

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 03/04/2024	
NAME OF PROVIDER OR SUPPLIER HARMONY AT AVON		STREET ADDRESS, CITY, STATE, ZIP CODE 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 IN00427240, IN00427876, IN00427415, and IN00429411. Complaint IN00427240 - No deficiencies related to the allegations are cited. Complaint IN00427876 - State deficiencies related to the allegations are cited at R0117. Complaint IN00427415 - State deficiencies related to the allegations are cited at R0117. Complaint IN00429411 - State deficiencies related to the allegations are cited at R0039. Survey dates: February 27, 28, 29, March 1, and 4, 2024 Facility number: 014959 Residential Census: 69	R 0000					

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	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 14, 2024.			
R 0039	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(n) (n) Residents may, throughout the period of their stay, voice grievances to the facility staff or to an outside representative of their choice, recommend changes in policy and procedure, and receive reasonable responses to their requests without fear of reprisal or interference. Based on interview and record review, the facility failed to address grievances in a manner which could be tracked for 3 of 3 months reviewed for grievance resolutions of the resident council and the facility's grievance log. Findings include: On 2/27/24 at 11:25 a.m., Resident F indicated she attended resident council meetings at the facility and the resident council did not get any answers from the Executive Director (ED) nor the facility staff for concerns brought up during the resident council meetings.	R 0039	R. 039 Residents Rights - Deficiency Action Plan: a. Immediate: The community has hired a new ED and HCD and both will begin employment by March 12, 2024. The ED and HCD will be trained on the policy and procedures for regarding the Residents Right to Voice Complaints, Grievances and Suggestions about the Community Operations. This will be completed by 4/28/24. b. Immediate: The ED or designee will implement a Grievance Binder to be held at the Concierge desk, and additional forms will be held at the nurse's station on Assisted Living first floor, and Harmony	04/28/2024

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On 2/27/24 at 12:05 p.m., during an interview with Resident C's family member, she indicated she had given the resident 8 pairs of pants for Christmas 2023, and 6 pairs of the pants were missing in January 2024. She had reported to the staff about the missing pants and did not get a resolution of replacements until family threatened to report the missing pants to the state department of health.

On 2/28/24 at 9:15 a.m. the ED provided 3 months of resident council meeting minutes and indicated the Life Enrichment staff took minutes for the meetings, and they should have given the resident council concerns to the appropriate managers, and a copy to the ED since the ED was the grievance official. Staff would address resident council concerns and verbally let the resident council know of a resolution at the next resident council meeting. The facility did not have any grievances filed for the last 3 months. If a resident or family member had a concern or grievance, they let the receptionist know or the department manager.

On 2/28/24 at 10:03 a.m., the receptionist at the front desk indicated she did not have a facility grievance form at the front desk. If someone had a

Square (memory care neighborhood). The binder will include Grievance Forms that will be available for the residents and/or families to fill out for concerns/grievances.

c.
Immediate: The ED or designee will review the minutes that have been recorded from each resident council meeting held monthly and provide a response to the concerns/grievances each month at Town Hall if applicable, or to the residents individually as needed. This will begin in April 2024 and will be ongoing.

d.
Immediate: The ED or designee will provide training to the residents regarding the Grievance Policy and Procedures, to include location of the forms, and follow up expectation. [This will be completed by 4/24/24.](#)

e.
Immediate: The ED or designee will provide training to all associates regarding the Grievance Policy and Procedures, to

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concern or grievance, she would send an email to the appropriate staff. If she needed to write something out, she would just make a note and the note would go to the appropriate staff person. When she emailed out a resident's concern, she emailed the ED a copy of the concern.

On 2/28/24 at 11:15 a.m., the Corporate Clinical Specialist provided a copy of the facility's grievance/concern form and indicated the grievance/concern forms would be available at the front desk for all the residents and families. A copy of a completed grievance form, with a concern, would be given to the appropriate manager and a copy would be given to the ED, who was the facility's grievance official. The ED should have been tracking residents' and families' grievances and documenting the grievances onto a grievance log. The ED should have been addressing the resident council concerns in writing and presented the grievance resolution at the next resident council meeting.

On 2/28/24 at 4:10 p.m., the Corporate Clinical Specialist provided and identified a document as a current facility policy titled, "Right to Voice Complaints, Grievances and Suggestions about the Community Operation," dated 03/2022. The policy indicated,

include location of the forms, and follow up expectation. This will be completed by 4/24/24.

f.

Long Term: The ED or designee will monitor the Grievance Binder to ensure placement and to ensure forms are available. This will be monitored each day Monday through Friday for 4 weeks, each day Monday through Friday biweekly for 4 weeks, and monthly for 3 months.

Responsible Party(ies)- ED or designee

Corrective Action Plan
Completion
Date: April 28, 2024

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"...Policy: The community shall encourage all residents to express their complaints and concerns about the community and to suggest remedies or improvements in its policies and services...Procedure: The community has various avenues for residents to voice complaints and grievances about community operations...1. Team members shall be empowered and coached to address resident complaints within their power to resolve them quickly...2. However, when a complaint cannot be resolved to full satisfaction or it is outside a staff member's scope, the team member shall direct the resident to the appropriate person in management...3. The Executive Director is always available to discuss resident concerns...4. The Residency Agreement outlines procedures to file complaints and grievances without intimidation, retaliation, or threats of retaliation...6. The community shall promote an active Resident's Council. The Life Enrichment Director shall meet the Council to receive suggestions and to review progress or problems in implementing its suggestions...."

This citation relates to Complaint IN00429411.

Based on interview and record review, the facility failed to address grievances in a manner

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which could be tracked for 3 of 3 months reviewed for grievance resolutions of the resident council and the facility's grievance log.

Findings include:

On 2/27/24 at 11:25 a.m., Resident F indicated she attended resident council meetings at the facility and the resident council did not get any answers from the Executive Director (ED) nor the facility staff for concerns brought up during the resident council meetings.

On 2/27/24 at 12:05 p.m., during an interview with Resident C's family member, she indicated she had given the resident 8 pairs of pants for Christmas 2023, and 6 pairs of the pants were missing in January 2024. She had reported to the staff about the missing pants and did not get a resolution of replacements until family threatened to report the missing pants to the state department of health.

On 2/28/24 at 9:15 a.m. the ED provided 3 months of resident council meeting minutes and indicated the Life Enrichment staff took minutes for the meetings, and they should have given the resident council concerns to the appropriate managers, and a copy to the ED

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On 2/28/24 at 10:03 a.m., the receptionist at the front desk indicated she did not have a facility grievance form at the front desk. If someone had a concern or grievance, she would send an email to the appropriate staff. If she needed to write something out, she would just make a note and the note would go to the appropriate staff person. When she emailed out a resident's concern, she emailed the ED a copy of the concern.

On 2/28/24 at 11:15 a.m., the Corporate Clinical Specialist provided a copy of the facility's grievance/concern form and indicated the grievance/concern forms would be available at the front desk for all the residents and families. A copy of a completed grievance form, with a concern, would be given to the appropriate manager and a copy would be given to the ED, who was the facility's grievance official. The ED should have

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been tracking residents' and families' grievances and documenting the grievances onto a grievance log. The ED should have been addressing the resident council concerns in writing and presented the grievance resolution at the next resident council meeting.

On 2/28/24 at 4:10 p.m., the Corporate Clinical Specialist provided and identified a document as a current facility policy titled, "Right to Voice Complaints, Grievances and Suggestions about the Community Operation," dated 03/2022. The policy indicated, "...Policy: The community shall encourage all residents to express their complaints and concerns about the community and to suggest remedies or improvements in its policies and services...Procedure: The community has various avenues for residents to voice complaints and grievances about community operations...1. Team members shall be empowered and coached to address resident complaints within their power to resolve them quickly...2. However, when a complaint cannot be resolved to full satisfaction or it is outside a staff member's scope, the team member shall direct the resident to the appropriate person in management...3. The Executive Director is always available to discuss resident concerns...4.

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	The Residency Agreement outlines procedures to file complaints and grievances without intimidation, retaliation, or threats of retaliation...6. The community shall promote an active Resident's Council. The Life Enrichment Director shall meet the Council to receive suggestions and to review progress or problems in implementing its suggestions...." This citation relates to Complaint IN00429411.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of	R 0117	R.117 Personnel-Deficiency Action Plan: a. Immediate: The community has hired a new ED and HCD and both will begin employment by March 12, 2024. The ED and HCD will be trained on Alzheimer's Behavior Management, and the ED, HCD or designee will train all associates that provide care or services to the memory care neighborhood. This will be completed by 4/28/24. b.	04/28/2024

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medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.

Based on observation, interview, and record review, the facility failed to ensure adequate staffing, supervision, and monitoring of residents in the secured Memory Care unit which resulted in resident-to-resident altercation with injury between Resident B and Resident C, an altercation between Resident G and H, and an altercation between Resident G and Resident J. This deficient practice had the potential to affect 32 of 32 residents who resided on the Memory Care Unit. (Residents C, B, K, L, G, H, and J)

Findings include:

1. On 2/27/24 at 12:05 p.m. during an interview with Resident C's family member, she indicated the facility staff had called her at 6:54 a.m. that morning and she was told another resident had pushed Resident C down. The facility had sent Resident C to the emergency room and the resident had a broken nose. Resident C had lived at the facility for a couple of years and

Immediate:

The ED, HCD or designee will audit the current staffing hours allotted for the memory care neighborhood and compare to the needs of the memory care residents. This will be done as new residents are admitted to memory care, or current residents have a change of condition.

c.

Immediate:

The ED, HCD or designee will increase caregiver hours to allow additional hours for the memory care neighborhood and adjust as resident needs arise. Resident behaviors will be monitored daily and staffing hours will be adjusted as needed.

d.

Long Term:

The HCD or designee will review residents progress notes weekly for behavioral changes of condition and will adjust staffing ratios as needed to provide adequate supervision and monitoring of residents in secured memory care neighborhood. The community will monitor behavior notes for

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has had multiple falls and had a broken her nose in another incident. The memory care unit did not have enough staff, with only 2 aides and a medication aide. The staff cannot keep track of the residents, while providing care to the others, especially in the mornings. The Administrator (ADM), Director of Nursing (DON), and the Memory Care Director (MCD) entered the resident's room. The ADM indicated she had begun the report of the incident with the residents and would submit the report to the State.

The facility had filed an incident report to the State, on 2/27/24 at 6:30 a.m. The report indicated Resident C was sitting in a chair in the living room when Resident B pulled Resident C up from the chair and pushed Resident C to the floor. The residents were separated, and Resident C was sent out via EMS to the hospital for evaluation and treatment. Resident B was monitored by staff for any additional behaviors. Both residents families, physicians, ADM, and DON were notified. Resident C had a bruise on her forehead and a broken nose.

2. The facility had filed an incident report to the State, on 1/30/24 at 5:02 p.m., which indicated, it was reported to the ADM, Qualified Medication Aide

compliance each week for 8 weeks, bi-weekly for 8 weeks, and monthly for 2 months.

Completion Date: April 28, 2024

Responsible Party(ies)- HCD or designee, ED for review

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(QMA) 4 was witnessed yelling with aggressive behavior to Resident K and Resident L. Residents K and Resident L were visually upset and crying, with no physical injuries noted. QMA 4 was escorted out of the community and terminated.			
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On 3/4/24 at 9:40 a.m., QMA 4 indicated on 1/29/24 at approximately 5:00 p.m., there were supposed to be 3 aides, but there were only 2 aides in the memory care unit and QMA 4. QMA 4 was transporting the meal cart to the memory care unit. The cart tipped over, the food fell onto the floor, and her foot was injured. Then QMA 4 escorted Resident K and Resident L to the assisted living dining room. QMA 4 indicated she was upset and yelling about the food on the floor, her foot hurting, and only having 2 aides to assist with the residents. "We needed more help." When she complained to the DON about the staffing, the DON told QMA 4 she would call and try to get more staff for the memory care unit. The nurse asked me to leave the facility, because QMA 4 was yelling. QMA 4 called the DON and the DON indicated QMA 4 needed to go home due to her yelling. QMA indicated she had not yelled at any of the residents, but was upset about the staffing, the meal cart tipping over, and her foot injury from the meal cart.

3. The facility had filed an incident report to the State, on 2/17/24 at 10:19 a.m. The report indicated Resident G and Resident H were in the dining room as the activity assistant came into the memory care unit and witnessed Resident G slap

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Resident H in the face causing Resident H to fall to the floor. The activity assistant separated the residents. The residents were placed on hourly checks for 24 hours with the appropriate notifications contacted about the incident.

The facility had filed an incident report to the State, on 2/27/24 at 12:17 p.m., Resident G and Resident J were helping in the memory care unit dining room, when Resident G reached up with her right hand and smacked Resident J on her right cheek with no injuries noted. The residents' families, physicians, ADM, and DON were notified.

4. During an interview, on 2/28/24 at 3:26 p.m., in the memory care unit, Resident H's family member indicated last night there was a wet brief tucked under the resident's sofa. Resident H needed help to get up and get to the bathroom. It took a very long time for staff to answer the call light. Sometimes, staff came in, said they would be right back, and then did not come back. The memory care unit needed more staff to help the residents and to watch the other residents.

On 2/28/24 at 11:30 a.m., during an anonymous family interview, they indicated there were concerns about the lack of

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staff in the memory care unit, for staff to observe and engage with all of the residents.

On 2/28/24 at 3:20 p.m., during an observation of the secured memory care unit, two residents were seated in the dining room with no staff in sight.

On 3/4/24 at 3/4/24 at 10:18 a.m., QMA 7 indicated she worked on the memory care unit and the unit was short staffed with only 2 aides. It was hard to get things done, like residents' showers, assisting residents to the bathroom, and keeping track of all other the residents with only 2 aides.

On 3/4/24 at 10:26 a.m., QMA 16 indicated she mainly worked on the memory care unit evening shift and at times there were only 1 or 2 aides, and it was difficult to get things done and watch residents on the memory care unit.

On 3/4/24 at 10:57 a.m., QMA 8 indicated she worked on the memory care unit. It was hard to get things done and watch the residents when there were only 2 CNAs on the unit.

On 3/4/24 at 1:25 p.m., the Memory Care Director (MCD) indicated the memory care unit staffing that day was 1 QMA and 2 aides. A third aide that was scheduled for the memory care unit had called off. It made

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it hard for the 2 aides to complete all their tasks and keep an eye on all the residents without a third aide.

On 3/4/24 at 1:38 p.m., CNA 13 indicated her shift started at 7:00 a.m. until 3:00 p.m. It was hard to get things done with only 2 aides on the memory care unit, such as residents' showers, ADL care, and watching the residents. In the mornings between 7:00 a.m. and 8:00 a.m., staff dressed and took residents to the tv room then at 8:00 a.m. they took the residents to the memory care dining room.

On 3/4/24 at 1:47 p.m., CNA 14 indicated she worked 7 a.m. to 3 p.m. shift in the memory care unit. It was difficult to get things done, like dressing residents, toileting care, showers, laundry, and watching the other residents also. The unit needed to have 3 aides to complete all the tasks and keep an eye on all the residents.

On 3/4/24 at 1:55 p.m., QMA 7 indicated the facility memory care unit was running short on staff with only 2 aides to assist residents and a QMA to pass medications.

On 3/4/24 at 2:05 p.m., the DON indicated an aide had called off that day for the memory care unit which left only

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2 aides and a QMA to pass medications. It was hard for staff to get tasks completed and watch the residents with only 2 aides on the unit.

On 2/28/24 at 11:57 a.m., the Corporate Clinical Specialist provided and identified a document as a current facility policy, titled, "Staffing," dated 03/2022. The policy indicated, "...Harmony Senior Services will provide a sufficient number of team members with adequate knowledge and skills to attain and maintain the physical, mental and psychosocial well-being of each resident as outlined in their individualized service plan ...Each Department Coordinator will develop and maintain an accurate working schedule of team members sufficient to provide all of the required care and services for the residents as outlined in the individualized services plan...When developing the team members schedule, consideration will be taken for those tasks that have specific time elements such as meals and medications, so that those care and services can be performed in a timely and organized fashion...Changes in the over-all number of team members being staffed will vary with the needs and service requirements (acuity) of the resident. This will be discussed at morning stand-up utilizing the

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daily communication log. The Executive Director/Healthcare Director or Designee will make the final decision as to the needs of the over-all community and in what department the staffing changes need to be made...."

This citation relates to complaints IN00427415 and IN00427876.

Based on observation, interview, and record review, the facility failed to ensure adequate staffing, supervision, and monitoring of residents in the secured Memory Care unit which resulted in resident-to-resident altercation with injury between Resident B and Resident C, an altercation between Resident G and H, and an altercation between Resident G and Resident J. This deficient practice had the potential to affect 32 of 32 residents who resided on the Memory Care Unit. (Residents C, B, K, L, G, H, and J)

Findings include:

1. On 2/27/24 at 12:05 p.m. during an interview with Resident C's family member, she indicated the facility staff had called her at 6:54 a.m. that morning and she was told another resident had pushed Resident C down. The facility had sent Resident C to the

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emergency room and the resident had a broken nose. Resident C had lived at the facility for a couple of years and has had multiple falls and had a broken her nose in another incident. The memory care unit did not have enough staff, with only 2 aides and a medication aide. The staff cannot keep track of the residents, while providing care to the others, especially in the mornings. The Administrator (ADM), Director of Nursing (DON), and the Memory Care Director (MCD) entered the resident's room. The ADM indicated she had begun the report of the incident with the residents and would submit the report to the State.

The facility had filed an incident report to the State, on 2/27/24 at 6:30 a.m. The report indicated Resident C was sitting in a chair in the living room when Resident B pulled Resident C up from the chair and pushed Resident C to the floor. The residents were separated, and Resident C was sent out via EMS to the hospital for evaluation and treatment. Resident B was monitored by staff for any additional behaviors. Both residents families, physicians, ADM, and DON were notified. Resident C had a bruise on her forehead and a broken nose.

2. The facility had filed an

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incident report to the State, on 1/30/24 at 5:02 p.m., which indicated, it was reported to the ADM, Qualified Medication Aide (QMA) 4 was witnessed yelling with aggressive behavior to Resident K and Resident L. Residents K and Resident L were visually upset and crying, with no physical injuries noted. QMA 4 was escorted out of the community and terminated.

On 3/4/24 at 9:40 a.m., QMA 4 indicated on 1/29/24 at approximately 5:00 p.m., there were supposed to be 3 aides, but there were only 2 aides in the memory care unit and QMA 4. QMA 4 was transporting the meal cart to the memory care unit. The cart tipped over, the food fell onto the floor, and her foot was injured. Then QMA 4 escorted Resident K and Resident L to the assisted living dining room. QMA 4 indicated she was upset and yelling about the food on the floor, her foot hurting, and only having 2 aides to assist with the residents. "We needed more help." When she complained to the DON about the staffing, the DON told QMA 4 she would call and try to get more staff for the memory care unit. The nurse asked me to leave the facility, because QMA 4 was yelling. QMA 4 called the DON and the DON indicated QMA 4 needed to go home due to her yelling. QMA indicated she had not yelled at any of the

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residents, but was upset about the staffing, the meal cart tipping over, and her foot injury from the meal cart.

3. The facility had filed an incident report to the State, on 2/17/24 at 10:19 a.m. The report indicated Resident G and Resident H were in the dining room as the activity assistant came into the memory care unit and witnessed Resident G slap Resident H in the face causing Resident H to fall to the floor. The activity assistant separated the residents. The residents were placed on hourly checks for 24 hours with the appropriate notifications contacted about the incident.

The facility had filed an incident report to the State, on 2/27/24 at 12:17 p.m., Resident G and Resident J were helping in the memory care unit dining room, when Resident G reached up with her right hand and smacked Resident J on her right cheek with no injuries noted. The residents' families, physicians, ADM, and DON were notified.

4. During an interview, on 2/28/24 at 3:26 p.m., in the memory care unit, Resident H's family member indicated last night there was a wet brief tucked under the resident's sofa. Resident H needed help to get up and get to the bathroom.

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It took a very long time for staff to answer the call light. Sometimes, staff came in, said they would be right back, and then did not come back. The memory care unit needed more staff to help the residents and to watch the other residents.

On 2/28/24 at 11:30 a.m., during an anonymous family interview, they indicated there were concerns about the lack of staff in the memory care unit, for staff to observe and engage with all of the residents.

On 2/28/24 at 3:20 p.m., during an observation of the secured memory care unit, two residents were seated in the dining room with no staff in sight.

On 3/4/24 at 3/4/24 at 10:18 a.m., QMA 7 indicated she worked on the memory care unit and the unit was short staffed with only 2 aides. It was hard to get things done, like residents' showers, assisting residents to the bathroom, and keeping track of all other the residents with only 2 aides.

On 3/4/24 at 10:26 a.m., QMA 16 indicated she mainly worked on the memory care unit evening shift and at times there were only 1 or 2 aides, and it was difficult to get things done and watch residents on the memory care unit.

On 3/4/24 at 10:57 a.m., QMA 8

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indicated she worked on the memory care unit. It was hard to get things done and watch the residents when there were only 2 CNAs on the unit.

On 3/4/24 at 1:25 p.m., the Memory Care Director (MCD) indicated the memory care unit staffing that day was 1 QMA and 2 aides. A third aide that was scheduled for the memory care unit had called off. It made it hard for the 2 aides to complete all their tasks and keep an eye on all the residents without a third aide.

On 3/4/24 at 1:38 p.m., CNA 13 indicated her shift started at 7:00 a.m. until 3:00 p.m. It was hard to get things done with only 2 aides on the memory care unit, such as residents' showers, ADL care, and watching the residents. In the mornings between 7:00 a.m. and 8:00 a.m., staff dressed and took residents to the tv room then at 8:00 a.m. they took the residents to the memory care dining room.

On 3/4/24 at 1:47 p.m., CNA 14 indicated she worked 7 a.m. to 3 p.m. shift in the memory care unit. It was difficult to get things done, like dressing residents, toileting care, showers, laundry, and watching the other residents also. The unit needed to have 3 aides to complete all the tasks and keep an eye on all

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the residents.

On 3/4/24 at 1:55 p.m., QMA 7 indicated the facility memory care unit was running short on staff with only 2 aides to assist residents and a QMA to pass medications.

On 3/4/24 at 2:05 p.m., the DON indicated an aide had called off that day for the memory care unit which left only 2 aides and a QMA to pass medications. It was hard for staff to get tasks completed and watch the residents with only 2 aides on the unit.

On 2/28/24 at 11:57 a.m., the Corporate Clinical Specialist provided and identified a document as a current facility policy, titled, "Staffing," dated 03/2022. The policy indicated, "...Harmony Senior Services will provide a sufficient number of team members with adequate knowledge and skills to attain and maintain the physical, mental and psychosocial well-being of each resident as outlined in their individualized service plan ...Each Department Coordinator will develop and maintain an accurate working schedule of team members sufficient to provide all of the required care and services for the residents as outlined in the individualized services plan...When developing the team members schedule,

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consideration will be taken for those tasks that have specific time elements such as meals and medications, so that those care and services can be performed in a timely and organized fashion...Changes in the over-all number of team members being staffed will vary with the needs and service requirements (acuity) of the resident. This will be discussed at morning stand-up utilizing the daily communication log. The Executive Director/Healthcare Director or Designee will make the final decision as to the needs of the over-all community and in what department the staffing changes need to be made...."

This citation relates to complaints IN00427415 and IN00427876.

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