| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING 00<br>B. WING | 05/10/2023 |

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

| (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 |
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| R 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00408034. This visit included a Residential COVID-19 Quality Assurance Walk Through.<br><br>Complaint IN00408034 - State deficiencies related to the allegations are cited at R0297.<br><br>Survey dates: May 9, and 10, 2023<br><br>Facility number: 014959<br><br>Residential Census: 56<br><br>These state residential findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on May 18, 2023. | R 0000 | | |
| R 0297<br><br>Bldg. 00 | 410 IAC 16.2-5-6(c)(1)<br>Pharmaceutical Services - Noncompliance<br>(c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident:<br>(1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.<br>Based on observation, record review, and interview, the facility failed to ensure routine medications were available for administration according to physician's orders and documented accurately when unavailable for 5 of 8 residents reviewed for availability of medications (Residents B, P, Q, R, and S).<br><br>Findings include: | R 0297 | R.297 Pharmaceutical Services – Noncompliance<br>Action Plan<br>a) Immediate: The HCD or designee will perform a medication cart audit weekly to identify the medications that are out of stock or not available and notify the pharmacy of the needs of the residents. | 11/24/2023 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Lorena Glover | Executive Director | 05/31/2023 |

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| | 1. On 5/9/23 at 2:15 p.m., Resident B's family member indicated they were concerned the resident had not gotten her glaucoma eye drops since early March 2023.<br><br>During a random medication observation on 5/10/23 at 12:15 p.m., Resident B's medication administration record (MAR), dated May 2023, was observed to have 37 entries of medications not available or awaiting pharmacy delivery.<br><br>Resident B's record was reviewed on 5/10/23 at 10:00 a.m. Diagnoses on Resident B's profile included, but were not limited to, dementia, congestive heart failure (CHF) (chronic condition in which the heart doesn't pump blood as well as it should), hypothyroidism (condition in which the thyroid gland doesn't' produce enough thyroid hormone), anxiety, depression, and hyperlipidemia (high levels of fat particles [lipids] in the blood).<br><br>Physician's orders for Resident B included,<br>a. On 6/26/22 Lumigan (lowers raised pressure in the eye to treat glaucoma) 0.1% eye drops instill 1 drop in both eyes at bedtime. MAR indicated the medication was unavailable for administration 5/1 - 5/9/23. Observation of 3 unopened bottles of Lumigan in the medication cart with QMA 10, with a dispense date on the label of 5/4/23.<br>b. On 6/26/22 Furosemide (diuretic to treat fluid retention [edema] and swelling caused by CHF) 20 milligrams (mg) take 1 tablet by mouth every morning. MAR indicated the medication was unavailable for administration 5/1 - 5/10. Qualified Medication Aide (QMA) 12 documented administering the medication on 5/8/23.<br>c. On 10/24/22 Atorvastatin (treats high cholesterol and triglyceride levels) 10 mg take 1 tablet by mouth daily. MAR indicated the medication was unavailable 5/1/ - 5/10/23. QMA's | | b) Immediate: The HCD or designee will train associates that are certified to pass medications on the policy “Reordering/Refill for all Routine Medications” to ensure that all associates understand the policy and procedures for medications.<br>c) Immediate: The HCD or designee will re-educate associates that are certified to pass medications on proper documentation on EMAR during a medication pass when medications are not available.<br>d) Immediate: The community has implemented a Medication Reorder Form to monitor and track the reordering of a resident’s medication. If medications are unavailable, medications will be reordered from a local pharmacy to ensure administration within a timely manner.<br>e) Long Term: The HCD or designee will continue to monitor pending orders in the EMAR system to ensure that all new orders have been communicated to pharmacy to ensure timely delivery of the medications.<br>Responsible Party(ies): HCD or designee<br>Corrective Action Plan Completion Date: 11/24/23 | |

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| | randomly documented administering the missing medication 5 of 10 doses.<br>d. On 12/12/22 Tylenol Extra Strength (analgesic to treat minor aches and pains and reduces fever) 500 mg caplet give 2 tablets by mouth for shoulder pain three times daily. MAR indicated the medication was unavailable for administration 5/1/ - 5/10/23. QMA's randomly documented administering the medication 15 of 28 doses.<br>e. On 4/2/23 Vitamin D3 2000 IU give 1 capsule by mouth every day. MAR indicated the medication unavailable for administration 5/1 - 5/9/23. QMA's randomly documented administering the medication 5 of 9 doses.<br><br>A handwritten memo hanging over the medication cart in the secured memory care unit, undated, signed by the Healthcare Director, indicated, "Nurses and QMA's if you do not have a medication 2 times, I must be notified by text no exceptions."<br><br>Confidential interviews were conducted during the survey and indicated:<br>a. Resident B had not been administered her Lumigan eye drops since March 4, 2023. The facility was responsible for ordering the resident's medications, and the medications were delivered to the facility.<br>b. A staff member indicated, she had not worked the evening shift, so it was not her responsibility to ensure Resident B's medications to include her Lumigan eye drops were available.<br><br>A progress notes for Resident B, dated 4/25/23 at 11:08 a.m., the Healthcare Director documented she had spoken to the pharmacy regarding the resident's Lumigan eye drops. There had been multiple attempts to re-order the medication since 3/26/23. The pharmacy supervisor indicated they | | | |

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| | would overnight the medication.<br><br>During an interview with the Healthcare Director on 5/10/23 at 10:52 a.m., she indicated she had not initially been aware Resident B had been without her Lumigan eye drops since 3/4/23. Records indicated the Lumigan was re-ordered on 3/26/23. On 4/2/23 the nurse had called to track the medication and was told by pharmacy the medication was in route. On 4/14/23 at a family meeting a daughter asked if the Lumigan eye drops had arrived. On 4/25/23 the Healthcare Director spoke to the pharmacy again about the Lumigan that had been ordered 3/26/23 and was told it had been delivered on 3/31/23, and she told them it still had not been delivered. After the 4/25/23 call the Healthcare Director received another confirmation the medication had arrived, but it had not, so on 5/4/23 the Healthcare Director spoke with the pharmacy again and through tracking was informed the United Postal Service (UPS) had lost the medication and had launched an investigation. Pharmacy finally overnighted the Lumigan eye drop medication and she thought it had arrived 5/4/23. The resident should have received at least 4 to 5 doses of the Lumigan eye drops. She could not explain why the drops were still unopened.<br><br>2. During a random medication observation on 5/10/23 at 12:23 p.m., Resident P's medication administration record (MAR), dated May 2023, was observed to have 5 entries of medications not available or awaiting pharmacy delivery.<br><br>Resident P's record was reviewed on 5/10/23 at 2:54 p.m. Diagnoses on Resident P's profile included but was not limited to dementia.<br><br>Physician's orders for Resident P included, | | | |

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| | a. On 6/21/22 Sertraline HCL (generic for Zoloft used to treat depression) 25 mg take 1 tablet by mouth daily. On 5/3/23 QMA 13 documented the medication was unavailable awaiting pharmacy delivery.<br>b. On 6/21/23 Aspirin 81 mg chewable take 1 tablet by mouth daily. MAR indicated the medication was unavailable for administration 5/1/23 - 5/7/23. QMA's randomly documented administering the medication 3 of 7 doses.<br><br>3. During a random medication observation on 5/10/23 at 12:25 p.m., QMA 10 indicated the Resident Q's Retaine eye drops were unavailable for administration.<br><br>Observation of the resident's MAR, dated May 2023, indicated 39 entries of medications not available or awaiting pharmacy delivery.<br><br>Resident Q's record was reviewed on 5/10/23 at 2:55 p.m. Diagnoses on Resident Q's profile included, but were not limited to, hypertension (high blood pressure), neuropathy (weakness, numbness, and pain from nerve damage usually in the hands and feet), and insomnia (persistent problems falling and staying asleep).<br><br>Physician's orders for Resident Q included,<br>a. On 10/9/22 Aspirin 81 mg chewable take 1 tablet by mouth daily. MAR indicated the medication was unavailable for administration 5/1/ - 5/10/23. QMA's randomly documented administering the medication 3 of 10 doses.<br>b. On 10/9/22 Atorvastatin 40 mg take 1 tablet by mouth daily. MAR indicated the medication was unavailable for administration 5/1/ - 5/9/23. QMA's randomly documented administering the medication 4 of 9 doses.<br>c. On 7/15/22 Duloxetine HCL 30 mg (generic for | | | |

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| | Cymbalta used to treat depression and anxiety) take 1 capsule by mouth daily. MAR indicated the medication was unavailable for administration 5/1/ - 5/10/23. QMA's randomly documented administering the medication 2 of 10 doses.<br>d. On 2/1/23 Retaine MGD eye drops (used to relieve dry, irritated eyes) instill 1 drop in both eyes four times daily. MAR indicated the medication was unavailable for administration 5/1/ - 5/10/23. QMA's randomly documented administering the medication 4 of 38 doses.<br><br>On 5/10/23 at 10:30 a.m. QMA 12 indicated, she had spoken to the pharmacy and Nurse Practitioner (NP) on 5/8/23 regarding Resident Q's Retaine eye drops and a new script was sent. She was not sure how long the resident had been without her eye drops.<br><br>4. During a random medication observation on 5/10/23 at 12:30 p.m., QMA 10 indicated Resident R's had an order for 2 different eye drops Latanoprost and Combigan. Both eye drops were used to lower raised pressure in the eye to treat glaucoma.<br><br>Observation of the resident's MAR, dated May 2023, indicated 1 entry of medications not available awaiting pharmacy delivery.<br><br>Resident R's record was reviewed on 5/10/23 at 3:00 p.m. Diagnoses on Resident R's profile included, but were not limited to, dementia, and glaucoma.<br><br>Physician's orders for Resident R included,<br>a. On 3/6/23 Latanoprost 0.005% instill 1 drop in both eyes every evening. MAR dated May 2023, indicated QMA's 11 and 14 documented administration of the eye drops every evening as | | | |

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| | ordered. Observation of 1 unopened bottle of Latanoprost in the medication cart, label indicated bottle 1/1, dispensed on 3/6/23.<br>b. On 3/6/23 Combigan 0.2% - 0.5% eye drops instill 1 drop in right eye at bedtime. MAR dated May 2023, indicated documentation of medication administered as ordered. Observation of 1 partially filled bottle of Combigan in the medication cart, label indicated bottle 1/1, dispensed on 3/6/23.<br>c. On 3/6/23 Melatonin 5 mg take 1 tablet by mouth at bedtime. On 5/5/23, QMA 14 documented medication unavailable awaiting delivery from pharmacy.<br><br>During an interview on 5/10/23 at 12:35 p.m., QMA 10 indicated she could not answer as to why the Latanoprost eye drop was being documented as being administered although it had never been opened after the dispense date of 3/6/23. She was also unsure how there could still be half a bottle of Combigan eye drops left if being administered daily as documented, after also being dispensed on 3/6/23.<br><br>5. During a random medication observation on 5/10/23 at 12:48 p.m., Resident S's MAR, dated May 2023, indicated 1 entry of medications not available awaiting pharmacy delivery, and 1 medication duplicate.<br><br>Resident S's record was reviewed on 5/10/23 at 3:15 p.m. Diagnoses on Resident S's profile included, but were not limited to, dementia without behaviors, and glaucoma.<br><br>Physician's orders for Resident S included,<br>a. 4/2/23 Docusate Sodium 100 mg take 1 capsule by mouth twice daily for constipation. On 5/2/23, QMA 10 documented medication unavailable awaiting delivery from pharmacy. | | | |

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| | b. 4/22/23 Lorazepam Intensol (controlled drug used to treat anxiety and sleeping problems) 2 mg/ml (milligram per milliliter) take 0.25 ml by mouth daily at bedtime. MAR, dated May 2023, indicated medication documented as administered as ordered.<br>c. 4/28/23 Lorazepam Intensol 2 mg/ml take 0.25 ml by mouth daily at bedtime and as needed for anxiety or shortness of breath. MAR, dated May 2023, indicated medication documented as administered as ordered. On 5/2/23, QMA 10 documented medication was a duplicate order.<br><br>During an interview with Licensed Practical Nurse (LPN) 6 on 5/9/23 at 9:54 a.m., she indicated her duties included electronic charting, assisting residents with their activities of daily living (ADL's), answering call lights, taking vital signs, and administering medications. She did not verbalize the ordering of medications.<br><br>During an interview on 5/9/23 at 10:37 a.m. QMA 10 indicated she was in charge of the secured memory care unit on that date. Her duties included passing pills and taking vital signs. She demonstrated on the MAR that medications could be re-ordered by pressing a button on the electronic screen.<br><br>During an interview on 5/9/23 at 11:00 a.m., QMA 11 indicated her duties included passing medications, charting, and taking vital signs. She indicated, medications were ordered by the nurse, usually faxed to the pharmacy as calling took longer to get.<br><br>During an interview on 5/10/23 at 3:58 p.m., the Healthcare Director indicated the QMA or nurse were responsible for re-ordering medications on the unit. The medications could be re-ordered by | | | |

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| | pressing the re-order button on the electronic medical record (EMR) MAR screen, or by calling the pharmacy. Residents had the option of utilizing the facility pharmacy, any local pharmacy, or use mail order; it was their choice. Medications were unavailable due to multiple reasons including staff not being diligent in monitoring and ordering when medications were running low, orders from the facility pharmacy had a minimum 3 day turnaround, and when family members had medications delivered to their homes they did not always bring in the total order to the facilities. As for staff signing as medications given when the medications were not available in the facility, medications should only be signed out after being administered.<br><br>On 5/10/23 at 2:35 p.m., the Healthcare Director provided a Medication Services policy, dated 4/2021, and indicated the policy was the one currently being used by the facility. The policy indicated, "Policy: It is the intent of [company name] to provide assistance with all aspects of medication services in a manner that provides for a safe, timely and standardized approach in medication administration. 1. The Healthcare Director will ensure that medication related services required or requested by each resident are provided in accordance with the assisted living, BOM [Business Office Manager], and pharmacy regulations governing our practice ...Pharmacies area requested to meet the following Minimum Quality Standards ...b. Must have the ability to provide 24-hour emergency services, including the delivery of medications seven days per week ...3. If the pharmacy chosen by the resident/family does not meet the minimum quality standards, the communities preferred backup pharmacy will be used in the event that medications are needed on an emergency basis...." | | | |

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| | On 5/10/23 at 2:35 p.m., the Healthcare Director provided a Re-ordering/Refill for all Routine Medications policy, dated 4/2021, and indicated the policy was the one currently being used by the facility. The policy indicated, " ...1. If the house pharmacy delivers to the community as part of their service agreement, all routine medications should be ordered prior to the blister pack running out ...Please allow 5 days for refills...."<br><br>This State Residential Finding relates to Complaint IN00408034. | | | |