Nursing Services spent many hours at the facility, they are not present in the building 24 hours a day and there were shifts and periods of time where the building was without a staff member with current CPR certification. Review of the facility policy and procedure regarding Staffing Requirements, provided by the Corporate Nurse Consultant on 2/15/2023 at 4:48 P.M., included the following: "...iii. The Assisted Living shall have an identified responsible	R 0117	A.) Immediate: The HCD/BOM will audit all personnel files to identify which associates need CPR and First Aid training. B.) Immediate: The training will be scheduled for all associates identified and attendance will be required to continue to maintain scheduled shifts. C.) Long Term: The HCD will document on the daily schedule which associates are CPR and First Aid trained in order to maintain compliance with regulations. Responsible Party(ies): HCD, or designee, BOM, ED for review Corrective Action Plan Completion Date: 3/31/23	03/31/2023

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	attendant who is alert and awake at all times and a sufficient number of employees to meet the resident's needs, including medical services as prescribed. The responsible attendant and direct care staff must be at least eighteen (18) years of age and capable of complying with statues and rules governing ACLFs...." There was no specific policy regarding CPR certifications just the afore mentioned policy indicating the employee complied with "statues and rules."			
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive			

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	reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			
	Based on record review and interview, the facility failed to ensure Mantoux tuberculin skin testing documentation was completed timely for 1 of 5 newly hired employees. (Employee 7) In addition, the facility failed to ensure a health screening form was thoroughly completed for 1 of 5 newly hired employees (Employee 8) Findings include: 1. During the initial review of employee files, conducted on 2/13/2023 at 11:00 A.M., there was no health screening form completed for Employee 8, with a work start date of 1/9/2023. Documentation, presented on 2/15/2023 at 9:30 A.M., indicated health screening form with Employee 8's signature, dated 1/10/2023 but all of the screening questions had been left blank. 2. During the initial review of employee files, conducted on 2/13/2023 at 11:00 A.M., there was no mantoux Tuberculin skin testing documented for Employee 7, with a work start date of 9/26/2023. Documentation, presented on 2/15/2023 at 9:30 A.M., indicated a tuberculin skin test had been administered to Employee 7 on 2/14/2023.	R 0121	a.) Immediate: The BOM or designee will audit all associate files to identify which associates personnel files are not in compliance with regulations and company policies and procedures for TB screening. b.) Immediate: Associates that have been identified as not in compliance will be required to become compliant with the regulations and company policies and procedures, and will have the first step TB skin test done by 3/31/23. c.) Long Term: The BOM will use a check list to monitor all required steps are completed before an associate can begin their employment. Once all items are completed the employee will then be scheduled for orientation and begin employment. This will include the first step TB screening. Responsible Party(ies): BOM or designee, ED for review	03/31/2023

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	The policy and procedure regarding screening of new employees was requested on 2/15/2023. The facility policy and procedure, titled "Infection Control" provided by the Corporate Nursing Consultant, on 2/15/2023 at 2:30 P.M., indicated the following: "TB (tuberculosis) testing/screening upon move-in and annually thereafter will be completed per the regulations in each state/common wealth: ...." There were specific instructions for 7 different states and/or common wreaths, but not Indiana. During an interview conducted on 2/15/2023 at 3:00 P.M., with Employee 4, the Corporate Nursing consultant, she indicated the corporation was based in another state and she was not clear on Indiana's state rules regarding tuberculin testing requirements and indicated the corporation would be updating their policy to include Indiana. In another section of the Infection Control Policy, titled, Tuberculosis- Associates, the following was included: "...Each newly hired employee will be screened for TB infection and disease after an employment offer has been made but prior to the employee's duty assignment. 2. The two step tuberculin skin test (TST) will be used for baseline testing unless there is documentation of previous TB testing in the last 12 months...."		Corrective Action Plan Completion Date: 3/31/23	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and			

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	education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation.			
	Based on record review and interview, the facility failed to ensure 1 of 5 personnel files for new employees contained documentation of the job description (Employee 7) and documentation of specific job skills orientation (Employee 7 and 8) Finding includes: During a review of the personnel files, conducted on 2/13/2023 at 11:00 AM., there was no job description and no orientation to job specific skills noted in the file for Employee 7. Employee 7 had a work start date of 9/26/2022 and was a licensed nurse. In addition, there was no documentation regarding specific job skills orientation for Employee 8. Employee 8 had a work start date of 1/9/2023 and was a department manager. On 2/15/2023 at 9:30 A.M., the Administrator presented a signed job description for Employee 7, dated 2/14/2023. In addition, the Administrator presented job specific orientation forms for both Employee 7 and 8 but the forms were completely blank and no task had been signed off regarding any job specific orientation. The self evaluation portion of the form was completed and signed by	R 0123	A.) Immediate: The BOM or designee will audit all associate files to identify which associates personnel files are not in compliance with regulations and company policies and procedures regarding job specific orientation and job descriptions. B.) Immediate: The BOM or designee will prepare and require all identified associates to complete the documentation by 3/31/23. C.) Long Term: The BOM will use a check list to monitor all required steps are completed before an associate can begin their employment. Once all items are completed the employee will then be scheduled and begin employment. Responsible Party(ies): BOM or designee, ED for review Corrective Action Plan Completion Date: 03/31/23	03/31/2023

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	Employee 7 on 2/14/2023. During an interview with Employee 4, the corporate nursing consultant, she indicated the facility had "90" days to complete the training. There was no explanation as to why Employee 7's orientation had not been documented as having been completed. Review of the facility policy and procedure, titled "Personnel File" provided by the Administrator on 2/15/2023 at 9:30 A.M., indicated the following: "...A personnel file will be kept for each team member.....The team member's personnel file should contain the following forms and information: ...Signed job description(s).... Completed Initial orientation and training....Training records and documentation...." Review of the job specific forms, titled "Completion Checklist" indicated the form contained specific job skills on the left hand column, titled "Onboarding Topic" and three columns on the left hand side for the new employee's initials, the assigned manager's initials and the date the skill or topic was completed. At the top of the form was the following instruction: "(To be delivered within week 1 of hire and evaluated within 90-day period)"			
R 0156 Bldg. 00	410 IAC 16.2-5-1.5(m) Sanitation and Safety Standards - Deficiency (m) The facility's food supplies shall meet the standards of 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food in 1 of 3 nutrition pantries was labeled and dated. Finding includes: During the environmental tour of the facility,	R 0156	A. A. Immediate: All items are to be removed from Activity Room refrigerator by 3/31/23. B. B. Immediate: Training will be provided to all staff members regarding policies and procedures of food storage, labeling and	03/31/2023

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	conducted on 2/14/2023 between 10:40 A.M. - 11:30 A.M., a plastic baggy with an unrecognizable food item and a clear plastic container with a white food item was noted stored in the 200 activity room refrigerator. During an interview with the Administrator, conducted at that time, she indicated the refrigerator was utilized by Activities and was not a staff storage refrigerator. The food items were not labeled, nor were they dated. There were also three bottles of drink mixes to make alcoholic drinks in the refrigerator. A policy regarding food storage in the refrigerators in the Activity room was requested, on 2/14/2023 at 11:50 P.M., but never received.		dating of food products. C. C. Long Term: Refrigerators will be monitored weekly for adherence to policies and procedures of labeling and dating of food products. D. Responsible Party(ies): LED or designee, ED for review E. Corrective Action Plan Completion: 03/31/23	
R 0187 Bldg. 00	410 IAC 16.2-5-1.6(k) Physical Plant Standards - Deficiency (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation, record review and interview, the facility failed to ensure hot water temperatures were maintained between 100 degrees and 120 degrees Fahrenheit on 2 off 3 floors containing resident rooms. Findings include: During the environmental tour of the facility, conducted on 2/14/2023 between 10:50 - 11:40 A.M., accompanied by the facility Administrator the following hot water temperatures were obtained:	R 0187	aa.) A.) Immediate: Scheduled a licensed contractor come out evaluate hot water controls and mixing valves to ensure proper temperatures are reached and not exceeded. b.) B.) Immediate: Ensure residents have access to showers and sinks with proper water temperatures. c.) C.) Long Term: Test hot water temperatures in occupied apartments weekly to ensure the proper water temperatures are	03/31/2023

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	Resident Room 209 had a hot water temperature at the kitchenette sink of 127 degrees Fahrenheit Resident Room 225 had a hot water temperature at the kitchenette sink of 125.6 degrees Fahrenheit and 129.4 degrees Fahrenheit at the bathroom sink Resident Room 309 had a hot water temperature at the kitchenette sink of 126.3 degrees Fahrenheit. There were three hot water heaters observed in a Maintenance room located on the first floor of the facility. There was no centralized mixing valve or thermostat noted in the room. During an interview with the Administrator, during the tour, she indicated hot water temperatures were not to exceed 120 degrees Fahrenheit. During an interview with the Administrator, conducted on 1/15/2023 at 11:40 A.M., she indicated since the building was new, all of the equipment and structure were still under warranty and she had notified the builder of the issues with the hot water temperatures. She indicated that each individual sink had a regulatory valve to control the amount of hot water flow to each faucet. She indicated the temperature was regulated via a centralized control board. She indicated the control board had to be replaced already on 1/31/2023 due to previous "issues." Review of the facility policy and procedure, titled, "Preventative Maintenance," provided by the Administrator on 2/15/2023 at 9:30 A.M. included the following: "...1. The Preventive Maintenance Plan (PMP) will be developed by the executive Director and the Maintenance Supervisor. 2. The PMP will include the following: a. Warranty requirements b. Usual and customary standards applicable to the equipment. 3. The preventative		being met. Test a minimum of 5 rooms weekly on each (first, second and third) floor, as well as Harmony Square. Responsible Party(ies): Maintenance Director or designee, ED for review Corrective Action Plan Completion Date: 3/31/23	

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	maintenance schedule will be monitored by the Direct Supply TELS system...." On 2/15/2023 at 11:00 A.M.\, and again at 3:00 P.M., information regarding the preventative maintenance program and schedule to monitor hot water temperatures was requested but was not provided. However, on 2/15/2023 at 2:00 P.M., a copy of hot water temperatures completed on 1/16, 1/17, 1/18 and 1/19/2023 by the Maintenance Supervisor was provided. The top of the form indicated the task was to, "Test and Log Hot Water Temperatures in various building locations Daily." The form indicated the hot water temperatures ranged from 107.4 - 116.4 degrees Fahrenheit. There was no other documentation provided and the Administrator indicated the Maintenance Supervisor was on vacation.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.			
	Based on observation, record review and interview, the facility failed to ensure a pre-admission evaluation was documented for 1 of 5 resident records reviewed. (Resident 9) Finding includes: During the initial tour of the facility, conducted on 2/13/2023 between 10:00 A.M. - 10:50 A.M., Resident 9 was observed in her apartment working on a puzzle. When asked if she had a way to call	R 0214	A.) Immediate: The HCD or designee will audit resident clinical charts to identify the residents that are missing assessments. B.) Immediate: The HCD or designee will perform assessments for listed residents and schedule care plan meetings with residents and/or POA's to review services provide and obtain signatures.	03/31/2023

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	for help, the resident obtained the keys to her apartment and indicated she was having trouble using them. Resident 9 also indicated she was not sure how long she had lived at the facility. The clinical record for Resident 9 was reviewed on 2/15/2023 at 10:00 A.M. Resident 9 was admitted to the facility on 1/16/2023 with diagnoses including, but not limited to, Alzheimer's dementia and depression. There was no documentation in the clinical record of a preadmission evaluation for Resident 9. During an interview with Employee 4, the Corporate nursing consultant, who was checking the facility's electronic charting system, she indicated she could not find a completed preadmission evaluation for Resident 9. Review of the facility policy and procedure, titled "Move-in Process (Day of Move-in) included the following information: "...1. All pre-move in paperwork must be received and reviewed for accuracy and completion...2. The Move-in Charge Proration Worksheet is to be completed prior to move-in to determine total charges owed at thee time of the move-in...." There was no specific policy regarding the timing of the Pre-admission clinical evaluation. During an interview, conducted on 2/15/2023 at 3:00 P.M., with Employee 4, the corporate nurse consultant, she indicated the pre-admission evaluation for Resident 9 should have been completed before the resident was admitted to the facility. She indicated the previous Director of Nursing Services had placed a large stack of clinical forms into a box and she could not locate any completed pre-admission evaluation for Resident 9.		C.) Long Term: The HCD or designee will audit 25% current census per week and complete accurate assessments with required signatures. Responsible Party(ies)-ED, HCD (interim), review by Corporate Clinical Specialist Action Plan Completion Date: 03/31/23	

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	02/15/2023

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HARMONY AT ELKHART	1129 PARKWAY AVENUE ELKHART, IN 46516

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R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.			
	Based on record review and interview, the facility failed to ensure resident weights were assessed and documented on admission for 4 of 5 residents reviewed. (Residents 6, 8, 9 and 10) Finding includes: The clinical records for Residents 6, 8, 9 and 10 were reviewed on 2/15/2023 at 9:30 A.M. There were no resident weights documented for Resident 6, 8, 9 and 10 upon their admission. Employee 4, the Corporate Nurse Consultant reviewed the "hard" (paper) charts and the electronic clinical records for each resident and confirmed there had been no weight obtained for each resident upon their admission. She indicated she was having the staff weigh each resident and obtain a set of vital signs on 2/15/2023. Employee 4 indicated the facility policy was to weigh each resident upon admission and every 6 months. A policy and procedure regarding obtaining the weight of each resident was requested on	R 0216	A.) Immediate: The HCD or designee will audit resident charts to identify the residents that are missing required documentation of weights. B.) Immediate: The HCD or designee will obtain the weights of the noted residents. An order will be placed in Accuflo for every resident to receive vitals and weights monthly. C.) Long Term: An admission weight will be obtained within the first 48 hours of the residents move in to the community. The HCD or designee will monitor and run report on all documentation of weights and vitals bi-weekly. Responsible Party(ies)- HCD or designee Corrective Action Plan Completion Date: 3/31/23	03/31/2023

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	2/15/2023 at 3:00 P.M. and was not provided.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to ensure a service plan was completed timely for 1 of 5 residents reviewed (Resident 6) and was not reviewed and signed by the resident and/or their representative for 3 of 5 residents reviewed. (Residents 6, 7, and 8)	R 0217	A.) Immediate: The HCD or designee will audit the resident's clinical chart to identify the residents that are missing the required clinical evaluation (assessment).	03/31/2023

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	Findings include: The clinical records for Residents 6, 7 and 8 were reviewed on 2/15/2023 at 9:30 A.M. There were no service plans available on the paper chart presented by the facility for each resident. Resident 6 was admitted to the facility on 1/17/2023, Resident 7 was admitted to the facility on 1/23/2023 and Resident 8 was admitted to the facility on 1/24/2023. The Corporate Nursing Consultant, Employee 4, located the following service plans on the facility's electronic charting system: Resident 6 had a service plan completed on 2/12/2023, Resident 7 had a service plan completed on 1/24/2023 and Resident 8 had a service plan completed on 1/24/2023. None of the service plans were signed by the resident and/or their representative. During an interview with Employee 4, conducted on 2/15/2023 at 2:30 P.M., she indicated the facility's previous Director of Nursing was not completing all of the required forms and/or assessments timely. Review of the facility's policy and procedure, titled, Initial Individualized Service Plans, provided by the Administrator on 2/15/2023 at 2:00 P.M. included the following: "...The Community shall develop an individualized Service Plan for each resident designed to maximize the resident's level of functional ability. A plan of care is to be developed on or within 7 days PRIOR to the day of admission to address the basic needs of the resident to protect the resident's health, safety, (sic) and welfare. Procedure: 1. The initial plan shall be developed		B.) Immediate: The HCD or designee will complete an assessment of resident's needs and generate a care plan. Once a care plan is completed, the assessment and care plan will be reviewed and signed by community designee and POA/resident. C.) Long Term: The HCD or designee will conduct audit on 35% (14 Charts) each week and correct as findings occur until completed. Responsible Party(ies)- ED, HCD or designee, LED Corrective Action Plan Completion Date: 3/31/23	

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		A. BUILDING 00 B. WING	02/15/2023

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	by a qualified staff member in accordance with the policy for individualized service plans and in accordance with applicable state regulations...."			
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, record review and interview, the facility failed to ensure 1 of 1 nursing staff observed administering injectable medication followed professional standards of practice. (Employee 3) Finding includes: During observation of a medication administration pass, conducted on 2/14/2023 between 8:30 A.M. - 9:30 A.M., Employee 3, a licensed nurse, was observed preparing to administer injectable Victoza and Glargine to Resident 3. Employee 3 sanitized her hands with hand sanitizing gel, obtained the two medication pens from the medication cart drawer, removed two insulin needle caps for the pens. She then double checked the physician's orders on the electronic system. Next, she dialed the prescribed doses, 1.8 for the Victoza and 22 units for the Glargine pen. Employee 3 did was not observed to prime either medication pen prior to administering the medication to Resident 3. During an interview with Employee 3, conducted after the medication administration pass was completed on 2/14/2023 at 9:30 A.M., she indicated she "sometimes forgets" to prime the pens. She then stated she primed one of the two	R 0296	A.) Immediate: The HCD or designee audited employee files to identify the employees that are qualified to perform insulin administration. B.) Immediate: All identified employees will be provided education and training on insulin administration and medication management policies and procedures. C.) Long Term: The community will ensure implementation medication management P&P with medication aides and LPN/RN during new hire orientation and signed acknowledgement of receiving and reviewal or P&P. Responsible Party(ies)-HCD or designee, ED, Corporate Clinical Specialist to review disciplinary action and BOM to monitor and ensure completion upon orientation process. Corrective Action Plan Completion Date: 3/31/23	03/31/2023

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	pens prior to the administration of the medication. However, the entire process was observed and at no time was Employee 3 observed priming the medication pens. Review of the facility's policy and procedure, titled, "Medication Services, included the following: "...It is the intent of Harmony Senior Services to provide assistance with all aspects of medication services in a manner that provides for a safe, timely and standardized approach to medication administration. Procedure: 1. The Healthcare Director will ensure that mediation related services required or requested by each resident are provided in accordance with the assist living, BOM, (sic) and pharmacy regulations governing our practice...." During an interview with the Administrator, conducted on 2/14/2023 at 12:00 P.M., she indicated there was not a specific facility policy regarding how to administer insulin and other medications with a KWIK pen. Review of the manufacturer's instructions regarding the injection of Basaglar (glargine) insulin via a KwikPen included the following instructions: "...Priming your Pen Prime before each injection. Priming means removing the air from the Needle and Cartridge that may collect during normal use. It is important to prime you Pen before each injection so that it will work correctly. If you do not prime before each injections, you may get too much or too little insulin. Step 6. To prime your Pen, turn the Dose Knob to select 2 units. Step 7 Hold you Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8 Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and '0'			

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	is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle...."			
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.			
	Based on observation, record review and interviews, the facility failed to ensure medications were obtained timely and/or accurately and administered timely for 4 of 5 residents observed receiving medications. (Residents 2, 3, 4 and 6) Findings include: A.During observation of a medication pass, conducted on 2/14/2023 between 8:30 A.M. - 10:30 A.M., the following was noted: 1. Employee 2, a nurse, administered daily and/or morning medication to Resident 2. Employee 2 indicated the resident was supposed to receive Loratadine 10 mg (milligram), and Memantine 10 mg but both medications were not available. She indicated they would have to be reordered from the pharmacy. 2. Employee 2 administered daily and/or morning medications to Resident 5. Employee 2 indicated the resident was supposed to receive Donepazil 5 mg one tablet but the medication was not available. She indicated the medication would have to be reordered from the pharmacy.	R 0297	a) A.) Immediate: The HCD or designee will perform a medication cart audit to identify the medications that are out of stock or not available and notify the pharmacy of the needs of the residents. b) B.) Immediate: The community and the pharmacy provider have established a new process in order to ensure timely retrieval of prescriptions when ordered for residents in a timely manner. If medications are unavailable, medications will be reordered from a local pharmacy to ensure administration within a timely manner. c) C.) Long Term: The HCD or designee will continue to monitor pending orders to ensure that all new orders have been communicated to pharmacy to ensure timely delivery of the medications. Responsible Party(ies): HCD or designee	03/31/2023

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	3. Employee 2 administered daily and/or morning medications to Resident 6. Employee 2 indicated the resident was supposed to receive Vitamin C 1000 mg one tablet daily but the medication was not available. She indicated she would have to reorder the medication from the pharmacy. 4. Employee 2 administered daily and/or morning medications to Resident 4. Employee 2 had only placed one Bumetadine 1 mg tablet into the medication cup but the order on the label on the bottle indicated the resident was to receive 2 tablets. Employee 2 was notified of the error and obtained an additional Bumetadine tablet for the resident. B.The physician's orders and Medication Administration Records for Residents 2, 4, 5 and 6 were reviewed on 2/14/2023 at 11:00 A.M. and the following was noted: 1. The physician's orders for Resident 2 included orders for the resident to have received two additional medications, Pantoprazole 40 mg one tablet every morning and Clonazepam .5 mg one tablet twice a day. Review of the medication administration record (MAR) for Resident 2 for February 2023 indicated the Pantoprazole medication was on the form and should have been administered. The Clonazepam was not on the form at all. In addition, the orders confirmed the resident should have received Loratatine and Memantine medications. 2. The physician's order for Resident 5 included orders for the resident to have received Donepazil 5 mg. 3. The physician's orders for Resident 6 included		Corrective Action Plan Completion Date: 3/31/23	

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	02/15/2023

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orders for the resident to have received Vitamin C 1000 mg one tablet once a day.

4. The physician's orders for Resident 4 included orders for the resident to have received Bumetadine 1 mg two tablets daily. In addition, there was an order for the resident to have received Lorazepam .5 mg one tablet daily. Review of the February 2023 MAR for Resident 4 indicated the Lorazepam medication was not listed on the form for staff to administer.

The concerns were brought to the attention of the Corporate Nurse Consultant and Administrator on 2/14/2023 at 12:00 P.M. During an interview with the Corporate Nurse Consultant on 2/15/2023 at 9:30 A.M., she indicated the facility was having a huge problem obtaining medications from their current pharmacy supplier. When queried if there was documentation nursing had alerted the physicians of the missed medications and/or any system to obtain medications from another pharmacy she indicated there was "probably no documentation." She indicated there were several documents, faxes, requesting medications from the facility to the current pharmacy provider.

Review of the facility policy and procedures regarding medication orders, ordering from pharmacy and documentation of orders and ordering the medications from the pharmacy provider did not contain a policy specifically addressing the procedure to follow if a medication that had been ordered was not received. There was a policy, titled, Missed or Refused Medications, provided by the Administrator on 2/15/2023 at 9:30 A.M. which indicated the following: "...Procedure: 1. Missed/refused medications are documented on he resident's medication administration record (MAR) 2. The

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	prescribing physician is notified in a timely manner of the resident's refusal and why. The responsible party is notified....."			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available.			
	Based on record review and interviews, the facility failed to ensure an emergency file was maintained for each resident. This deficient practice affected 5 of 5 residents reviewed. (Residents 6, 7, 8, 9 and 10) Finding incudes: On 2/15/2023 at 2:00 P.M., the Corporate Nurse Consultant was quiried regarding an emergency file for each resident in the building but specifically for Residents 6, 7, 8, 9 and 10. She indicated the facility should have a record that contained emergency informaiton, a picture of	R 0356	A.) Immediate: The Emergency Profile Binder will be audited to identify residents that have missing emergency profiles. B.) Immediate: The community will ensure completion of the resident Emergency Profile for the identified residents. C.) Long Term: The community will monitor and perform an audit on 35% (14 Charts) each week and correct as findings occur until completed. Responsible Party(ies)- ED, Sales	03/31/2023

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	each resident and some life background information. She indicated the Life Services Director should have the file. On 2/15/2023 at 3:00 P.M., the Corporate Nurse Consultant presented a large 3 ring binder but most of the informaiton was missing and/or incomplete for all residents, including Residents 6, 7, 8, 9 and 10. A policy regarding maintenance of an emergency file was requested on 2/15/2023 at 3 P.M. and was not provided.		Director, HCD or designee, LED Corrective Action Plan Completion Date: 3/31/23	
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, record review and interviews, the facility failed to ensure 1 of 1 staff observed administering medications followed standard infection control procedures while administering injectable medications. (Employee 2) Finding includes: During the observation of a medication administration pass, with Employee 2, a nurse, the following was noted: Employee 2 sanitized her hands with hand sanitizer gel, obtained two insulin pens from the medication cart, checked the electronic medication record to ensure the correct order was being followed, opened and placed the needles onto each pen, dialed the pens to the prescribed ordered dose, assisted the resident	R 0406	A.) Immediate: HCD or designee will perform an audit of employees to identify the employees that are qualified to perform medication administration. B.) Immediate: All identified employees will be provided education and training on proper PPE and medication administration and medication management policies and procedures. C.) Long Term: The HCD or designee will perform medication pass audits will be performed weekly x4 weeks, then bi-weekly x4 weeks and following these audits will be complete monthly.	03/31/2023

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	with lifting up her shirt, cleansed the resident's abdomen with alcohol and then injected the medications - one on each side of the resident's abdomen. Employee 2 did not wear gloves for any part of the procedure. During an interview with Employee 4, the facility corporate nurse consultant, on 12/14/2023 at 12:00 P.M. she confirmed the facility policy was to wear gloves when administering injectable medications. Review of the facility policies and procedure, titled, Medication Management Plan, included the following: "...c. The Assisted Living and its employees shall adopt and utilize standard precautions in accordance with guidelines established by the Centers for Disease Control and Prevention (CDC) for preventing transmission of infections, HIV, (sic) and communicable diseases, including adherence to a hand hygiene program which shall include:...ii. Use of gloves during each resident contact with blood or where other potentially infectious materials, mucous membranes, and non-intact skin could occur...."		Responsible Party(ies)- ED, HR and HCD or designee. Corrective Action Plan Completion Date: 3/31/23	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be			

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	performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure newly admitted residents received a tuberculin skin test (Mantoux) test upon admission and the two step method was performed when required. Findings include: During a review of the clinical records for Residents 6, 7, 8, 9 and 10, completed on 2/15/2023 at 9:30 A.M., there was no documentation regarding any tuberculin (Mantoux) skin testing upon admission performed. There was a preciously documented Tuberculin (Mantoux) skin test for Resident 8, copied from a previous healthcare facility and dated as completed on 9/15/2022. Resident 8 was admitted to the facility on 1/24/2023. During an interview with Employee 4, the Corporate Nurse Consultant she indicated the State regulations were different from other states and she thought the chest x-rays were sufficient. Review of the facility's policy and procedure, titled, Tuberculosis- Residents, included the following: "...3. A person shall have a physical examination by an independent physician, including the two step test for tuberculosis, within 30 days prior to the date of admission...."	R 0410	A.) Immediate: The HCD or designee will audit the resident charts to identify the residents that are not in compliance with the required TB skin test. B.) Immediate: The HCS or designee will complete 2-Step TB Mantoux skin test on stated residents above and complete audit on all residents to ensure all TB screening/test are completed. C.) Long Term: HCD and ED to collaborate with DSM and implement pre-admission check list and ensure all TB test/screening are included. The HCD will continue to monitor administration of TB skin test to maintain compliance. Responsible Party(ies)- ED, HR, Sales Director and HCD or designee. Corrective Action Plan Completion Date: 3/31/23	03/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/15/2023

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

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