

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 04/25/2024	
NAME OF PROVIDER OR SUPPLIER HARMONY AT ELKHART		STREET ADDRESS, CITY, STATE, ZIP CODE 1129 PARKWAY AVENUE, ELKHART, , 46516					
(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 Complaints IN00433057, IN00432078, IN00431982 and IN00430174. Complaint IN00433057 - No deficiencies related to the allegations are cited. Complaint IN00432078 - No deficiencies related to the allegations are cited. Complaint IN00431982 - State deficiencies related to the allegations are cited at R0090 and R0241. Complaint IN00430174 - No deficiencies related to the allegations are cited. Survey dates: April 23, 24 & 25, 2024 Facility number: 014916 Residential Census: 52 These State Residential Findings are cited in accordance	R 0000					

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	with 410 IAC 16.2-5. Quality Review completed on 4/26/2024.			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or	R 0090	a.Immediate: The HCD, ED or designee will provide education of all clinical staff members that handle medication regarding Harmony Senior Services policy. This is to ensure that all staff handling medication have working knowledge of the policy. This has potential to have widespread effect on residents b.Immediate: The HCD, ED or designee will implement the new narcotic shift count sheets that were created. This is to ensure that two staff members are counting the medication before and after each shift is completed. The logs will be reviewed by the HCD for compliance. c.Long Term: The HCD, ED or designee will following monitoring for 4 weeks daily, weekly monitoring for 2 month, and monthly monitoring for 3 month. This is to ensure the medications are being counted properly and per the policy. Correction Completion date: May 13, 2024	05/13/2024

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nursing care or other health care services as requested by the resident or resident's legal representative.

(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.

(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:

(A) employee's full name; and

(B) dates and hours worked during the past twelve (12) months.

(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.

(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request

Based on interview and record review, the facility failed to ensure the facility policy was followed related to accurate counting of controlled substances for 3 of 3 medication carts reviewed for controlled substances. (Carts: Memory

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Care, 2, and 3)

Findings include:

1. On 4/24/24 at 10:10 A.M., the Controlled Substance Shift Count log on the memory care unit was reviewed with the Qualified Medication Aide (QMA) 5.

The log indicated from 3/31/24 to 4/24/24, the off-going nurse did not sign the log on 1st shift on the following days: 3/31/24, 4/5/24, 4/7/24, 4/8/24, 4/10/24, 4/11/24, 4/17/24, 4/20/24, and 4/24/24.

The on-coming nurse did not sign the log on 1st shift on the following days: 4/17/24, 4/19/24, 4/20/24.

The off-going nurse did not sign the log on 2nd shift on the following days: 4/5/24, 4/19/24, 4/20/24, and 4/23/24.

The on-coming nurse did not sign the log on 2nd shift on the following days: 4/3/24, 4/10/24, 4/18/24, 4/19/24, 4/20/24.

The off-going nurse did not sign the log on 3rd shift on the following days: 4/10/24, 4/18/24, 4/19/24, 4/20/24.

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The on-coming nurse did not sign the log on 3rd shift on the following days: 4/6/24, 4/7/24, 4/9/24, 4/10/24, 4/16/24, 4/19/24.

The same nurses signed the Controlled Substance Shift Count log on both the out-going and in-coming shifts, which indicated the nurse counted alone on the following dates and times: 3/31/24 3rd shift, 4/1/24 1st shift, 4/3/24 3rd shift, 4/5/24 1st shift, 4/6/24 2nd shift, 4/8/24 3rd shift, 4/13/24 3rd shift, 4/14/24 3rd shift, 4/16/24 2nd shift.

During an interview with QMA 5 on 4/24/24 at 10:10 A.M., she indicated controlled substances should be counted and accounted for at every shift change, and the facility had shift change every 8 hours, so controlled substances should be counted 3 times in a 24 hour span. QMA 5 indicated the nurse and/or QMA going off-shift and the nurse and/or QMA coming on-shift were to observe and count the remaining controlled substances, check it against each resident's Controlled Substance Record, then both nurses were to sign-off on the Controlled Substance Shift Count together.

2. On 4/24/24 at 2:00 P.M., the Controlled Substance Shift

Count logs for Medication Carts 2 and 3 were reviewed.

The Cart 2 log indicated from 3/31/24 to 4/24/24, the off-going nurse and/or QMA did not sign the log on 1st shift on the following days: 4/9/24, 4/12/24, 4/13/24, 4/20/24, 4/22/24, and 4/23/24.

The on-coming nurse and/or QMA did not sign the log on 1st shift on the following days: 4/7/24, 4/11/24, 4/16/24, and 4/21/24.

The off-going nurse and/or QMA did not sign the log on 2nd shift on the following days: 4/14/24, 4/16/24, 4/21/24, and 4/24/24.

The on-coming nurse and/or QMA did not sign the log on 2nd shift on the following days: 4/9/24, 4/11/24, 4/12/24, 4/16/24, 4/19/24, and 4/20/24.

The off-going nurse and/or QMA did not sign the log on 3rd shift on the following days: 4/9/24, 4/13/24, 4/19/24, and 4/20/24.

The on-coming nurse and/or QMA did not sign the log on 3rd shift on the following days: 4/8/24, 4/11/24, 4/12/24, 4/19/24, 4/21/24, and 4/22/24.

The same nurses and/or QMAs signed the Controlled Substance Shift Count log on both the out-going and in-coming shifts, which indicated

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the nurse and/or QMA had counted alone on the following dates and times: 4/17/24 3rd shift, and 4/23/24 3rd shift.

3. The Cart 3 log indicated from 3/31/24 to 4/24/24, the off-going nurse and/or QMA did not sign the log on 1st shift on the following days: 4/4/24, 4/9/24, 4/12/24, 4/13/24, 4/18/24, 4/20/24, 4/22/24, and 4/23/24.

The on-coming nurse and/or QMA did not sign the log on 1st shift on the following days: 4/7/24.

The off-going nurse and/or QMA did not sign the log on 2nd shift on the following days: 4/1/24, 4/4/24, 4/5/24, 4/7/24, and 4/15/24.

The on-coming nurse and/or QMA did not sign the log on 2nd shift on the following days: 3/31/24, 4/7/24, 4/11/24, 4/12/24, and 4/20/24.

The off-going nurse and/or QMA did not sign the log on 3rd shift on the following days: 4/19/24, and 4/22/24.

The on-coming nurse and/or QMA did not sign the log on 3rd shift on the following days: 4/7/24, 4/11/24, 4/12/24, 4/19/24, 4/21/24, and 4/22/24.

The same nurses and/or QMAs signed the Controlled Substance Shift Count log on

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both the out-going and in-coming shifts, which indicated the nurse and/or QMA had counted alone on the following dates and times: 4/3/24 3rd shift, 4/4/23 3rd shift, 4/5/24 3rd shift, 4/15/24 1st shift, 4/17/24 3rd shift, and 4/23/24 3rd shift.

On 4/24/24 at 12:45 A.M. an interview with the Director of Nursing indicated controlled substances were to be counted from shift to shift by 2 nurses and/or QMAs and signed off on the Controlled Substance Shift Count log.

During an interview on 4/4/24 at 2:20 P.M., the Administrator indicated controlled substances should be counted between each shift by two nurses and/or QMAs and documented. The Administrator indicated the facility's Controlled Substance Shift Count logs were lacking signatures to indicate controlled substances counts were completed per policy.

On 4/4/24 at 12:48 P.M., the Director of Nursing provided a policy, titled "Narcotics & Preventing Drug Diversion," dated 4/21, and indicated it was the current facility policy. The policy indicated, "...shift counts will be conducted to ensure that all doses have been properly accounted for and to prevent drug diversion..."

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This State Residential finding relates to Complaint IN00431982

Based on interview and record review, the facility failed to ensure the facility policy was followed related to accurate counting of controlled substances for 3 of 3 medication carts reviewed for controlled substances. (Carts: Memory Care, 2, and 3)

Findings include:

1. On 4/24/24 at 10:10 A.M., the Controlled Substance Shift Count log on the memory care unit was reviewed with the Qualified Medication Aide (QMA) 5.

The log indicated from 3/31/24 to 4/24/24, the off-going nurse did not sign the log on 1st shift on the following days: 3/31/24, 4/5/24, 4/7/24, 4/8/24, 4/10/24, 4/11/24, 4/17/24, 4/20/24, and 4/24/24.

The on-coming nurse did not sign the log on 1st shift on the following days: 4/17/24, 4/19/24, 4/20/24.

The off-going nurse did not sign the log on 2nd shift on the following days: 4/5/24, 4/19/24, 4/20/24, and 4/23/24.

The on-coming nurse did not sign the log on 2nd shift on the following days: 4/3/24, 4/10/24,

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4/18/24, 4/19/24, 4/20/24.

The off-going nurse did not sign the log on 3rd shift on the following days: 4/10/24, 4/18/24, 4/19/24, 4/20/24.

The on-coming nurse did not sign the log on 3rd shift on the following days: 4/6/24, 4/7/24, 4/9/24, 4/10/24, 4/16/24, 4/19/24.

The same nurses signed the Controlled Substance Shift Count log on both the out-going and in-coming shifts, which indicated the nurse counted alone on the following dates and times: 3/31/24 3rd shift, 4/1/24 1st shift, 4/3/24 3rd shift, 4/5/24 1st shift, 4/6/24 2nd shift, 4/8/24 3rd shift, 4/13/24 3rd shift, 4/14/24 3rd shift, 4/16/24 2nd shift.

During an interview with QMA 5 on 4/24/24 at 10:10 A.M., she indicated controlled substances should be counted and accounted for at every shift change, and the facility had shift change every 8 hours, so controlled substances should be counted 3 times in a 24 hour span. QMA 5 indicated the nurse and/or QMA going off-shift and the nurse and/or QMA coming on-shift were to observe and count the remaining controlled substances, check it against each resident's Controlled

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Substance Record, then both nurses were to sign-off on the Controlled Substance Shift Count together.

2. On 4/24/24 at 2:00 P.M., the Controlled Substance Shift Count logs for Medication Carts 2 and 3 were reviewed.

The Cart 2 log indicated from 3/31/24 to 4/24/24, the off-going nurse and/or QMA did not sign the log on 1st shift on the following days: 4/9/24, 4/12/24, 4/13/24, 4/20/24, 4/22/24, and 4/23/24.

The on-coming nurse and/or QMA did not sign the log on 1st shift on the following days: 4/7/24, 4/11/24, 4/16/24, and 4/21/24.

The off-going nurse and/or QMA did not sign the log on 2nd shift on the following days: 4/14/24, 4/16/24, 4/21/24, and 4/24/24.

The on-coming nurse and/or QMA did not sign the log on 2nd shift on the following days: 4/9/24, 4/11/24, 4/12/24, 4/16/24, 4/19/24, and 4/20/24.

The off-going nurse and/or QMA did not sign the log on 3rd shift on the following days: 4/9/24, 4/13/24, 4/19/24, and 4/20/24.

The on-coming nurse and/or QMA did not sign the log on 3rd shift on the following days: 4/8/24, 4/11/24, 4/12/24,

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4/19/24, 4/21/24, and 4/22/24.

The same nurses and/or QMAs signed the Controlled Substance Shift Count log on both the out-going and in-coming shifts, which indicated the nurse and/or QMA had counted alone on the following dates and times: 4/17/24 3rd shift, and 4/23/24 3rd shift.

3. The Cart 3 log indicated from 3/31/24 to 4/24/24, the off-going nurse and/or QMA did not sign the log on 1st shift on the following days: 4/4/24, 4/9/24, 4/12/24, 4/13/24, 4/18/24, 4/20/24, 4/22/24, and 4/23/24.

The on-coming nurse and/or QMA did not sign the log on 1st shift on the following days: 4/7/24.

The off-going nurse and/or QMA did not sign the log on 2nd shift on the following days: 4/1/24, 4/4/24, 4/5/24, 4/7/24, and 4/15/24.

The on-coming nurse and/or QMA did not sign the log on 2nd shift on the following days: 3/31/24, 4/7/24, 4/11/24, 4/12/24, and 4/20/24.

The off-going nurse and/or QMA did not sign the log on 3rd shift on the following days: 4/19/24, and 4/22/24.

The on-coming nurse and/or QMA did not sign the log on 3rd

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shift on the following days:
4/7/24, 4/11/24, 4/12/24,
4/19/24, 4/21/24, and 4/22/24.

The same nurses and/or QMAs signed the Controlled Substance Shift Count log on both the out-going and in-coming shifts, which indicated the nurse and/or QMA had counted alone on the following dates and times: 4/3/24 3rd shift, 4/4/23 3rd shift, 4/5/24 3rd shift, 4/15/24 1st shift, 4/17/24 3rd shift, and 4/23/24 3rd shift.

On 4/24/24 at 12:45 A.M. an interview with the Director of Nursing indicated controlled substances were to be counted from shift to shift by 2 nurses and/or QMAs and signed off on the Controlled Substance Shift Count log.

During an interview on 4/4/24 at 2:20 P.M., the Administrator indicated controlled substances should be counted between each shift by two nurses and/or QMAs and documented. The Administrator indicated the facility's Controlled Substance Shift Count logs were lacking signatures to indicate controlled substances counts were completed per policy.

On 4/4/24 at 12:48 P.M., the Director of Nursing provided a policy, titled "Narcotics & Preventing Drug Diversion," dated 4/21, and indicated it was

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	the current facility policy. The policy indicated, "...shift counts will be conducted to ensure that all doses have been properly accounted for and to prevent drug diversion..." This State Residential finding relates to Complaint IN00431982			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure a qualified staff member administered and signed out medications during a medication pass for 3 of 4 residents who were observed during medication administration. (Residents K, M and N) Findings include: During an interview, on 4/23/24 at 3:47 P.M., the DON indicated CNA 4 was completing her	R 0241	A. Immediate: The HCD, ED or designee will provide education of all clinical staff members that handle medication regarding Harmony Senior Services policy. All clinical staff handling medication will be fully licensed. This is to ensure that all staff handling medication have working knowledge of the policy. This has potential to have widespread effect on residents B. Immediate: The ED, Business office manager or designee will audit all licensure of clinical staff. This is to ensure that all staff administering medications are qualified staff members. Any time a new staff member is added to the roster we will add to license book. C. Long Term: The HCD, ED or designee will following monitoring for 4 weeks daily, weekly monitoring for 2 month, and monthly monitoring for 3	05/20/2024

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clinical's for a QMA (Qualified Medication Aide) certificate, at the facility, on 4/5/24. The DON indicated she had observed CNA 4 set up her medication pass, which was set up correctly, and then let her pass those medications without her supervision. The DON indicated she was in the facility and did not leave the facility, until the medication pass was completed. She was not sure which residents received those medications from CNA 4 on that day.

A facility schedule for 4/5/24 indicated CNA 4 worked the 2nd shift (2:00 P.M.-10:00 P.M.) on the 100-300 hallways.

A Clinical Site Agreement, dated 3/17/24, indicated " ...The Hoosier-Health Training Center, LLC was an approved site for conducting the ISDH Qualified Medication Aid (QMA) Course. The above listed facility has secured an agreement with Harmony at Elkhart that will serve as Practicum site under the direct supervision of a designated licensed nurse, the student must perform 50 procedures required with 100% accuracy. Student name: [name of CNA 4]...."

During an interview on 4/24/24 at 12:50 P.M., the Program Director for the QMA class, with Hoosier Healthcare Training

month. This is to ensure that all clinical staff members are qualified and licensed.

Corrected Completion Date: May 20, 2024

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OMB NO. 0938-0391

Center LLC indicated the QMA had completed the classroom portion and had been directed to complete her clinical practicum at her place of employment, Harmony at Elkhart. The facility had signed a contract, qualifying them to be a clinical site for the QMA clinical practicum requirement. She indicated an RN or a charge nurse was to supervise the 40 hours of on site clinical experience. Supervision meant on site, in person visual supervision of the student during a medication administration pass.

During an interview on 4/24/24 at 2:38 P.M., QMA 10 indicated she had observed CNA 4 with a medication cup administering medications to a resident (could not remember which resident) on the Assisted Living side of the campus (not in the memory care unit) and the DON was not observed to be supervising CNA 4.

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2. The Medication Administration Record (MAR) for Resident K, dated 4/5/24, indicated she had been administered 2 medications (duloxetine and diclofenac gel) at 5:00 P.M., 1 medication (hydrocodone), at 7:00 P.M. and 1 medication (gabapentin), at 8:00 P.M. All four medication administered were signed out by QMA 11.

The MAR for Resident M, dated 4/5/24, indicated he had been administered 2 medications (carvedilol and Colace) at 5:00 P.M. by QMA 11.

The MAR for Resident N, dated 4/5/24, indicated she had been administered 2 medications (Colace and midodrine) at 5:00 P.M. by QMA 11.

On 4/25/24 at 10:45 A.M., the DON indicated she had checked the time sheet/clock for QMA 11 and she had clocked in at 6:00 A.M. and clocked out at 9:00 A.M. QMA clocked back in at 9:30 A.M. and clocked out for the day at 3:30 P.M.

On 4/25/24 at 10:52 A.M., an interview was conducted with the DON and QMA 11. The DON indicated QMA 11 had worked 6:00 A.M. to 3:30 P.M. on 4/5/24, but neither could explain why her initials appeared as administering medications for Residents K, M

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and N on that date at 5:00 P.M., 7:00 P.M. and 8:00 P.M. The DON indicated her initials should have been documented as administering the medications for CNA 4.

On 4/25/24 at 9:36 A.M., the Corporate Clinical Specialist provided a policy titled, "Medication Management Plan", undated and indicated the policy was the one currently used by the facility. The policy indicated "...Procedure: To ensure understanding of the medication procedures, responsibilities, and management for the administration of ordered medications and treatments to the residents of [name of facility]...." All Licensed nursing staff (LPN/RN) and QMAs shall adhere to the policy and procedures set forth. "...9. All (E) MARs shall contain the signatures and initials of all appropriate staff members administering medications from that (E) MAR to ensure all medications, supplements, and/or treatments have been completed...15. The oversight, management and supervision of the medication program on a day to day basis is the direct responsibility of the Healthcare Coordinator...."

This State Residential finding relates to Complaint IN00431982.

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Based on interview and record review, the facility failed to ensure a qualified staff member administered and signed out medications during a medication pass for 3 of 4 residents who were observed during medication administration. (Residents K, M and N)

Findings include:

During an interview, on 4/23/24 at 3:47 P.M., the DON indicated CNA 4 was completing her clinical's for a QMA (Qualified Medication Aide) certificate, at the facility, on 4/5/24. The DON indicated she had observed CNA 4 set up her medication pass, which was set up correctly, and then let her pass those medications without her supervision. The DON indicated she was in the facility and did not leave the facility, until the medication pass was completed. She was not sure which residents received those medications from CNA 4 on that day.

A facility schedule for 4/5/24 indicated CNA 4 worked the 2nd shift (2:00 P.M.-10:00 P.M.) on the 100-300 hallways.

A Clinical Site Agreement, dated 3/17/24, indicated " ...The Hoosier-Health Training Center, LLC was an approved site for conducting the ISDH Qualified Medication Aid (QMA) Course.

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The above listed facility has secured an agreement with Harmony at Elkhart that will serve as Practicum site under the direct supervision of a designated licensed nurse, the student must perform 50 procedures required with 100% accuracy. Student name: [name of CNA 4]...."

During an interview on 4/24/24 at 12:50 P.M., the Program Director for the QMA class, with Hoosier Healthcare Training Center LLC indicated the QMA had completed the classroom portion and had been directed to complete her clinical practicum at her place of employment, Harmony at Elkhart. The facility had signed a contract, qualifying them to be a clinical site for the QMA clinical practicum requirement. She indicated an RN or a charge nurse was to supervise the 40 hours of on site clinical experience. Supervision meant on site, in person visual supervision of the student during a medication administration pass.

During an interview on 4/24/24 at 2:38 P.M., QMA 10 indicated she had observed CNA 4 with a medication cup administering medications to a resident (could not remember which resident) on the Assisted Living side of the campus (not in the memory care unit) and the DON was not

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observed to be supervising CNA 4.

2. The Medication Administration Record (MAR) for Resident K, dated 4/5/24, indicated she had been administered 2 medications (duloxetine and diclofenac gel) at 5:00 P.M., 1 medication (hydrocodone), at 7:00 P.M. and 1 medication (gabapentin), at 8:00 P.M. All four medication administered were signed out by QMA 11.

The MAR for Resident M, dated 4/5/24, indicated he had been administered 2 medications (carvedilol and Colace) at 5:00 P.M. by QMA 11.

The MAR for Resident N, dated 4/5/24, indicated she had been administered 2 medications (Colace and midodrine) at 5:00 P.M. by QMA 11.

On 4/25/24 at 10:45 A.M., the DON indicated she had checked the time sheet/clock for QMA 11 and she had clocked in at 6:00 A.M. and clocked out at 9:00 A.M. QMA clocked back in at 9:30 A.M. and clocked out for the day at 3:30 P.M.

On 4/25/24 at 10:52 A.M., an interview was conducted with the DON and QMA 11. The DON indicated QMA 11 had worked 6:00 A.M. to 3:30 P.M. on 4/5/24, but neither could explain why her initials

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appeared as administering medications for Residents K, M and N on that date at 5:00 P.M., 7:00 P.M. and 8:00 P.M. The DON indicated her initials should have been documented as administering the medications for CNA 4.

On 4/25/24 at 9:36 A.M., the Corporate Clinical Specialist provided a policy titled, "Medication Management Plan", undated and indicated the policy was the one currently used by the facility. The policy indicated "...Procedure: To ensure understanding of the medication procedures, responsibilities, and management for the administration of ordered medications and treatments to the residents of [name of facility]...." All Licensed nursing staff (LPN/RN) and QMAs shall adhere to the policy and procedures set forth. "...9. All (E) MARs shall contain the signatures and initials of all appropriate staff members administering medications from that (E) MAR to ensure all medications, supplements, and/or treatments have been completed...15. The oversight, management and supervision of the medication program on a day to day basis is the direct responsibility of the Healthcare Coordinator...."

This State Residential finding relates to Complaint

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FORM APPROVED

OMB NO. 0938-0391

	IN00431982.			
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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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