| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING 00<br>B. WING | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| FORT HARRISON ALF OPERATIONS | 8025 DOUBLEDAY DRIVE<br>INDIANAPOLIS, IN 46216 |

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| R 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00450570, IN00448695, and IN00448352.<br><br>Complaint IN00450570 - State deficiencies related to the allegation(s) are cited at R187 and R273.<br><br>Complaint IN00448352 - State deficiencies related to the allegation(s) are cited at R240.<br><br>Complaint IN00448695 - No deficiencies related to the allegation(s) are cited.<br><br>Survey Dates: January 7 and 8, 2025<br><br>Facility Number: 014109<br><br>Residential Census: 50<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on January 10, 2025. | R 0000 | | |
| R 0187<br><br>Bldg. 00 | 410 IAC 16.2-5-1.6(k)<br>Physical Plant Standards - Deficiency<br><br>Based on observation, interview, and record review, the facility failed to maintain water temperatures between 100 and 120 degrees Fahrenheit at point of contact for 3 of 3 residents whose water temperatures were retrieved. (Residents D, E, and F)<br><br>Findings include:<br><br>An entrance conference interview was conducted | R 0187 | Water temperature levels in resident areas will be maintained between 100-120 degrees Fahrenheit<br><br>Maintenance Director and maintenance assistant will conduct daily checks in resident's apartment for four weeks and | 01/28/2025 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Dametria Marshall | Executive Director | 01/28/2025 |

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| | with the ED (Executive Director) on 1/7/25 at 11:43 a.m. She indicated the facility had an issue with the hot water in the facility recently. They prepared for a recent snowstorm, on 1/3/25, by allowing the water to drip from faucets in residents' rooms. When they did that, the pressure wasn't coming out as strongly in Resident D's, E's, and F's apartments. They turned the dripping off, and the pressure came back to the apartments, except in Resident E's apartment. They had plumbers come out, but a particular part was needed, that didn't come in until yesterday, 1/6/25. The part was installed yesterday, and everything was fixed yesterday. They offered Resident E the use of another apartment for bathing, until his was fixed. Resident E declined the offer, but his apartment was fine now. She stated, "Now, everything is fine."<br><br>The Maintenance Director was not available in the facility on 1/7/25. So, an observation of the retrieval of water temperatures by the Maintenance Assistant for the kitchen sinks and bathroom sinks in Resident D's, E's, and F's apartments was made on 1/7/25 at 2:10 p.m. The water temperature at the kitchen sink of Resident F was retrieved at 134 degrees Fahrenheit and the bathroom sink at 132 degrees Fahrenheit. The water temperature at the kitchen sink of Resident E was retrieved at 133 degrees Fahrenheit and the bathroom sink at 130 degrees Fahrenheit. The water temperature at the kitchen sink of Resident D was retrieved at 132 degrees Fahrenheit and the bathroom sink at 138 degrees Fahrenheit.<br><br>An interview was conducted with Resident E during retrieval of his water temperatures on 1/7/25 at 2:10 p.m. He indicated he'd lived in his apartment for about six weeks. He just got hot water back in his room yesterday. It took a long | | weekly checks thereafter to make sure all temperatures are in compliance with Indiana state regulations<br><br>Executive Director conducted in-service with maintenance assistant and maintenance director on 1-8 on proper water temperatures. If temperatures are not in proper range, they are to notify the ed immediately<br><br>Maintenance Director to keep a log of temperatures of resident's temperatures daily for two weeks and weekly thereafter to make sure all temperatures are in compliance with Indiana state regulations | |

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| | time for the water to get hot. He was "scalded" in the shower a couple weeks ago, as it was difficult to balance the hot and cold water.<br><br>An interview was conducted with the Maintenance Assistant, on 1/7/25 at 2:10 p.m., after retrieval of water temperatures. He indicated he was unaware what the range of acceptable water temperatures was. The facility had a "busted" water heater that needed replaced, and thought they were waiting on insurance approval.<br><br>On 1/7/25 at 3:00 p.m., the ED provided water temperature logs from October 2024 to present. The last water temperature retrieval date was 12/26/24 and there were no temperatures retrieved for Resident D's, E's, and F's apartments.<br><br>An interview was conducted with the ED on 1/7/25 at 2:33 p.m. She indicated they had a water heater that wasn't working, but it wasn't affecting anything. Maintenance staff was responsible for obtaining residents' room water temperatures routinely, but they hadn't done it recently. She was unaware residents had high water temperatures in their apartments until they were checked by the Maintenance Assistance just now.<br><br>An observation of the retrieval of water temperatures by the Maintenance Director for the kitchen sinks and bathroom sinks in Resident D's, E's, and F's apartments was made on 1/8/25 at 11:18 a.m. The water temperature at the kitchen sink of Resident F was retrieved at 126.1 degrees Fahrenheit and the bathroom sink at 125.6 degrees Fahrenheit. The water temperature at the kitchen sink of Resident E was retrieved at 124.5 degrees Fahrenheit. The water temperature at the kitchen sink of Resident D was retrieved at 124.5 degrees | | | |

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| | Fahrenheit and the bathroom sink at 124.1 degrees Fahrenheit.<br><br>The Water Temperature policy was provided by the BOM (Business Office Manager) on 1/8/25 at 2:10 p.m. It read, " Water temperature levels in resident areas will be maintained between 100-120 degrees Fahrenheit."<br><br>This Residential Tag relates to Complaint IN00450570. | | | |
| R 0240<br><br>Bldg. 00 | 410 IAC 16.2-5-4(d)<br>Health Services - Deficiency<br><br>Based on interview and record review, the facility failed to provide a resident's medication, as ordered, and ensure routine psychological follow-up, as recommended, for 1 of 3 residents reviewed for dignity. (Resident B)<br><br>Findings include:<br><br>The clinical record for Resident B was reviewed on 1/8/25 at 2:35 p.m. Her diagnoses included, but were not limited to, mood disorder, depression, and anxiety.<br><br>An interview and observation were conducted with Resident B in her apartment on 1/7/25 at 2:52 p.m. She indicated she'd been dealing with a rat infestation since May 2024. She saw them and their droppings everywhere. She indicated she had 37 flea bites on her at one time from the rats. There was a homemade rat trap in the corner of her living room made with a white pail and a water bottle.<br><br>An interview was conducted with the owner of | R 0240 | DON will audit cart every Monday and Friday. the ADON will audit the cart Monday through Friday weekly times four weeks times four months<br><br>Adon will Mon through Fri and don will monitor every Friday bi weekly thereafter<br><br>DON will make sure if any changes in residents bx progress notes will be put in immediately and all persons needed to be notified will be notified immediately<br><br>ED will continue to have monthly pest control mogohney come monthly or as often as needed. | 01/28/2025 |

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| | the facility's pest control provider on 1/8/25 at 11:40 a.m. He indicated he'd been in Resident B's room several times. Resident B told them she had mice and rats on the bed and in the apartment, but they never found anything. Resident B would insist various particles in her apartment were droppings, but they weren't. Sometimes, there was a confrontation, and Resident B would get very angry. He spoke with the facility management about it. He stated, "I've never found evidence of pests in there ever, rats, mice or roaches."<br><br>An interview was conducted with Family Member 2 on 1/8/25 at 10:51 a.m. She indicated she understood there were mental health issues with Resident B, and she was going to encounter problems, because "she's hard to handle." Resident B called her yesterday, 1/7/25, crying and informed her she was locked outside after smoking. DA (Dietary Aide)/Housekeeper 4 was nearby when this happened.<br><br>An interview was conducted with DA/Housekeeper 4 on 1/8/25 at 1:31 p.m. He indicated the door to the side of the building couldn't be left propped open, because it would sound an alarm, but that was the door Resident B preferred to use to go outside to smoke. He stated, "You got to learn how to cope with her based on her mood."<br><br>An interview was conducted with the Executive Director (ED) on 1/8/25 at 2:12 p.m. She indicated Resident B "went off" yesterday about the side door. The ED informed her where she was able to smoke in front of the building.<br><br>An interview was conducted with the ED, BOM (Business Office Manager), and ADON (Assistant Director of Nursing) on 1/8/25 at 2:30 p.m. The ED | | | |

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| | indicated Resident B's behaviors were new for her, and "she wasn't like this on admission," in January 2024. She was calm then. Around October 2024, Resident B started to say there were rats and roaches in her room. She gradually started yelling, not being able to have a conversation. Anytime she spoke to anyone, it was very aggressively. There was a resident council meeting, and they didn't vote her in, so she was asking other residents why they didn't choose her. The ADON indicated she knew there was something more going on with Resident B, when she started talking about rats, so she spoke with the DON (Director of Nursing) about it at that time. The DON informed her she was going to speak with the nurse practitioner (NP) about it. The BOM indicated when Resident B did not get her way, she threatened to call the State daily.<br><br>A telephone interview was conducted with the DON in the presence of the ED, ADON, and BOM on 1/8/25 at 2:59 p.m. She indicated she had a discussion with NP 8 about Resident B alleging rats in her apartment. She also spoke with the geri [geriatric]-psyche NP, NP 7, who saw her on 8/29/24, but mostly she spoke with NP 8. Resident B was currently taking clonazepam for her anxiety.<br><br>The most recent progress note from NP 8 was dated 10/16/24. It did not reference an increase in agitation, aggression, or rats in her apartment.<br><br>The second most recent progress note from NP 8 was dated 9/4/24. It referenced follow-up visit for reports of itching, insect bites, potentially caused by what Resident B believed were dust mites in her mattress. It did not reference an increase in agitation, aggression, or rats in her apartment.<br><br>On 1/8/25 at 2:55 p.m., the ADON reviewed the NP | | | |

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| | communication binder and indicated there was no communication to the NP in regards to Resident B's increased agitation, aggression, or rats in her apartment going back to October 2024.<br><br>The most recent psychiatric progress note, written by NP 7, in Resident B's clinical record was dated 8/29/24. It indicated she was seen for follow up on depression and anxiety symptoms. It read, "She was previously started on clonazepam. She was previously experiencing anxiety related to another resident at the facility who has since moved out. She does have some anxiety today related to her mother who is in town that she has not seen for the past 20 years. She is tearful at times. She reports not sleeping well at night and having nightmares. She does like to spend time in her garden and outdoor activities. Emotional support and cognitive therapy provided today. Increasing clonazepam for better symptom management. Continue nursing staff support. Routine psyche follow up in 4 weeks." It indicated her thought processes were tangential (diverging from a previous course or line; erratic) and her mood was anxious. The assessment/plan section of the note indicated to continue amitriptyline 25 mg (milligrams) daily for now for depression and may consider dose increase; to continue Lamictal 100 mg in the morning for mood disorder and may consider dose increase; to increase clonazepam to 0.5 mg twice daily for anxiety, and to continue to monitor for worsening symptoms. "Continue the current psychiatric plan of care. Will continue to monitor safety, moods, sleep, and behaviors... Please notify [name and title of NP 7] for any psychiatric questions, concerns, or changes."<br><br>There were no subsequent psyche notes in Resident B's clinical record to indicate a 4-week follow up or any routine follow up after the above | | | |

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| | 8/29/24 visit note.<br><br>A telephone interview was conducted with the DON in the presence of the ED and BOM on 1/8/25 at 4:04 p.m. She indicated she'd reached out to NP 7 some time ago about another resident, and he informed her to talk to NP 8, so she just spoke to NP 8 for residents now. She thought Resident B may need a medication evaluation.<br><br>The January 2025, December 2024, and October 2024 MARs (medication administration records) indicated Resident B was not administered her evening dose of clonazepam on 1/4/25, 1/6/25, 10/18/24, 10/19/24, 10/20/24, 10/25/24, and 10/27/24; her morning dose of Clonazepam on 12/7/24, 12/19/24, 12/28/24, 12/29/24, 10/8/24, 10/12/24, 10/13/24, 10/19/24, 10/22/24, 10/25/24, 10/27/24, and 10/30/24; or her Lamictal on 12/7/24, 12/19/24, 12/28/24, 12/29/24, but there was no documentation as to why.<br><br>An interview was conducted with the ADON on 1/8/25 at 3:12 p.m. She indicated she didn't know why Resident B wasn't administered the above medications. If she was outside smoking or missed the time frame, she didn't get them.<br><br>The current service plan, last revised 1/8/25, indicated Resident B would be supported to take all her medications safely and as ordered. Her service plan did not reference her need to monitor or receive services for her mental health.<br><br>The Medication Administration Record policy was provided by the BOM on 1/8/25 at 3:45 p.m. It read, "Check MAR/TAR [medication/treatment administration record] at the end of each shift to make sure you have not forgotten to initial any medications given." | | | |

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| | This Residential Tag relates to Complaint IN00448352.<br><br>410 IAC 16.2-5-5.1(f)<br>Food and Nutritional Services - Deficiency | | | |
| R 0273<br><br>Bldg. 00 | Based on observation, interview, and record review, the facility failed to wash dishes in accordance with the machine's data plate and manufacturer's instructions and log dishwasher temperatures for the potential to affect 50 of 50 residents in the facility.<br><br>Findings include:<br><br>An observation of the mechanical dishwasher was made with the DM (Dietary Manager) in the kitchen on 1/7/25 at 12:20 p.m. The data plate on the side of the dishwasher indicated the wash temperature needed to reach a minimum temperature of 155 degrees Fahrenheit for 49 seconds. The DM ran the dishwasher through three cycles. The wash temperature hit a maximum temperature of 90 degrees Fahrenheit the first two cycles and 100 degrees Fahrenheit for the third cycle. The January 2025 Dish Washer Temperature Log was posted on the wall behind the dishwasher. The field to indicate the week being reflected indicated the month of January, instead of an actual week. The day(s) fields were completed Sunday through Wednesday, each with a.m. wash temperatures of 180 degrees Fahrenheit and p.m. wash temperatures of over 150 degrees Fahrenheit. The day(s) fields did not reflect specific dates.<br><br>An interview was conducted with the DM, on 1/7/25 at 12:20 p.m., during the above observation. | R 0273 | the facility failed to wash dishes in accordance with the machine's data plate and manufacturer's instructions and log dishwasher temperatures for the potential to affect 50 of 50 residents in the facility.<br><br>Executive Director conducted an in-service on 1-8 with DM and staff on the proper water temperatures for the dishwasher<br><br>DM will monitor the temperature logs to ensure all temperature logs are completed daily.<br><br>maintenance will ensure preventative maintenance is completed monthly for four weeks and every three months thereafter<br><br>Kitchen staff will ensure to inform Maintenance and ED of any concerns that may appear in the kitchen immediately.<br><br>Facility had dishwasher serviced by state chemicals they came out on 1-28-25 and serviced dishwasher. The dish washer is | 01/28/2025 |

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| | She indicated she thought the Dish Washer Temperature Log represented last week, 12/29/24 through 1/1/25, because she hadn't changed it yet this week, but usually changed it every Monday. This was the only log they had. She was unaware the dishwasher was not reaching the minimum wash temperature, as there was a specific staff member who usually washed dishes and logged daily temperatures.<br><br>The Dishwasher policy was provided by the ED (Executive Director) on 1/8/25 at 12:20 p.m. It did not reference ensuring the dishwasher reached the appropriate wash or rinse temperatures or logging dishwasher temperatures routinely.<br><br>This Residential Tag relates to Complaint IN00450570. | | currently reaching proper temperatures accordance to the machine plate of the manufactures | |