STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00371802. Complaint IN00371802 - Substantiated. No State Residential Findings related to the allegations were cited. Unrelated deficiency is cited. Survey date: 3/17/22 Facility number: 014045 Residential Census: 98 The Harrison at Eagle Valley was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00371802. Quality review completed on March 28, 2022.	R 0000		
R 0295	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(a)	R 0295	**This plan of correction is submitted as required under State and**	04/06/2022

(a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents.

Based on observation, interview, and record review, the facility failed to ensure medications were secure for residents without a self-medication administration assessment or a physician's order for 3 of 3 residents reviewed for medication administration (Resident B, C, and D), failed to ensure unrefrigerated and open insulin had an open date for 1 of 3 residents reviewed for medication administration (Resident B), and failed to ensure the physician was aware of all resident medications for 2 of 3 residents reviewed for medication administration (Resident B and D).

Findings include:

1. On 3/17/22 at 10:38 a.m., Resident B's kitchen was observed. A Lantus (insulin) pen, a Humalog (insulin) pen and 2 opened tubes of Diclofenac sodium (anti-inflammatory pain reliever) were observed on the kitchen table. All the medications had an open date sticker, but no open date was written on them. In her refrigerator was an

Federal law.
The submission of this Plan of Correction does not constitute an admission on the part of The Harrison as to the accuracy of the surveyors' findings or the conclusions drawn therefrom.
Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis.
The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

· What corrective action(s) will

	opened box of Trulicity (weekly injection to control blood sugar) and a plastic bag of 4 more insulin pens. During an interview, on 3/17/22 at 10:48 a.m., Resident B indicated she gave her own insulin, but the nurses observed her doing it. During an interview, on 3/17/22 at 11:44 a.m., the Director of Nursing (DON) indicated the facility was doing Resident B's medication after she was found unresponsive after giving the wrong dose of insulin. No medications should have been in her room. On 3/17/22 at 3:48 p.m., the DON indicated Resident B no longer used the diclofenac, so it was removed from her room. 2. On 3/17/22 at 11:27 a.m., Resident C indicated the facility nurses brought his medication. He had Flonase (steroid anti-inflammatory for allergies) and a Breo (improves lung function) inhaler in his room. These medications were observed when he removed them from a small plastic cabinet. 3. On 3/17/22 at 1:22 p.m., Resident D indicated she had the facility nurses bring her medications. On her living room table, Nitroglycerin (treatment for chest pain), generic Pepto		be accomplished for those residents found to have been affected by the deficient practice; · 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; . What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; . 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?; and . By the date the systemic changes will be completed.	

	Bismal (treatment for stomach upset), Benadryl (antihistamine to stop allergies) and an Anoro (controls symptoms of breathing disorders) inhaler were observed. On 3/17/22 at 3:54 p.m., the DON provided the current physician's orders for Resident D. A review of the orders indicated she did not have orders for generic Pepto Bismal and Benadryl. On 3/17/22 at 4:02 p.m., the DON indicated she would need to get an order for Resident D's medications or remove them from her room. During an interview, on 3/17/22 at 3:02 p.m., the DON indicated Resident B, C, and D did not have self-administration assessments or physician's order to self-medicate and should not have medications in their rooms. A current policy, titled, "Resident Self-Management of Medications," with no date, was provided by the Executive Director (ED), on 3/17/22 at 4:00 p.m. A review of the policy indicated, " ...Some residents may prefer to manage all or part of their medications without our assistance. If this is the case, first verify that the Resident's physician has indicated that the Resident is capable of		R 295 1. Resident B’s Diclofenac, Lantus pen, Humalog pen, a box of Trulicity, and the plastic bag of 4 insulin pens were removed from the room and secured in the medication cart. ResResident C’sorders were obtained for the resident to self-administer and keep at the bedside the following medications Breo and Flonase. Resident D’s orders were obtained for resident D to self-administer and keep at the bedside the following medications Pepto-Bismol and Albuterol. Resident D’s Anoro and Nitroglycerin were removed and secured in the medication cart. The Wellness Director completed a self-medication assessment with the resident, and this will be reviewed every 6 months and/or a change of condition. 2. The	

	self-administering medications...Self Medication assessments should be done as indicated by state regulations...If the Resident does not choose to obtain a physician order, self medication cannot occur...." Based on observation, interview, and record review, the facility failed to ensure medications were secure for residents without a self-medication administration assessment or a physician's order for 3 of 3 residents reviewed for medication administration (Resident B, C, and D), failed to ensure unrefrigerated and open insulin had an open date for 1 of 3 residents reviewed for medication administration (Resident B), and failed to ensure the physician was aware of all resident medications for 2 of 3 residents reviewed for medication administration (Resident B and D). Findings include: 1. On 3/17/22 at 10:38 a.m., Resident B's kitchen was observed. A Lantus (insulin) pen, a Humalog (insulin) pen and 2 opened tubes of Diclofenac sodium (anti-inflammatory pain reliever) were observed on the kitchen table. All the medications had an open date sticker, but no open date was written on them.		Community reviewed each resident's record to determine which residents if any, could be affected by the alleged deficient practice. 3. The Wellness Director completed a self-medication assessment with the resident and this will be reviewed every 6 months and/or a change of condition. 4. The Executive Director or designee will audit 5 individual random residents' apartments for medication compliance each week x 4 weeks, then bi-weekly x 4 weeks, and then monthly x 6 months. 5. Systemic changes completed: April 6, 2022	

In her refrigerator was an opened box of Trulicity (weekly injection to control blood sugar) and a plastic bag of 4 more insulin pens.

During an interview, on 3/17/22 at 10:48 a.m., Resident B indicated she gave her own insulin, but the nurses observed her doing it.

During an interview, on 3/17/22 at 11:44 a.m., the Director of Nursing (DON) indicated the facility was doing Resident B's medication after she was found unresponsive after giving the wrong dose of insulin. No medications should have been in her room.

On 3/17/22 at 3:48 p.m., the DON indicated Resident B no longer used the diclofenac, so it was removed from her room.

2. On 3/17/22 at 11:27 a.m., Resident C indicated the facility nurses brought his medication. He had Flonase (steroid anti-inflammatory for allergies) and a Breo (improves lung function) inhaler in his room. These medications were observed when he removed them from a small plastic cabinet.

3. On 3/17/22 at 1:22 p.m., Resident D indicated she had the facility nurses bring her medications. On her living room table, Nitroglycerin (treatment

for chest pain), generic Pepto Bismal (treatment for stomach upset), Benadryl (antihistamine to stop allergies) and an Anoro (controls symptoms of breathing disorders) inhaler were observed.

On 3/17/22 at 3:54 p.m., the DON provided the current physician's orders for Resident D. A review of the orders indicated she did not have orders for generic Pepto Bismal and Benadryl.

On 3/17/22 at 4:02 p.m., the DON indicated she would need to get an order for Resident D's medications or remove them from her room.

During an interview, on 3/17/22 at 3:02 p.m., the DON indicated Resident B, C, and D did not have self-administration assessments or physician's order to self-medicate and should not have medications in their rooms.

A current policy, titled, "Resident Self-Management of Medications," with no date, was provided by the Executive Director (ED), on 3/17/22 at 4:00 p.m. A review of the policy indicated, " ...Some residents may prefer to manage all or part of their medications without our assistance. If this is the case, first verify that the Resident's physician has indicated that the

	Resident is capable of self-administering medications...Self Medication assessments should be done as indicated by state regulations...If the Resident does not choose to obtain a physician order, self medication cannot occur...."			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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