STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/16/2024

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 IN00431478, IN00432006, IN00436578, and IN00439090. Complaint IN00431478 - No deficiencies related to the allegations are cited. Complaint IN00432006 - State deficiencies related to the allegations are cited at R0117. Complaint IN00436578 - No deficiencies related to the allegations are cited. Complaint IN00439090 - No deficiencies related to the allegations are cited. Survey dates: August 13, 14, 15, and 16, 2024 Facility number: 014959 Residential Census: 57	R 0000	No Response given.	

	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 29, 2024.			
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 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.	R 0117	R.117 Personnel-Deficiency Action Plan: a. Immediate: Resident J.C. was given a call on 9/5/2024 that a letter will be sent shortly for a 30-day discharge notice forhistory of aggressive behaviors throughout her entire stay with Harmony. b. Immediate: The ED, HCD or designee will audit the current staffing hours allotted for the memory care neighborhood and compare to the needs and acuity of the memory care residents. ED, HCD or designee will review the acuity and needs and make adjustments as needed. c. Long Term:	10/14/2024

	Based on interview, observation, and record review, the facility failed to ensure adequate staffing, supervision, and monitoring of residents in the secured Memory Care unit which resulted in a resident-to-resident altercation between Resident J and Resident K and an altercation with injury between Resident F and G. This deficient practice had the potential to affect 19 of 19 residents who resided on the Memory Care Unit. (Residents C, J, K, F, G, and P) Findings include: During the facility entrance conference, on 8/13/24 at 11:05 a.m., the Director of Nursing (DON) indicated she was the facility's Director of Nursing and also the Memory Care Coordinator until the facility hired a new staff member into the Memory Care Coordinator position. On 8/13/24 at 12:04 p.m., during an observation of the memory care dining room lunch service, two staff were passing lunch plates to the residents and one staff was assisting a resident with eating for 17 residents in the dining room. The Corporate Regional Program Specialist was observed in the memory care unit kitchen, plating the residents' lunches and handing		The HCD or designee will review residents' progress notes dailyfor behavioral changes of condition and review with ED weekly. The ED will determine staffing ratios as needed to provide adequate supervision and monitoring of residents in secured memory care neighborhood. The community will monitor behavior notes for compliance each week on going. d. Long Term: The HCD will audit and update all memory care resident's care plans. The HCD will audit and update 5 care plans each week until completed. Routine audits will occur quarterly thereafter. e. Long Term: The ED/HCD will coordinate resident behavior training quarterlyfor current staff and all new employees will receive training within the 1st 90 days of employment. [JN1]Cathleen	

	the plates to the staff to serve to the residents. Qualified Medication Aide (QMA) 10, on 8/13/24 at 12:39 p.m., indicated there was one Certified Nursing Aide (CNA) and two QMAs for 19 residents on the memory care unit. The staff assisted the memory care unit residents with ambulation, toileting, eating, grooming, and showers. At times, it was difficult to get things done and watch all the residents on the memory care unit. If a resident needed an as needed medication or had a fall or accident, staff would contact the DON to come to the memory care unit. On 8/14/24 at 10:04 a.m., Resident C's family member indicated Resident C had resided on the memory care unit. The family felt Resident C was not taken care of at the facility in the unit. The memory care unit did not have enough staff. The staff could not keep track of the memory care residents, while providing care to the others, especially in the mornings. The facility had filed an incident report to the Indiana Department of Health, on 8/4/24 at 8:25 p.m., that indicated Resident K was wandering throughout the memory care unit and wandered into Resident J's room. Resident J became		O’brien has a nice behavior tracking log you might what to use instead of a PN review [JH2]	

	agitated with Resident K and pushed him out of his room, and punched Resident K in the hands, resulting in Resident K falling to the floor. The residents were separated and directed back to their rooms. The facility had filed an incident report to the Indiana Department of Health, on 8/8/24 at 5:50 p.m., Resident K was found lying on the floor in the hallway outside of his room after dinner. The resident complained of pain to the right side. Resident K was transported to the hospital emergency room for evaluation and treatment.			

During an interview, on 8/16/24 at 11:05 a.m., Resident K's family member indicated, on 8/4/24, Resident K had wandered into Resident J's room. Resident J got upset and kicked Resident K out of his room. The resident's care on the unit was okay, but in the last 3 weeks Resident K had falls and wandered into other residents' rooms. There was not enough staff on the memory unit to watch and care for all the residents, with only 2 CNAs and an QMA. Staff called him one evening in August 2024 about 9:30 p.m. and indicated staff could not find Resident K on the unit. Then they called me back and indicated staff had found Resident K on the floor sleeping in another resident's room.

The facility had filed an incident report to the Indiana Department of Health, on 8/8/24 at 8:45 p.m., which indicated upon hearing noise in the hallway the staff came out of another resident's room and found Resident F lying on the floor complaining of pain to her lower back and the back of her head. Resident G was standing in the hallway and indicated to the staff that she had pushed Resident F down. Resident G was redirected to her room and slammed the door when she went into the room. Resident F was taken to the emergency room and sustained a fractured

hip.

During an interview, on 8/14/24 at 3:20 p.m., the Director of Nursing (DON) indicated she was currently the Memory Care Unit Director and also the Director of Nursing. Prior to becoming the DON, in March 2024, she was the Memory Care Unit Director exclusively. The Memory Care Unit Director's office was located on the memory care unit, close to the residents' lounge area and nurses' desk, and she was able to better watch and assist with the memory care unit residents. The memory care unit was staffed with a nurse or QMA and three CNAs for all three shifts until 7/27/24, when the facility's corporation instructed the facility to only staff a nurse or QMA and two CNAs on the third shift from 7/28/24 forward for each shift. Since reducing the staff on the memory care unit, the unit had more resident incident reportable incidents submitted to the Indiana Department of Health.

On 8/16/24 at 10:27 a.m., CNA 11 indicated she had a system for the residents' care, but it was hard to complete residents' showers, toileting, activities with the residents, and watch all the other residents on the memory care unit with only 2 CNAs. Many of the residents' incidents have happened in the dining

room because of only having 2 CNAs to watch and assist all of the residents in the memory care unit.

On 8/16/24 at 12:26 p.m., Resident P's family member indicated, the memory care unit did not have enough staff. There was only three staff members on the memory care unit for serving meals, getting other residents to the dining room, and escorting the residents back out of the dining room after the meals. Staff bend over backwards to help the residents, but there was not enough staff for all of the residents on the unit.

On 8/14/24 at 4:10 p.m., the Administrator (ADM) 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 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 Complaint IN00432006.			

Based on interview, observation, and record review, the facility failed to ensure adequate staffing, supervision, and monitoring of residents in the secured Memory Care unit which resulted in a resident-to-resident altercation between Resident J and Resident K and an altercation with injury between Resident F and G. This deficient practice had the potential to affect 19 of 19 residents who resided on the Memory Care Unit. (Residents C, J, K, F, G, and P)

Findings include:

During the facility entrance conference, on 8/13/24 at 11:05 a.m., the Director of Nursing (DON) indicated she was the facility's Director of Nursing and also the Memory Care Coordinator until the facility hired a new staff member into the Memory Care Coordinator position.

On 8/13/24 at 12:04 p.m., during an observation of the memory care dining room lunch service, two staff were passing lunch plates to the residents and one staff was assisting a resident with eating for 17 residents in the dining room. The Corporate Regional Program Specialist was observed in the memory care unit kitchen, plating the residents' lunches and handing

the plates to the staff to serve to the residents.

Qualified Medication Aide (QMA) 10, on 8/13/24 at 12:39 p.m., indicated there was one Certified Nursing Aide (CNA) and two QMAs for 19 residents on the memory care unit. The staff assisted the memory care unit residents with ambulation, toileting, eating, grooming, and showers. At times, it was difficult to get things done and watch all the residents on the memory care unit. If a resident needed an as needed medication or had a fall or accident, staff would contact the DON to come to the memory care unit.

On 8/14/24 at 10:04 a.m., Resident C's family member indicated Resident C had resided on the memory care unit. The family felt Resident C was not taken care of at the facility in the unit. The memory care unit did not have enough staff. The staff could not keep track of the memory care residents, while providing care to the others, especially in the mornings.

The facility had filed an incident report to the Indiana Department of Health, on 8/4/24 at 8:25 p.m., that indicated Resident K was wandering throughout the memory care unit and wandered into Resident J's room. Resident J became

	agitated with Resident K and pushed him out of his room, and punched Resident K in the hands, resulting in Resident K falling to the floor. The residents were separated and directed back to their rooms. The facility had filed an incident report to the Indiana Department of Health, on 8/8/24 at 5:50 p.m., Resident K was found lying on the floor in the hallway outside of his room after dinner. The resident complained of pain to the right side. Resident K was transported to the hospital emergency room for evaluation and treatment.			

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room because of only having 2 CNAs to watch and assist all of the residents in the memory care unit.

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On 8/14/24 at 4:10 p.m., the Administrator (ADM) 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 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 Complaint IN00432006.			

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