STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155852	A. BUILDING -- B. WING	04/09/2025

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/09/2025 Facility Number: 013702 Provider Number: 155852 AIM Number: 300018569 At this Emergency Preparedness survey, Harrison Springs Health Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 58 certified beds. At the time of the survey, the census was 55. Quality Review completed on 04/10/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/09/2025 Facility Number: 013702 Provider Number: 155852 AIM Number: 300018569 At this Life Safety Code survey, Harrison Springs Health Campus was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ryan Morton	Executive Director	04/23/2025

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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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in all resident sleeping rooms. The facility has a capacity of 58 and had a census of 55 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing storage services were sprinklered. Quality Review completed on 04/10/25			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through the courtyard exit was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15, staff and visitors if needing to exit the facility. Findings include: Based on interview and observations during a	K 0222	The submission of this plan of correction does not indicate an admission by Harrison Springs Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided and the living environment provided to the residents of Harrison Springs Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial	04/10/2025

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	tour with the Director of Plant Operations (DOPO) and Facility Maintenance Support representative (FMS) on 04/09/25 at 12:15 p.m. the gate exiting from the dining hall through the courtyard to the public way, was magnetically locked and could be opened by entering a four digit code but the code was not posted at the exit. This finding was acknowledged by the Director of Plant Operations and Facilities Maintenance Support Professional at the time of observation and again at the exit conference with the Director of Plant Operations, Facilities Management Support Professional and Administrator present. 3.1-19(b)		compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. If there are any questions, please contact me at (812) 738 0317. Sincerely, Ryan Morton, Executive Director Harrison Springs Health Campus Ryan.Morton@Harrisonspringshc.com **K 222 Egress Doors** Compliance Date: 4/10/25 1. The Director of Plant Operations posted a legible code at the outdoor gate exiting the dining hall through the courtyard to the public way. 2. All occupants had the potential to be affected by the deficient practice. 3. The Director of Plant Operations is now knowledgeable of ensuring that codes must be posted beside outdoor courtyard gates to accommodate residents without a	

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			clinical diagnosis requiring specialized security measures. 4. As a quality measure, the Director of Plant Operations will ensure outdoor gate codes are visually inspected quarterly.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect 5 staff and 20 residents. Findings include: Based on interview and observations during a tour with the Director of Plant Operations (DOPO) and Facility Maintenance Support representative (FMS) on 04/09/25 at 12:15 p.m. the corridor door from the kitchen into the dining area, equipped with a self-closing device, failed to close and latch positively into the door frame. This finding was acknowledged by the Director of Plant Operations and Facilities Maintenance Support Professional at the time of observation and again at the exit conference with the Director of Plant Operations, Facilities Management Support Professional and Administrator present. 3.1-19(b)	K 0321	**K 321 Hazardous Areas-Enclosure** Compliance Date: 4/15/25 1. The Director of Plant Operations replaced the corridor door closer from the kitchen to the dining area with a new self-closing device. 2. All occupants had the potential to be affected by the deficient practice. 3. The Director of Plant Operations is now knowledgeable of ensuring that hazardous area doors must be provided with a properly working self-closing device. 4. As a quality measure, the Director of Plant Operations will ensure that all hazardous area door-closing devices are tested. Any findings will be reviewed at least quarterly and ongoing in the campus Quality Assurance	04/15/2025

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			Performance Improvement meetings.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review and interview with the Director of Plant Operations (DOPO) and Facility Maintenance Support representative (FMS) on 04/09/25 at 9:45 a.m., 8 of 12 quarterly fire drills were conducted near the end of the month, around the 30th day of the month. These conditions do not allow fire drills to be conducted on unexpected and unpredictable days. This finding was acknowledged by the Director of Plant Operations and Facilities Maintenance Support Professional at the time of observation and again at the exit conference with the Director of Plant Operations, Facilities Management Support Professional and Administrator present. 3.1-19(b)	K 0712	**K 712 Fire Drills** Compliance Date: 4/10/25 1. The Director of Plant Operations conducted a fire drill 4-10-25 at an unexpected time on an unexpected day to immediately comply with the requirement. 2. All occupants had the potential to be affected by the deficient practice. 3. The Director of Plant Operations is now knowledgeable of ensuring that monthly fire drills are to be conducted during unexpected times and days. 4. As a quality measure, the Director of Plant Operations will complete fire drills at random days and times. Fire drill dates and times will be monitored by Quality Assurance Performance Improvement meetings monthly.	04/10/2025
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and	K 0921	**K 921 Electrical Equipment –**	04/22/2025

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	interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. Findings include: Based on records review, interview and tour with the Director of Plant Operations (DOPO) and Facility Maintenance Support representative (FMS) on 04/09/25 at 10:45 a.m. and facility tour throughout the afternoon, no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section		**Testing and Maintenance** 1. The Director of Plant Operations identified and tested all existing patient care-related electrical equipment. 2. All occupants had the potential to be affected by the deficient practice. 3. The Director of Plant Operations is now knowledgeable of ensuring that patient care-related electrical equipment is tested annually or after any repair/servicing. 4. As a quality measure, the Director of Plant Operations will review PCREE testing compliance monthly. Audit results will be reported during the monthly Quality Assurance Performance Improvement meetings.	

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	10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour throughout the afternoon revealed that the facility provided electric beds for all residents. The DOPO stated that PCREE such as nebulizers, oxygen concentrators, and other electrical medical equipment was present and in use at the facility and that they had recently became aware of the requirement and were purchasing equipment to conduct the required testing. This finding was acknowledged by the Director of Plant Operations and Facilities Maintenance Support Professional at the time of observation and again at the exit conference with the Director of Plant Operations, Facilities Management Support Professional and Administrator present. 3.1-19(b)			