STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY AT AVON	2141 NORTH DAN JONES ROAD, AVON, , 46123

(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 IN00461351 and IN00461521. Complaint IN00461351 - State deficiencies related to the allegation are cited at R0052. Complaint IN00461521 - No deficiencies related to the allegations are cited. Survey date: July 7 and 8, 2025 Facility number: 014959 Residential Census: 63 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 15, 2025.	R 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review.**	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be	R 0052	**What corrective actions will be accomplished for those residents found to have been affected by the**	08/29/2025

	free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident was not neglected following a fall resulting in a resident lying on the floor for 1 hour and 42 minutes for 1 of 3 residents reviewed for neglect (Resident B). Findings include: During an interview on 7/7/25 at 2:49 p.m., Resident B indicated she fell on 5/21/25 in the bathroom and pushed her alert pendant. It took 2 hours for staff to answer her alert pendant. She had been unable to reach her phone or she would have called the Director of Nursing (DON). She had originally refused to go to the hospital for evaluation because her children were out of town and she only had some ankle pain. There had been several instances when the staff had taken a long time to answer her alert pendant, if at all. She had needed more help		**deficient practice:** All residents had the potential to be affected. No residents were adversely affected. All nursing staff will receive education on timely response to care calls. Educate team on call light expectations.Additional monitoring measures will be implemented to ensure prompt follow-up, with on-site leadership providing oversight to verify compliance. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected. No other residents were identified to be affected. **What measures will be int into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**	

since the fall in May. She had been independent with her care but now required assistance to the bathroom during her recovery. On 7/5/25, she had pushed her alert pendant at 2:00 a.m., when she needed to go to the bathroom. She sat on the side of the bed for 20 minutes and decided to lay back down as it had seemed no one was coming. She had a brief on and hoped it would hold through the night. At 7:40 a.m., CNA 8 came in the room to say good morning. He had indicated to her there was no alarm even though she was sure she had pushed the button. On 7/6/25, she needed assistance getting her wet gown off and her brief pulled up. She pressed her alert pendant around 4:40 a.m., and no one came until 9:00 a.m. She was very uncomfortable and cold. She would not get upset if staff woke her up after her alert pendant had been activated.

The clinical record for Resident B was reviewed on 7/7/25 at 11:23 a.m. Diagnoses included heart disease, depressive and anxiety disorders, and obesity.

A Service Plan Detail report, dated 12/30/24, indicated Resident B had no communication impairment, long-term or short-term memory impairment and was oriented to person, place, time, and

Staff will be educated on call light response expectations. The Ciscor app will be downloaded on the nursing cell phone at the community to assist with call light response supervision. The nursing team will be educated on the Ciscor app as an additional tool to supplement the current call system.

How the corrective actions will be monitored to ensure the deficient practice will not recur-i.e., what quality assurance program will be put into place:

The Director of Nursing will audit call light response five times weekly for four weeks, twice weekly for four weeks, weekly for four weeks, monthly for four months, and then randomly thereafter.
Compliance findings will be tracked through an audit log. Corrective action will be administered as needed for insufficient call response.

By what date the systemic changes will be put into place:

	situation. The resident was independent with mobility and ambulation, required no assistance transferring or moving about her room or the building. A nursing progress note, dated 5/21/25 at 10:34 p.m., Licensed Practical Nurse (LPN) 2 indicated Resident B was found on the floor close to her living room, lying down with a pillow underneath her head. The resident indicated she had fallen while on the toilet in the bathroom and scooted herself to the living room. Resident B was assisted off the floor by four staff members. Resident B requested her children not be notified. A nursing progress note, dated 5/22/25 at 2:13 p.m., entered by the Director of Nursing (DON) included: "Writer received a phone call from resident [Resident B] late yesterday evening around 10:30 p.m. stating that she had fallen and did not want her children to be call [SIC] due to them not being in town. She also stated that she did not want to go to the hospital...." A document provided by the DON on 7/7/25 at 2:33 p.m., identified as the alert pendant log, indicated Resident B had activated her call light pendant on 5/21/25 at 8:07 p.m. The		8/29/25	

response time indicated 1 hour and 42 minutes.

A statement by CNA 3, dated 5/21/25, indicated she had been caring for another resident and had turned the volume down on her radio that received call alerts. When she had completed her care of the resident and left her room, she turned up her radio and was alerted that Resident B had called. When she arrived at her room, she found the resident on the floor. She left CNA 4 with the resident and went to get the LPN 2. The resident had indicated she had been on the floor for a long time.

A statement by LPN 2, dated 5/21/25, indicated she had been called to Resident B's room due to a CNA finding her on the floor. The resident was on the floor close to her living room. It took four staff to assist the resident off the floor after obtaining vital signs. This occurred around 9:40 p.m.

A statement by CNA 4, dated 5/22/25, included she had been with CNA 3 assisting another resident for an extended period of time.

A nursing progress note, dated 5/23/25 at 2:33 p.m., Qualified Medication Aide (QMA) 7 indicated Resident B had a fall two days ago and was exhibiting

increased need for assistance with her activities of daily living including ambulating, dressing, and toileting. She was observed groaning frequently, particularly with movement and repositioning. She reported pain to her right shoulder and hip. The resident had initially refused to be sent to the hospital. After continuous monitoring and education, she had agreed to be sent to the hospital.

An acute care hospital after visit summary, dated 5/23/25, indicated the resident had a sprained left ankle.

A nurse practitioner progress note, dated 5/29/25, indicated the resident had a fall in her apartment on 5/21/25. She had initially refused to go to the emergency room but ended up going over the weekend. Her blood pressure was running high, and she had complained of left ankle pain as well as right shoulder pain. The patient reported they completed X-rays of her left ankle and foot, wrapped her ankle with an ace bandage and told her to rest it. Today she was complaining of right shoulder pain. She denied X-rays being done in the emergency room. She was unable to raise her right arm, and her pain was not well controlled.

An acute care hospital after visit

summary, dated 5/30/25, indicated the resident had a dislocated right shoulder joint and a closed fracture of the right shoulder.

A current Service Plan Detail report, dated 6/16/25, indicated Resident B had no communication impairment, long-term or short-term memory impairment and was orient to person, place, time, and situation. The resident required 1-2 staff assistance with toileting and transferring with the use of a gait belt.

A document provided by the DON on 7/7/25 at 2:33 p.m., identified as the alert pendant log, included Resident B had activated her call light pendant as follows:

On 7/5/25 at 1:58 a.m. The response time indicated 5 hours and 26 minutes.

On 7/6/25 at 4:32 a.m. The response time indicated 4 hours and 20 minutes.

The DON provided statements regarding lengthy pendant alerts for Resident B on 7/5/25 and 7/6/25, as follows:

a. QMA 5 had indicated she had gone into Resident B's room to answer her alert pendant and found her sleeping. In the past the resident had become upset when she was woken up in the

early morning hours.

b. CNA 8 indicated he had gone to Resident B's room several times, and the resident was either sleeping or indicated she had not needed anything. The resident reset her alert pendant on her own.

c. CNA 9 indicated Resident B may have had to wait because several residents needed assistance first thing in the morning with getting up and escorted to breakfast, which Resident B did not attend.

During an interview on 7/8/25 at 10:11 a.m., the DON indicated regarding the lengthy call light responses for Resident B on 7/5/25 and 7/6/25 were due to the two CNAs staffed for the Assisted Living being very busy in the mornings getting residents up and escorted to the dining room for breakfast. Resident B had been informed that during these hours it was difficult for staff to assist her getting ready for the day. She had spoken to her about this, and she felt they had agreed that staff would be available at 9:00 a.m.

During an interview on 7/8/25 at 11:10 a.m., LPN 2 indicated the night of 5/21/25, she was on a 30 minute break and was called by staff on the phone regarding Resident B being found on the

floor. LPN 2 indicated she turned her radio off during her breaks which alerted staff when an alert pendant was activated. When she arrived at the resident's room, she was on the floor and complained that she had been on the floor for hours. LPN 2 checked the resident's vital signs and talked with her. She was very hard to get off the floor. She believed, but was unsure, they arrived to the resident's room before 9:00 p.m. The resident was denying any pain. It took four staff members to get the resident off the floor.

During an interview at 7/8/25 at 11:46 a.m., CNA 6 indicated Resident B was "testing" staff frequently by putting her alert pendant on to see how long it took for it to be answered. At times she just wanted staff to put a blanket on her or pick up her remote. She would not allow staff to turn off the alert and wanted to do it herself.

The DON had indicated there was no policy regarding answering pendant alerts. She indicated she had been working with staff on time management.

This citation relates to Complaint IN00461351.

Based on record review and interview, the facility failed to ensure a resident was not neglected following a fall

resulting in a resident lying on the floor for 1 hour and 42 minutes for 1 of 3 residents reviewed for neglect (Resident B).

Findings include:

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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