

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/10/2022	
NAME OF PROVIDER OR SUPPLIER HARRISON AT EAGLE VALLEY, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 IN00387033. Complaint IN00387033 - Substantiated. State Residential Findings related to the allegations are cited at R044 and R214 Survey date: August 10, 2022. Facility number: 014045 Residential Census: 104 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 23, 2022.	R 0000					
R 0044	Residents' Right - Deficiency 410 IAC 16.2-5-1.2(r)(1-5) (r) The transfer and discharge rights of residents of a facility are as follows:	R 0044	This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of as to the accuracy of the surveyors' findings or the			08/31/2022	

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	(1) As used in this section, "interfacility transfer and discharge" means the movement of a resident to a bed outside of the licensed facility. (2) As used in this section, "intrafacility transfer" means the movement of a resident to a bed within the same licensed facility. (3) When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility. (4) Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless: (A) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility; (C) the safety of individuals in the facility is endangered; (D) the health of individuals in the facility would otherwise be endangered; (E) the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or (F) the facility ceases to operate.		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 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 and by the date the systemic changes will be completed. R044Resident B is no longer residing in the Community. The	
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(5) When the facility proposes to transfer or discharge a resident under any of the circumstances specified in subdivision (4)(A), (4)(B), (4)(C), (4)(D), or (4)(E), the resident ' s clinical records must be documented. The documentation must be made by the following:

(A) The resident ' s physician when transfer or discharge is necessary under subdivision (4)(A) or (4)(B).

(B) Any physician when transfer or discharge is necessary under subdivision (4)(D).

Based on record review and interview, the facility failed to ensure a resident had the right to be informed of her transfer/discharge rights and notified of the facilities bed-hold policy prior to her discharge to the hospital for 1 of 3 residents reviewed for transfer and discharge (Resident B).

Findings include:

During a confidential interview on 8/10/22 at 9:15 a.m., it was indicated Resident B had been sent to the hospital, then later discharged to a nursing home for rehabilitation. Upon conversations with the nursing home and the facility, the plan had been for Resident B to return to her home at the facility where she had lived for the past 7 years. However, the day before she was due to return,

Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. All nursing staff were in-serviced on the process of transfer/discharge including resident right to be informed of transfer/discharge and the Community bed-hold policy

The Wellness Director or designee will monitor all discharges for 4 weeks to ensure compliance is met. Systemic change date August 31, 2022

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the facility denied her readmission and indicated she would need to go to a psychiatric facility for treatment and evaluation before she would be allowed to return. Resident B had already paid in full for the month of July, but now the facility would not allow her to return. They "just basically dumped someone who has been a resident for 7 years, without any notice, explanation."

On 8/10/22 at 11:25 a.m., Resident B's record was reviewed. She had been a resident at the facility since her initial admission in 2016 but had recently been sent to the hospital on June 13th, 2022. She was a private pay resident.

The record lacked documentation of any initial admission, and/or current acknowledgement that Resident B and/or her healthcare representative had been provided a copy of the facilities bed-hold policy.

On 8/10/22 at 11:00 a.m., the Director of Nursing (DON) provided a copy of the facilities bed-hold policy, it was reviewed at this time. The policy was titled, "Licensed Residential Facility Bed Hold Policy," dated 9/11/17. The policy indicated, "...Private Pay Bed Hold Policy: the resident may reserve their apartment during leaves of

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absence by continuing to pay the monthly rent as stated in their Resident Agreement. For instance, when the resident had moved to another facility [hospital] or passed away, the Room & Board rate will continue until the resident has satisfied the termination requirements set forth in the Resident Lease Agreement."

On 8/10/22 at 11:00 a.m., the DON provided a copy of the facilities current policy titled, "Resident Bill of Rights," the policy was dated 2002, and revised 2008. The policy indicated, " ...V. the resident has the right to be provided, at the time of admission to the community/facility, the following ... D. Information on related charges, admission, readmission, and discharge policies of the community/facility ... XVIII. The transfer and discharge rights of the community/facility are as follows: A. Interfacility transfer and discharge means movement of a resident to a bed outside of the community/facility ... C. when the transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for the continuity of care shall be provided by the community/facility ... D. Healthcare communities must permit each resident to remain

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in the facility and not transfer or discharge the resident from the community/facility unless: 1. The transfer/discharge is necessary for the resident's welfare and the needs cannot be met in the community/facility ... F. Before an interfacility transfer or discharge occurs, the community/facility must, on a form prescribed by the department, do the following: Notify the resident of the transfer or discharge and the reason for the move, in writing, and in a language and manner that the resident understands ... H. Notice may be made as soon as practicable before transfer or discharge...."

During an interview on 8/10/22 at 1:10 p.m., where the Executive Director (ED), and DON were present, the ED indicated it appeared that a notice of transfer and/or a bed hold policy had not been provided to Resident B, either at the time of her transfer, or as soon as practicable after her transfer.

This State Residential Finding relates to Complaint IN00387033.

Based on record review and interview, the facility failed to ensure a resident had the right to be informed of her transfer/discharge rights and notified of the facilities bed-hold

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policy prior to her discharge to the hospital for 1 of 3 residents reviewed for transfer and discharge (Resident B).

Findings include:

During a confidential interview on 8/10/22 at 9:15 a.m., it was indicated Resident B had been sent to the hospital, then later discharged to a nursing home for rehabilitation. Upon conversations with the nursing home and the facility, the plan had been for Resident B to return to her home at the facility where she had lived for the past 7 years. However, the day before she was due to return, the facility denied her readmission and indicated she would need to go to a psychiatric facility for treatment and evaluation before she would be allowed to return. Resident B had already paid in full for the month of July, but now the facility would not allow her to return. They "just basically dumped someone who has been a resident for 7 years, without any notice, explanation."

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The record lacked documentation of any initial admission, and/or current acknowledgement that Resident B and/or her healthcare representative had been provided a copy of the facilities bed-hold policy.

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On 8/10/22 at 11:00 a.m., the DON provided a copy of the facilities current policy titled, "Resident Bill of Rights," the policy was dated 2002, and revised 2008. The policy indicated, "...V. the resident has the right to be provided, at the time of admission to the community/facility, the following

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During an interview on 8/10/22 at 1:10 p.m., where the

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	Executive Director (ED), and DON were present, the ED indicated it appeared that a notice of transfer and/or a bed hold policy had not been provided to Resident B, either at the time of her transfer, or as soon as practicable after her transfer. This State Residential Finding relates to Complaint IN00387033.			
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (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 record review and interview, the facility failed to ensure a resident had a semi-annual service plan updated and implemented in a timely manner for 1 of 3 residents reviewed for service plans (Resident B). Findings include: During a confidential interview on 8/10/22 at 9:15 a.m., it was indicated that Resident B's	R 0214	This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of 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,	08/31/2022

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FORM APPROVED

OMB NO. 0938-0391

service plans were not accurate or up to date. The latest Service plan had been completed in May of 2022 but still reflected Resident B as a "Level I" candidate (meaning she received the lowest level of assistance). Resident B had several recent hospitalizations, illnesses, and had experienced an overall decline in her health. Resident B should have been assessed at a higher level of care.

On 8/10/22 at 11:25 a.m., Resident B's closed record was reviewed. She had been a resident at the facility since her initial admission in 2016 but had recently been sent to the hospital on June 13th, 2022.

There was a semi-annual service plan, dated 9/15/21, which indicated Resident B received Level I services. The Service Plan was not signed by the Resident nor her healthcare representative.

On 8/10/22 at 12:50 p.m., the Director of Nursing (DON), provided a copy of Resident B's most recent Service Plan and it was reviewed at this time. The Service Plan, dated 5/4/22, indicated Resident B remained on Level I services, and was also not signed by the Resident and/or her healthcare representative.

attorney, or shareholder of the Community or affiliated companies. What corrective action(s) will 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 and by the date the systemic changes will be completed.

R214

1. Resident B is no longer residing in the Community.
2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice.
3. The Wellness Director audited all resident records to ensure that assessments were in compliance. In addition, appropriate staff will be in-serviced on ensuring

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During an interview on 8/10/22 at 1:10 p.m., where the Executive Director (ED), and DON were present, the ED indicated service plans should be updated every 6 months. Resident B's service plan should have been updated 6 months after her last assessment in September, which meant she should have been reassess in March. Her most recent service plan was two months late. The DON indicated the most recent service plan had not been printed and placed on her chart, therefor it had not been signed by the resident and/or her healthcare representative.

On 8/10/22 at 11:00 a.m., the DON provided a copy of the facilities current policy titled, "Resident Bill of Rights," the policy was dated 2002, and revised 2008. The policy indicated, "...X. the resident will have the right to the following:
A. participation in the development of his or her service plan and in any updates of that service plan...."

This State Residential Finding relates to Complaint IN00387033.

Based on record review and interview, the facility failed to ensure a resident had a semi-annual service plan updated and implemented in a

residents service plans are updated semi-annually and in a timely manner.

4. Wellness Director or designee will monitor upcoming assessments to remain in compliance with State Regulations. In addition, the Wellness Director or designee will monitor assessments weekly for 4 weeks and monthly thereafter to ensure compliance.

5. Systemic change date August 31, 2022

2.

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timely manner for 1 of 3 residents reviewed for service plans (Resident B).

Findings include:

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This State Residential Finding

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	relates to Complaint IN00387033.			
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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
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