STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155852	A. BUILDING 00 B. WING	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON SPRINGS HEALTH CAMPUS	871 PACER DRIVE NW CORYDON, IN 47112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: March 20, 21, 24, 25, 26, and 27, 2025 Facility number: 013702 Provider number: 155852 AIM number: 300018569 Census Bed Type: SNF: 38 SNF/NF: 16 Residential: 27 Total: 81 Census Payor Type: Medicare: 16 Medicaid: 24 Other: 14 Total: 54 This deficiency refects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 1, 2025.	F 0000		
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to ensure the physician was notified and/or follow up with the physician when a resident's surgical wound opened up for 1 of 2 residents reviewed for quality of care. (Resident 20)	F 0684	This plan of correction is to serve as Harrison Springs Health Campus credible allegation of compliance. Submission of this plan of correction does not constitute an admission by	04/08/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ryan Morton	Executive Director	04/09/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Findings include: The record for Resident 20 was reviewed on 3/21/25 at 8:30 a.m. The resident's diagnoses included, but were not limited to, acquired absence of the left toe, an open wound of the left foot, gangrene, orthopedic aftercare, and diabetes. The care plan, dated 2/7/25, indicated that the resident had a surgical incision. The interventions included, but were not limited to, administer analgesics per the physician's order, observe the surgical incision for signs of infection, observe the surgical site to ensure well approximated and for non-healing, and treatment to the surgical site as ordered by the physician. The physician's order, dated 2/8/25, indicated staff were to paint the resident's left foot surgical wound with betadine, cover with gauze, wrap with kerlix dressing, and apply ace wrap. The Admission Minimum Data Set (MDS) assessment, dated 2/10/25, indicated the resident was cognitively intact. The resident had a surgical wound and required surgical wound care. The physician's note, dated 2/18/25, indicated the resident's pain in his left foot had worsened. He also reported increased drainage from the surgical site. Due to the increased pain, increased drainage, dorsal flap redness, extending necrosis, and increasingly cool temperature to the dorsal and planter flap of the left foot. The physician believed the resident was going to need a more proximal amputation. The physician indicated the foot had not progressed and only worsened. A call was placed for vascular surgery for the resident to be seen.		Harrison Springs Health Campus or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility, nor does this submission constitute an agreement or admission of the survey allegations. Attached you will find the plan of correction for Harrison Springs Health Campus annual survey that was completed on 3/27/2025. The plan of correction and specific correction actions are prepared and/or executed in compliance with State and Federal Laws. The campus' date of alleged compliance is: 4/8/2025. We initiated immediate interventions when concerns were identified during recertification survey. The facility respectfully requests from the department a desk review for substantial compliance. If you need any information or paperwork, please contact me at 1(812)-738-0317. Sincerely, Ryan Morton, Executive Director ***F684 Quality of Care*** ***What Corrective action (s) will be accomplished for those residents found to have been**	

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	The nurse's note, dated 2/22/25 at 4:50 p.m., indicated the nurse went to complete the resident's dressing change per the physician's order. The resident's incision sight was observed to have a small 3 milligram (mm) by 1 mm open area along with one staple still left in place. The weekend supervisor was notified, and the treatment was completed. The nurse's note, dated 2/22/25 at 5:01 p.m., indicated a staple was observed on the resident's right foot incision. The physician had removed other staples earlier in the week. The physician's office was notified about the staple, but could only leave a voicemail. There were no signs of infection noted. The nurse's note, dated 2/25/25 at 11:30 a.m., indicated the Nurse Practioner (NP) requested to see the resident's left foot. The foot dressing was unwrapped, and the NP examined the site of the resident's amputation. The site had dehisced and had an area on the bottom of foot. New orders were received to send the resident to the hospital emergency room for evaluation and treatment. The record lacked documentation indicating the physician was informed that the residents surgical wound had opened. During an interview, on 3/25/25 at 1:10 p.m., RN 3 indicated the residents wound gradually opened. She did not feel it all happened at once. She did not know what day the wound started to open. On the day the resident was sent to the hospital she was assisting the NP with the residents' dressing change. After removing the dressing, the wound had dehisced, and the resident was sent to the hospital.		**affected by the deficient practice;** *Identified resident 20 that campus failed to notify physician regarding surgical incision that opened had surgical repair and remains at campus without s/s of infection to left above the knee surgical incision. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** *All residents currently residing in the campus with surgical incisions assessed for abnormal findings to the surgical incision on 4/3/2025 and 4/4/2025. No residents identified with any abnormal findings to surgical incisions. *All residents currently residing in the campus with surgical incisions had their progress notes reviewed for any missing provider/physician notification documentation 4/3/2025 and 4/4/2025. No residents identified with missing provider/physician documentation. ***What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;**	

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	During an interview, on 3/25/25 at 1:40 p.m., LPN (Licensed Practical Nurse) 4 indicated he walked in the room while the nurse was changing the resident's dressing change. The doctor had removed his staples, and the nurse indicated one staple was left. LPN 4 indicated he called and left a voicemail about the staple. The nurse would have had to call the doctor and inform him about the open incision. He did not know if there was a follow up with the physician or NP. He indicated normally the NP would document in the progress notes, but the LPN did not see any documentation indicating there was a follow up with the physician or NP. During an interview on 3/26/25 at 11:30 a.m., LPN 5 indicated she informed the Supervisor/Charge Nurse that the resident's wound had opened, and a staple was observed. The Supervisor indicated he would notify the physician, and the LPN assumed the physician was informed. She did not recall if there was a follow up with the physician or not. The LPN indicated she notified her supervisor and thought the Supervisor notified the physician about the wound opening. The Physician Notification policy, dated 9/12/17 and revised 12/17/24, included, but was not limited to, "...11. Attempts to notify the physician/provider and their response should be documented in the resident electronic health record.12. The 24-Hour report shall be utilized for nurse to nurse communication regarding the status of the notification and response back. 13. If the attending physician, or their practitioner does not respond to notification attempts the Medical Director and Director of Health Services should be notified for further instructions." 3.1-37(a)		*Clinical Support provided Education to DHS/ADHS regarding reviewing the FAR Facility Activity Report daily for any documented abnormal findings and verifying medical provider notification, assessment of surgical incisions per physician orders and notification to provider for any abnormal findings, utilization of the 24 hour report for communication between shifts, and regarding physician/provider response: If a provider/physician does not respond to notification attempts, the Medical director will be notified. Education completed on 4/1/2025. *After the DHS and ADHS were provided the above education, the ADHS then provided education to licensed nurses regarding assessment of surgical incisions per physician orders and notification to provider for any abnormal findings, utilization of the 24 hour report for communication between shifts, and regarding physician/provider response: If a provider/physician does not respond to notification attempts, the Medical director will be notified. Education began on 4/1/2025 and completed on 4/7/2025. **How the corrective action (s)	

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			will be monitored to ensure the deficient practice will not recur, i.e…, what quality assurance program will be put into practice? *DHS/ADHS will pull and review the FAR report for the previous day as it relates to surgical incisions for any documented abnormal findings of the surgical incision and verify medical provider notification documentation present and if the provider fails to respond that the medical director notification occurred and that there is notification documentation present daily Monday through Friday to ensure that all tasks completed including proper notifications for 1 month, then 3 times weekly x 2 weeks then once weekly x 2 weeks then once every 2 weeks, then once every one month x 3 months. Findings suggestive of 100% compliance may result in cessation of the monitoring plan. *DHS or designee will review the 24 hour report for nurse to nurse communication daily Monday through Friday to verify usage and verify that the status of physician notification and response back from the physician is complete x 1 month, then 3 times weekly x 2 weeks then once weekly x2 weeks then once every 2 weeks, then once every one month x 3	

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			months. Findings suggestive of 100% compliance may result in cessation of the monitoring plan. **Date of compliance 4/8/2025** **Resident identifier list** **Resident 20 Marvin Briscoe**	
R 0000 Bldg. 00	This visit was for a State Residential License Survey. This visit included a Recertification and State Licensure Survey. Survey Dates: March 20, 21, 24, 25, 26, and 27, 2025 Facility: 013702 Residential Census: 27 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on April 1, 2025.	R 0000		
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency Based on record review and interview, the facility failed to ensure appropriate transfer techniques were implemented when transferring a resident for 1 of 3 residents reviewed for Health Services. (Resident 4)	R 0240	This plan of correction is to serve as Harrison Springs Residential Campus credible allegation of compliance. Submission of this plan of correction does not constitute an admission by	04/08/2025

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	Findings include: The record for Resident 4 was reviewed on 3/26/25 at 9:02 a.m. The resident's diagnoses included, but were not limited to, dementia without behaviors, atherosclerotic heart disease, and chronic kidney disease. The care plan, dated 10/3/24, indicated the resident had a preference to sit on the floor purposefully to play with the stuffed dog, perform yoga and other activities as determined by resident. The intervention, dated 10/3/24, indicated that staff were to allow for the resident to sit on the floor per the resident's preference. The Interdisciplinary Team's (IDT) note, dated 12/4/24 at 1:45 p.m., indicated the resident had an episode of trouble walking on the right leg, was unable to hold a glass in her right hand, upon assessment, neurological checks were within normal limits. The physician was notified with a new order to start aspirin daily. The resident had increased weakness to the bilateral lower extremities. Therapy would continue working with the resident. The State Reportable, dated 3/21/25, indicated on 3/19/25, Resident 19 observed Qualified Medication Aide (QMA) 6 transferring Resident 4 from the wheelchair into the salon chair on 3/19/25. Resident 19 indicated that Resident 4 was plopped in her wheelchair. She didn't initially report the incident because she felt that the QMA didn't intend to cause harm to Resident 4. Resident 19 indicated that QMA 6 could benefit from additional training in safe transfer education. Resident 4 was assessed to be severely cognitively impaired, which rendered her account of the event unreliable. On 3/22/25, a head to toe		Harrison Springs Residential Campus or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility, nor does this submission constitute an agreement or admission of the survey allegations. Attached you will find the plan of correction for Harrison Springs Residential Campus annual survey that was completed on 3/27/2025. The plan of correction and specific correction actions are prepared and/or executed in compliance with State and Federal Laws. The campus' date of alleged compliance is: 4/8/2025. We initiated immediate interventions when concerns were identified during recertification survey. The facility respectfully requests from the department a desk review for substantial compliance. If you need any information or paperwork, please contact me at 1(812)-738-0317. Sincerely, Ryan Morton, Executive Director ***R240*** ***What Corrective action (s) will be accomplished for those residents found to have been affected by the deficient**	

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	assessment was performed on Resident 4, which indicated no bruising or injury. QMA 6 was immediately suspended, pending investigation. The investigation was started per policy and procedure. The Brief Interview of Mental Status (BIMS) assessment, dated 3/21/25, indicated the resident was severely cognitively impaired. The resident required assistance from one staff member for transfers at the time of the incident, which was changed to the resident requiring two staff members for transfers. The Social Service note, dated 3/21/25 at 3:24 p.m., indicated that when the resident was asked, "Are there any staff members you do not feel comfortable helping you." The resident did not answer with body language or verbally. Staff members indicated the resident had not had a change in psychosocial behaviors. The nurse's note, dated 3/23/25 at 1:22 p.m., indicated that the resident was alert during transfers and repositioning. The hospice nurse and facility nurse noticed a new onset of swelling to the right wrist, which was warm and tender to the touch. The hospice nurse ordered an x-ray and encourage fluids. As needed Tylenol was given. The nurse's note, dated 3/23/25 at 11:55 p.m., indicated the x-ray of the right wrist results were received with no fracture or dislocation and was unremarkable, with no new orders at this time. The Sit/Pivot Transfer Review training was conducted by the Occupational Therapy (OT) Director on 3/24/25 for QMA 6. The Occupational Therapy Tool kit indicated, but was not limited to, "1. Help the person scoot to the edge of the chair.		**practice;** Identified resident 4 was transferred using incorrect safe transfer technique. No injury identified from incorrect safe transfer technique. Safe transfer technique identified as 2 person assist with gait belt. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** *All residents currently residing on Assisted living will have an assessment to determine the residents safe transfer status by 4/5/2025 by Director of Assisted Living. *All residents currently residing on Assisted living will have their transfer status updated to the determined safe transfer status on the CRCA sheet and the plan of care by 4/5/2025 by Director of Assisted Living. ***What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;** *ADHS provided education to DAL regarding assessment of residents on Assisted Living for any change in transfer identified with updates	

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	Squat in front and grab the transfer belt. Keep your knees bent and your back straight. 2. Block the weaker knee, in case it buckles. Rock the person forward, until their bottom lifts. The person can push up from the chair..." During a confidential interview, between 3/20/25 and 3/27/25, Staff B indicated Resident 19 reported the incident that occurred on 3/19/25 with Resident 4 and QMA 6. Resident 19 indicated the QMA threw Resident 4 down into a chair like a sack of potatoes. During an interview on 3/24/25 at 2:18 p.m., Resident 19 indicated she was in the beauty shop getting her hair done on 3/19/25, when QMA 6 brought Resident 4 into the beauty shop. The QMA had the Resident 4's arms up as the QMA plopped Resident 4 into a chair very hard. Resident 19 indicated that she knew the QMA could be rough because, she had been rough with her before. The Beautician, asked Resident 19, "Did you see that?" Resident 19 didn't know the resident, but the Beautician told her what the resident's name was. It was Resident 4, a resident in the Assisted Living (AL) Unit called Legacy Lane. The Beautician came to the facility on Wednesdays. The Beautician was also in the facility Thursday or Friday. Resident 19 felt that QMA 6 was just rough with the transfer and needed to be trained. Resident 19 told a Certified Nurse Aide (CNA) about what had happened and the CNA told the office. The office came to her to get a statement. During an interview, on 3/25/25 at 2:10 p.m., the Vice President of Clinical Records indicated that Resident 4 was being placed into a salon chair by the QMA and the resident stiffened up and it probably looked as if the resident was plopped		to plan of care and therapy referral if applicable. Education completed 4/1/2025. *ADHS provided education to DAL regarding pulling and reviewing the Facility Activity report for the previous day as it relates to identifying any transfer status/change in condition with safe transfer status daily Monday through Friday during CCM. Education completed 4/1/2025. *ADHS provided education to LLC regarding notification of identified change in transfer status to DAL to allow for DAL to assess for change in safe transfer status. Education completed by 4/4/2025. *Once ADHS provided education to LLC and DAL, the DAL provided Education to licensed nurses regarding identification of change in transfer status/change in status with event opened and notification to Director of Assisted living and/or Legacy Lane Coordinator when a change in transfer status is identified to allow for director of Assisted living to assess for change in safe transfer status, for Director of Assisted Living to complete therapy referral if applicable. Education completed on 4/5/2025. ***How the corrective action (s)**	

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	into the chair, but that was the policy on how to transfer the resident. During an interview, on 3/26/25 at 8:32 a.m., QMA/Dementia Unit Coordinator 6 indicated the resident had dyskinesia (uncontrolled shakes) and that during the transfer, the resident locked up and the QMA had the resident hug her, then her knees gave out and the resident landed in the chair. A training was conducted for her and a gait belt would be used now. Resident 4 required one staff member for transfers before and now she required two staff members, so it wouldn't happen again. She indicated that she was suspended for two days or four days if the weekend was counted, because she was off normally. She received education on transferring. She presented the transfer education, dated 3/24/25. During an interview, on 3/26/25 at 11:55 p.m., the Beautician indicated she filled out a report on 3/22/25 about the incident. Resident 4 had been brought into the salon and it wasn't a smooth transition from the wheelchair into the salon chair. The momentum of the lift went with the resident, and the QMA went down into the chair with the resident. The QMA had hold of the back of the waste band of the resident's pants and asked the resident to give her a hug. They didn't use a gait belt with transferring the resident and she felt that another person or a gait belt was needed for the transfer. The resident's family member had transferred the resident in the past from the wheelchair into the salon chair and from the salon chair into the wheelchair. On 3/26/25 at 12:15 p.m., the Director of Nursing (DON) provided a copy of the investigation and education for the transfer of the resident into her wheelchair.		**will be monitored to ensure the deficient practice will not recur, i.e…, what quality assurance program will be put into practice?** *DAL will pull and review the Facility Activity report for the previous day as it relates to identifying any transfer status/change in condition with safe transfer status daily Monday through Friday to ensure that all tasks completed including proper notifications for 1 month, then 3 times weekly x 2 weeks then once weekly x 2 weeks then once every 2 weeks, then once every one month x 3 months. Findings suggestive of 100% compliance may result in cessation of the monitoring plan. **Date of compliance 4/8/2025** **Resident identifier list** **Resident 4 Phyllis Houser**	

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	During an interview, on 3/26/25 at 12:34 p.m., the OT Director indicated Resident 4 went on hospice in January 2025. The resident went to requiring staff assistance when the resident had stroke-like symptoms. The OT Director indicated Resident 4 needed a scan conducted before she would be able to assess the resident and the family didn't want to put the resident through the scans. Resident 4 had some dyskinesia in November or December. The resident required mild assistance at that time. If it was the initial transfer for the resident, then it was appropriate to transfer the resident by her waste band. For the transfer from the chair into her wheelchair, it wasn't appropriate, and she would recommend a gait belt. That was why the QMA was educated on transfers. The OT Director provided the Physical Therapy notes for the resident with the last note dated 1/20/25. During an interview, on 3/27/25 at 10:10 a.m., the Executive Director (ED) indicated the facility had no policy for transfers. They followed the education for transfers. The Past noncompliance began on 3/19/25 and the deficient practice corrected by 3/24/25 after the facility implemented a systemic plan that included the following actions: The facility completed staff education on transfers (3/24/25), facility wide resident interviews completed related to abuse (3/21/25), a dementia unit wide skin sweep was completed on 3/21/25, and all employee files were audited to ensure 100% compliance of abuse and dementia training.			