STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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 the Investigation of Complaints IN00420198, IN00418411 and IN00418416. Complaint IN00420198- Federal/State deficiencies related to the allegations are cited at F690 and F695. Complaint IN00418411- No deficiencies related to the allegations are cited. Complaint IN00418416- No deficiencies related to the allegations are cited. Survey dates: November 1, 2, 3, 6, and 8, 2023. Facility number: 010597 Provider number: 155657 AIM number: 200204440 Census Bed Type: SNF/NF: 73 Total: 73 Census Payor Type: Medicare: 6 Medicaid: 55 Other: 12 Total: 73 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 16, 2023.	F 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey conducted November 1 through 8, 2023. Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **Brandon Jensen, LNHA**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review and interview, the facility failed to ensure appropriate oversight of medication administration during 2 of 3 random observations. (Residents 6 and 38) Findings include: 1. During an observation on 11/5/23 at 12:24 p.m., there was a medication cup sitting on Resident 6's bedside table. The cup contained the following: a white round tablet, which was imprinted with gc 422; a yellow round tablet, imprinted with an e; a small pink round tablet, imprinted with PH 034; a small orange round tablet, imprinted with 5729; a small white round tablet, imprinted with c73; and a blue capsule, imprinted with t026 120. The resident indicated she had no idea how long the medications had been there. No staff were present in the resdient's room. During an interview on 11/1/23 at 8:50 a.m., LPN (Licensed Practical Nurse) 6 indicated she took the medications in about 20 minutes prior the resident's breakfast tray arriving. She was not supposed to leave the medications and never would again. The resident usually took her pills herself, one at a time, in applesauce and she disliked staff doing it for her. She reviewed the resident's MAR (Medication Administration Record), and her pill packets, and identified the medications as the resident's Colace, cardizem, Pepcid, metoprolol, aspirin, and iron. The record for Resident 6 was reviewed on 11/1/23	F 0554	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Residents 6 and 38 were not harmed by the alleged deficient practice. LPN 6 was immediately educated on the “medication administration” policy. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by the alleged deficient practice. An audit of all resident rooms was completed to ensure no medications have been left at the bedside. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DON/Designee held an in-service for all nurses and QMAs to provide education and expectations as it relates to the " medication administration" policy and procedures. **STEP 4 Corrective actions to be monitored to ensure the**	12/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	at 10:00 a.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, irritable bowel syndrome without diarrhea, hypertension, traumatic subdural hemorrhage without loss of consciousness, and gastro-esophageal reflux disease without esophagitis. The Quarterly MDS (minimum data set) assessment, dated 8/28/23, indicated the resident was moderately cognitively impaired. The physician's orders indicated the resident was currently receiving Cardizem extended release 24 hour 12 mg (milligrams) every morning for hypertension, Pepcid 40 mg every morning for GERD, ferrous sulfate (iron) extended release tablet 150 mg every morning for anemia, metoprolol tartrate 25 mg every morning and bedtime for hypertension, and Colace 100 mg 1 tablet twice daily for constipation. The MAR (medication administration record) indicated all of the medications had been documented as administered on 11/1/23 during the morning medication pass by LPN 6. The resident's record lacked documentation of any orders, care plan, or assessments for self-administration of medications. 2. During an observation on 11/1/23 at 9:00 a.m., Resident 38 was resting in bed. He had a medication cup on his bedside table. The cup contained 13 tablets of various shapes, colors, and sizes. The resident indicated his nurse left them there that morning, and they did not usually do that. He then took the medications. No staff was present in the resident's room. During an interview on 11/1/23 at 9:10 a.m., LPN 6		**deficient practice will not recur:** The DON/Designee will observe 3 nurses medication pass a week x 4 weeks, then 2 nurses medication pass a week x 4 weeks, then 1 nurses medication pass a week x 4 weeks for no less than 3 months and compliance is maintained to ensure proper medication administration procedures. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	indicated she thought the resident had taken the medications. She thought she saw him move the cup towards his mouth. She identified the medications she'd administered that morning as the colace 100 mg, gabapentin 300 mg, vitamin D 50 mcg (micrograms), vitamin C, aspirin 81 mg, clonidine 0.1 mg, ferrous sulfate 325 mg, lasix 20 mg, metformin 1000 mg, lopressor 25 mg, protonix 40 mg, zoloft 25 mg, and xarelto 20 mg. She had brought them in around 7:45 a.m. The record for Resident 38 was reviewed on 11/1/23 at 10:30 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus type 2, hypertension, atrial fibrillation, and iron deficiency anemia. The physician's orders indicated the resident was currently receiving the following medications: aspirin 81 mg in the morning, clonidine 0.1 mg in the morning for hypertension, colace 100 mg twice daily for constipation, ferrous sulfate 325 mg every morning and bedtime for iron deficiency anemia, gabapentin 300 mg in the morning for pain, lasix 20 mg in the morning for edema,, metformin 1000 mg in the morning for diabetes mellitus type 2, metoprolol succinate 25 mg every morning for hypertension, protonix 20 mg every morning for GERD (gastro-esophageal reflux disease), xarelto 20 mg every morning for atrial fibrillation, vitamin C 500 mg every morning and bedtime for iron deficiency anemia, vitamin D 50 mcg tablet daily for vitamin D deficiency, and zoloft 25 mg every morning for depression. The MAR indicated the resident's morning medications had been last administered on 11/1/23 by LPN 6. The resident's record lacked documentation of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	any orders, care plan, or assessments for self-administration of medications. The most current Medication Administration Policy included, but was not limited to, "... Procedure... bb. Remain with resident until the medication is swallowed... cc. Do not leave medication at bedside..." 3.1-11(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to include the resident in the care plan meetings when developing her plan of care (Resident 51), and to revise a resident's plan of care when the discharge plan changed (Resident 59) for 2 of 34 residents care plans reviewed. Findings include: 1. During an interview with Resident 51 on 11/2/23 at 10:23 a.m., she indicated she had been in the facility for two years and thought her last care plan meeting was maybe a year ago. This was about the time the Social Worker started and she hadn't had one since. The day she was finally able to get out of bed and up into her power chair after recuperating from surgery, the Social Worker came and told her there was going to be a care plan meeting. The meeting only dealt with her weight and never discussed any other issues, such as her desire to discharge from the facility. Her family had not been involved in the meeting either and she could not remember having any other meetings after this one. She did not feel like this was a true care plan meeting. The record for Resident 51 was reviewed on 11/3/23 at 12:40 p.m. The diagnoses included, but were not limited to, personal history of traumatic brain injury, unspecified intracranial injury with loss of consciousness of unspecified duration, morbid obesity, post-traumatic stress disorder, paraplegia, and adjustment disorder with mixed anxiety and depressed mood. The Quarterly Minimum Data Set (MDS) assessments, dated 2/22/23, 3/6/23, 6/15/23, 9/15/23 and 9/22/23, and the Annual MDS	F 0657	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Residents 51 and 59 were not harmed by the alleged deficient practice. A care plan meeting was held for residents 51 and 59 and care plans were updated as appropriate. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who currently reside in the facility have the potential to be affected by the alleged deficient practice. An audit of all resident care plan meetings and care plans was completed to ensure completion and residents/resident representatives have been invited to attend. Any resident care plan not completed and/or resident/resident representatives not yet invited were scheduled and invitations sent. All resident care plans were audited to ensure that appropriate discharge care plans are in place. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The ED/Designee held an in-service for IDT team and the	12/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	assessment, dated 5/19/23, indicated the resident was alert and oriented. During an interview on 11/6/23 at 8:30 a.m., the Executive Director (ED) indicated the Social Worker was responsible for sending out care plan letters to the residents and families and took the notes. Everyone was responsible for making their own changes to the care plans as needed. During an interview on 11/6/23 at 9:55 a.m., the Social Worker indicated the former Director of Nursing (DON) was the one who insisted on doing the documentation for the care plan meetings in August and September. On 11/6/23 at 10:12 a.m., the Regional Director of Clinical Operations (RDCO) presented a letter, dated 2/6/23, given to the resident, in which the resident was invited to her care plan meeting. The IDT (Interdisciplinary Team) notes, dated 2/21/23, indicated the resident was present for this meeting. The record was lacking documentation of any additional care plan meeting invitations to the resident or her family or IDT notes of what was discussed in the meetings or if the resident attended any further meetings. 2. On 11/1/23 at 11:01 a.m., Resident 59 indicated he still wanted to return home once he got his medical issues resolved and that was his plan since admission on 2/1/23. The record for Resident 59 was reviewed on 11/6/23 at 3:20 p.m. The diagnoses included, but were not limited to, immobility syndrome (paraplegic), muscle weakness, diabetes mellitus due to underlying condition with unspecified		Social Service Designee to provide education and expectations as it relates to the "Plan of care overview" policy and procedures including resident/representative involvement and appropriate goal planning. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The ED/Designee will audit 5 residents a week x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week x 4 weeks for no less than 3 months and compliance is maintained to ensure resident/representatives care plan participation opportunities and appropriate discharge goals. The ED/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	complications, other symptoms and signs involving the musculoskeletal system, and muscle wasting and atrophy. The Quarterly MDS assessments, dated 3/14/23, 6/7/23 and 9/7/23, indicated the resident was alert and oriented. The Quarterly MDS assessment, dated 3/14/23, indicated the active discharge planning was occurring for the resident to return to the community. The Social Worker, Physician/NP (Nurse Practitioner), and therapy notes initially indicated the resident planned to return home after the completion of therapy. The Quarterly MDS assessments, dated 6/7/23 and 9/7/23, indicated there was no active discharge planning occurring and the resident was not going to be returning to the community. The Social Worker notes, dated 2/28/23, 6/7/23 and 9/12/23 subsequently indicated the plan was for the resident was to remain in the long term facility. During an interview with the Social Worker on 11/8/23 at 9:15 a.m., she indicated the resident no longer had a home to be discharged to nor would any Assisted Living facility accept him due to the amount of care he needed. The resident's family member was very involved in the resident's care and helped the resident make a decision to remain in the facility long term. During an interview with PT (Physical Therapist) 13 on 11/8/23 at 9:20 a.m., she indicated the resident was going to remain in the facility for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	long term due to his care needs and that his family member gently reminded the resident why he could not return to home. A care plan, dated 3/14/23, indicated the resident wished to be discharged to home. The goal was for the resident to be be discharged to an appropriate location based upon physical and cognitive status. The approaches included: discuss the feelings and concerns of the resident, and resident representative, with impending discharge; notify the medical provider of discharge plans; provide contact numbers for all community referrals; provide education to resident and resident representative regarding equipment, treatments, and medication; and determine gaps in abilities that will affect discharge. The record lacked documentation of the resident's care plan being updated since being implemented on 3/14/23 to reflect the resident's need for long term care. On 11/6/23 at 2:17 p.m., the Regional Director of Clinical Operations (RDCO) presented a copy of the facility's current policy titled Plan of Care Overview. This policy included, but was not limited to, "Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs of the residents...The purpose of the policy is to provide guidance to the facility to support the inclusion of the residents or resident representative in all aspects of person-centered care planning and that this planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices, and preferences including, but not limited to, goals related to their daily routines and goals			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	to potentially return to a community setting. Procedure: 1. General Care Planning (PoC) Goals and Guidelines:...b. Resident/representatives will be offered opportunities to voice their views...c. Resident/representatives will have the right to participate in the development and implementation of his/her own PoC including but not limited to:...ii. Right to identify individuals or roles to be included in the planning process...iv. Right to participate inn goal establishment and outcomes...d. The facility will:...iii. Review care plans quarterly and or with significant changes in care..." During an interview with the Executive Director (ED) on 11/8/23 at 1:00 p.m., he indicated the facility created a Quality Assurance and Performance Improvement plan on 10/1/23 to address care plans not being documented per company policy due to lack of information to be sent out for scheduling, lack of accountability to attend meetings and that people forgot and did not attend the meetings. The plan had a column for the current percentage (QM - Quality Measures) - number of care plans documented correctly which was blank. The Preintervention column - the current QM percentage, amount to be completed, number of residents that trigger, etc. was also left blank. The First, Second, and Final Re-measurement - what the goal would be for the next percentage for each item identified were blank and only gave a date as to when they would assess the issues. The ED indicated they did do an audit of just how many residents were affected and had care plans not updated or not being invited to their care plan			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	meetings but was unable to provide that number or when the next review would be for each of the residents affected. The care plans would be updated with documentation of attendance by the residents only when they came up for their next review. 3.1-35(c)(2)(C) 3.1-35(d)(2)(B)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure appropriate documentation of assessments and monitoring for a change in condition for (Resident 47), and to follow up in obtaining IV (intravenous) infusions as ordered and documentation of assessments for (Resident 226) for 2 of 5 residents reviewed for Quality of Care. Findings include: 1. The record for Resident 47 was reviewed on 11/2/23 at 10:16 a.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, type II diabetes, COPD (chronic obstructive pulmonary disease),	F 0684	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Residents 47 and 226 were not harmed by the alleged deficient practice. Resident 47 was assessed to ensure no further concerns. The physician who ordered the transfusion for resident 226 was contacted orders received and followed as indicated. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who had a change in	12/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	dysphagia, pneumonia, vascular dementia, atherosclerotic heart disease, and anemia. The Quarterly MDS (Minimum Data Set) assessment, dated 4/12/23, indicated the resident was severely cognitively impaired. The nurse's note, dated 2/22/23 at 9:39 a.m., indicated therapy was assisting the resident to get in her chair with a Hoyer lift. The resident became unresponsive. Her vitals were obtained, and her blood pressure was 78/48 mmHg (millimeter of mercury), heart rate was 56, her O2 (oxygen saturation) was 94% on room air, and her respirations were 13. The resident would take 10 normal breaths, and then a couple of very shallow respirations. The NP (Nurse Practitioner) 7 was notified and came to assess the resident. The resident was taken to the nurse's station to be closely monitored. The record lacked documentation indicating the resident was monitored and assessed for signs and symptoms and interventions were implemented. The NP progress note, dated 2/22/23 at 5:41 p.m., indicated therapy was getting the resident up from the bed in the a.m., and into a chair. She had an episode where she became unresponsive, and her blood pressure dropped. She came to with a sternal rub and her blood pressure came back up to 90/60 mmHg. However, the nurse asked the NP to see the resident again later in the day due to increased lethargy. The nurse indicated she was having trouble getting the resident to swallow her medication and she wasn't talking as much. When the NP first saw her, she was answering her questions, however after a few minutes she stopped responding and her blood pressure was		condition or a NA Thiosulfate infusion order could be affected by the deficient practice. A 30 day-look back of all resident change in conditions was completed to ensure proper documentation indicating the resident was monitored and assessed for signs and symptoms and interventions in place. An audit was done of all residents with an admission order for NA Thiosulfate to ensure the ordering physician had been contacted if appropriate. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DON/Designee held an in-service for all nurses to provide education and expectations as it relates to the "Clinical Documentation Standards" policy and procedures including proper documentation of resident change in condition indicating the resident was monitored and assessed for signs and symptoms and interventions in place and timely physician follow up when questions arise with a new order. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Designee will audit 5 residents a week x 4 weeks, then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	low again at 78/48 mmHg. The resident was a full code at that time. The NP also discussed with the resident's significant other about her continually declining status and with the history of a stroke it might be hard for her to fully recover her previous strength. The resident was sent to the hospital due to decreased mental status and unresponsiveness with hypotension. The NP note, dated 2/27/23 at 5:51 p.m., indicated the resident returned from the hospital. She was admitted to the hospital for altered mental status and UTI (urinary tract infection). She was treated with antibiotic and cefdinir ordered for continuation. The nurse alerted the NP that the resident was very lethargic and complaining of a sore throat. She was having trouble taking her medications but was able to take medications crushed in applesauce. When the NP assessed the resident her 02 (oxygen)saturation was 80%. The 02 was turned up to 5L (liters) and a breathing treatment provided, however her oxygen saturation was only 83%. She was very lethargic and unable to answer all questions. The resident kept stating that her bottom hurt. She was unable to state the year or where she was. The resident was difficult to arouse at times. Due to the resident's increased lethargy and confusion, she was sent to the hospital for evaluation. The NP note, dated 3/6/23 at 5:35 p.m., indicated the resident was readmitted from the hospital. She was admitted for an elevated troponin and pneumonia which was evident on the CT (Computed Tomography) scan. She was monitored, given IV antibiotics, and steroids. They also started her on Keppra twice a day due to her off and on altered mental status and lethargy. She failed her swallow study while at the hospital and a PEG (percutaneous endoscopic		3 residents a week x 4 weeks, then 1 resident a week x 4 weeks for no less than 3 months and compliance is maintained to ensure proper documentation of resident change in condition indicating the resident was monitored and assessed for signs and symptoms, appropriate interventions in place and timely physician follow up when questions arise with a new order. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	gastrostomy) tube was placed and she was NPO (nothing by mouth) with tube feedings. She was alert, but still significantly confused and unable to identify place, time, or situation. The NP note, dated 3/8/23 at 5:05 p.m., indicated the resident had a decrease in responsiveness and she was very lethargic and not responding well. She has had several episodes of hypotension and decreased responsiveness recently that results in readmission to the hospital. The NP went to assess the resident and gave a vigorous sternal rub, she moaned in response, but did not open her eyes or speak. Her vital signs were stable. While the NP was talking to the family the nurse rechecked the resident's vital signs about 20 minutes later and her blood pressure was dropping. The NP had an extensive and lengthy conversation with the resident's significant other about advanced care planning and goals of care. The significant other stated she had always wanted to be a DNR (Do Not Resuscitate), however she was currently CPR (cardiopulmonary resuscitation) at the facility due to her inability to make her own decisions, no immediate family member or POA (power of attorney). The NP explained to the resident's significant other the situation and discussed her recent hospitalizations as well as guarded prognosis due declining health and frequent admissions. He voiced understanding, and was very tearful, and stated he only wanted what was best for the resident. They discussed various code status and what each one entailed. 2. The record for Resident 226 was reviewed on 11/6/23, at 11:44 a.m. The diagnoses included, but were not limited to, cachexia, encephalitis and encephalomyelitis, COPD, type II diabetes, calciphylaxis, other disorders of calcium			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	metabolism, colostomy, severe protein malnutrition, anemia, resistant staphylococcus aureus infection, epilepsy and epileptic syndromes, hypotension, and stage 3 chronic kidney disease. The Admission MDS (Minimum Data Set) assessment, dated 5/9/23, indicated the resident was cognitively intact. The record lacked documentation indicating the resident was monitored and assessed for signs and symptoms and interventions were implemented. The NP note, dated 9/8/23 at 1:51 p.m., indicated that she spoke to the resident's family, and they were concerned if the NA (Sodium) Thiosulfate infusions needed restarted or not. She contacted the physician, and family wanted another physician to be consulted first. Staff were to call and get a follow up appointment with that office as soon as possible and ask if the infusions could be restarted before the appointment or if he wanted to see her first. The record lacked documentation indicating the physician was notified about the NA Thiosulfate infusion, and any attempts to make appointment for the resident to see the physician. The physician's order, dated 11/6/23, indicated that the September order was now documented. The nurse's note, dated 9/10/23 at 8:15 p.m., indicated the EMS (Emergency Medical Services transported the resident to the hospital. The resident's family were made aware of the resident's change in condition and transfer to the hospital.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	The nurses note, dated 10/7/23 at 10:26 p.m., indicated the resident was sent to the hospital for possible seizure. The nurses note, dated 10/10/23 at 11:46 a.m., indicated the resident was intubated in the emergency room and transferred to another larger hospital and admitted into ICU (Intensive Care Unit) on a ventilator. During an interview on 11/3/23 at 8:45 a.m., the DON (Director of Nursing) indicated when there was a change in the resident's condition there should be documentation in the nurse's notes and an assessment completed. During an interview on 11/3/23 at 9:35 a.m., Regional Director of Clinical Operations indicated the SBAR (Situation Background Assessment and Recommendation) was documentation the resident had a change in condition. There should be documentation in the nurse's notes indicating the resident's symptoms and what interventions did the nurse provide. During an interview on 11/8/23 at 10:29 a.m., the DON indicated someone dropped the ball when the NP documented she wanted the physician called about the NA Thiosulfate infusion being restarted and to make an appointment with the physician as soon as possible. She indicated the order was put in on Monday 11/6/23 and she was waiting for the physician's office to respond. The most current Clinical Documentation Standards policy, included, but was not limited to, " ...b. The nurse is expected to: i. Document accurately and truthfully to the best of his/her knowledge, what is heard or seen during assessments or encounters that concern the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	resident ... iii. Document entries during the work shift and complete all entries before leaving the facility for that tour/shift iv. Document the status of the resident including changes ..." 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure interventions for fall prevention were implemented after a resident experienced a fall for 1 of 3 residents reviewed for accidents. (Resident 35) Findings include: 1. The record for Resident 35 was reviewed on 11/3/23 at 11:00 a.m. The diagnoses included, but were not limited to, pain in the left hip, difficulty walking, need for assistance with personal care, restless leg syndrome, and chronic pain syndrome. The nurse's note, dated 10/27/23, indicated the resident's roommate had called for the nurse at 3:34 a.m. stating the resident had fallen. The resident had a large amount of blood from her head. She wanted to go to the hospital.	F 0689	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Resident 35 was not harmed by the alleged deficient practice. Resident 35's care plan was reviewed and updated with appropriate fall intervention. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who had a fall could be affected by the alleged deficient practice. A 30-day lookback of all resident falls was completed to ensure appropriate fall interventions were implemented.	12/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	The IDT (Interdisciplinary Team) follow-up note, dated 10/27/23 at 9:57 a.m., indicated the resident had fallen walking to the toilet. The root cause of the incident was failure to use her bedside commode. The intervention put into place was sending the resident to the emergency department. The care plan was not updated. The care plan lacked documentation of any new preventative interventions identified and implemented to address the root cause of the resident's fall. During an interview on 11/6/23 at 1:02 p.m. LPN (Licensed Practical Nurse) 8 indicated when a resident fell they were supposed to make a new intervention with each fall. She liked to look at the bigger picture and see what was going on at the time. Sending the resident to the emergency room was not a preventative intervention it would not prevent a future fall. They were supposed to update care plans after falls. During an interview on 11/6/23 at 1:50 p.m., the DON (Director of Nursing) indicated for falls they would discuss it in the morning meeting. They met and discussed what interventions the residents had, how they fell, what they needed, and then add the intervention to the care plan. They did a root cause analysis, developed a new intervention, and added it to the care plan for every fall. The most current Fall Prevention and Management policy included, but was not limited to, "... Investigation: Once the resident is safely transferred, a fall investigation should begin. Ask the resident what they were doing when they fell... Post Fall Intervention: Attempt to put an intervention in place that could prevent further		**STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DON/Designee held an in-service for all nurses to provide education and expectations as it relates to the “Fall Prevention and Management" policy and procedures including the implementation of appropriate fall interventions. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Designee will audit 5 falls a week x 4 weeks, then 3 falls a week x 4 weeks, then 1 fall a week x 4 weeks for no less than 3 months and compliance is maintained to ensure appropriate fall interventions have been implemented. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	falls... Attempt to identify why the resident fell and put an immediate intervention in place... Documentation... Update the care plan with the new interventions... Interdisciplinary Team Review... The IDT team should review all information for all falls at the next Daily Clinical Meeting. The team should discuss the fall, potential causes of the fall, interventions put into place and if they are effective. A deep root cause investigation should be discussed. The care plan should be reviewed to identify if interventions are appropriate or if new interventions should be added." 3.1-45(a)(1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on record review and interview, the facility failed to ensure the resident's urinary symptoms were assessed while awaiting the results of a urinalysis for 1 of 3 residents reviewed for urinary tract infections (Resident C). Findings include: The record for Resident 20 was reviewed on 11/2/23 at 1:00 p.m. The diagnoses included, but were not limited to, dementia and unspecified urinary incontinence. The care plan, initiated on 10/6/20 and last revised on 7/8/21, indicated the resident had a potential for complications with bowel and bladder incontinence. The interventions included, but were not limited to, monitor labs as ordered, report results to the physician, and staff were to report changes in the urinary status to the physician. The nurse's note, dated 10/9/23 at 11:49 a.m., indicated the resident was refusing to turn and reposition. The nurse's note, dated 10/10/23 at 12:16 p.m., indicated the resident continued to refuse to turn	F 0690	The facility respectfully requests an IDR for this alleged deficiency related to the date and time labs were received and resulted. **STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Resident C was part of a confidential survey and therefore not identified. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who had a urinary tract infection could be affected by the alleged deficient practice. A 30-day lookback of all UTIs was completed to ensure timely physician notifications and assessment of urinary symptoms were completed. **STEP 3 Measures/systemic**	12/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	and reposition. The Social Services note, dated 10/10/23 at 3:27 p.m., indicated the resident was having behaviors of being resistive to care. A care plan meeting was requested with the family. The physician's order, dated 10/10/23, indicated to collect a urinalysis (U/A), one time only, to rule out infection. The lab results report indicated a urinalysis specimen, collected on 10/11/23 at 12:00 a.m., was received at 2:30 a.m. The urine clarity was turbid (cloudy or thick), was 1+ (abnormal) for protein, positive for nitrates 2+ for leukocytes, greater than 50 for red blood cells, 6 to 20 for white blood cells, many bacterial cells, had calcium oxalate crystals, mucous, budding yeast, and white blood cell clumps present, and the specimen met criteria for a culture. The record lacked documentation of any communication with the physician regarding infection concerns, any follow up on the urinalysis preliminary results, any assessment of the resident's urinary symptoms, or monitoring between 10/10/23 and 10/13/23 for signs of infection. The physician's note, dated 10/13/23 at 6:48 p.m., indicated the nurse called reporting the patient had altered mental status and was "all slumped over." The resident was twitching and had foaming secretions coming out of her mouth. She was cool and clammy. Her blood pressure was 242/84 mmHg (millimeters of mercury), her respirations were 24 breaths per minute, her heart rate was 100 beats per minute, and her oxygen was 82% on 3 lpm. The resident was a DNR, so the		**changes put into place to ensure the deficient practice does not recur:** The DON/Designee held an in-service for all nurses to provide education and expectations as it relates to the “Clinical Documentation Standards" and “Notification of Change in Condition” policy and procedures including the timely physician notifications and appropriate assessment of urinary symptoms. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Designee will audit 5 UTIs a week x 4 weeks, then 3 UTIs for week x 4 weeks, then 1 UTI a week x 4 weeks for no less than 3 months and compliance is maintained to ensure timely physician notifications and assessment of urinary symptoms were completed. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	physician instructed the nurse to contact the family and see what they preferred to be done for her. If they wanted the resident to go to the ER (Emergency Room) or stay in the facility. The physician's note, dated 10/13/23 at 6:56 p.m., indicated the resident's family requested to send the resident to the ER. The nurse's note, dated 10/13/23 at 7:27 p.m., indicated the resident was taken to the ER via EMS (emergency medical services) and a report was called. The nurse's note, dated 10/13/23 at 7:30 p.m., indicated two CNAs had asked the nurse to look at the resident. She was quiet, eyes closed, and had not eaten her supper. Her nasal cannula was in place with oxygen set at 3 lpm (liters per minute). The resident roused to her name and opened her eyes. She then rolled her eyes and closed them. The physician was contacted and indicated to ask the family what they wanted. The family was contacted and requested to send the resident to the ER. The physician was contacted again and agreed to send her out. EMS was called. She was taken to the ER via EMS. The hospital report, dated 10/13/23, indicated the resident presented to the hospital on 10/13/23 with confusion. She was sent from the facility for altered mental status. She had a history of dementia but was more confused than her baseline. She was found without oxygen, but usually wore 3 liters per minute via nasal cannula. In the ER she was placed on heated high flow oxygen at 55 liters per minute with an FiO2 of 48%. Her chest x-ray was highly concerning for pulmonary edema versus multifocal pneumonia. Her labs were remarkable for a WBC (white blood			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	cell) count of 22.8, her urinalysis was positive for nitrates, leukocytes, WBC, and bacteria. She was started on vancomycin and Zosyn. She was asleep but arousable. She was alert to herself, but unable to answer any questions. Her active diagnosis included acute or chronic respiratory failure, sepsis secondary to a UTI and multifocal pneumonia and acute on chronic respiratory failure COPD. The patient met criteria for inpatient status. The plan for the resident's care included gentle IV (intravenous) hydration, IV antibiotics, continuing oxygen supplementation, weaning as tolerated, with the patient's baseline being 3 lpm via nasal cannula. The final culture report for the urinalysis obtained on 10/10/23 resulted on 10/14/23. The report indicated the resident had 70-99,000 CFU/mL (colony-forming units per milliliter) of Escherichia Coli. The nurse's note, dated 10/16/23 at 10:52 a.m., indicated the resident was admitted to the hospital with a UTI (urinary tract infection), sepsis, and pneumonia. During an interview on 11/2/23 at 8:39 a.m., Resident C's family member indicated she had requested the resident have a urinalysis back on 9/28/23 and no testing had been done. She now believed she'd had a UTI from then until she went out to the hospital. They told her at the hospital she had a severe UTI. During an interview on 11/6/23 at 12:43 p.m., LPN 8 indicated a urinalysis was typically done for signs and symptoms of a UTI if they were trying to rule out an infection. If she did a urinalysis on a resident, she would think they would want to monitor the resident's temperature, and especially			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	with the resident's age range they would want to monitor for any type of behaviors, how often she was being changed. She would expect nursing staff would want to monitor and chart on any type of urinary symptoms. If she obtained an order for a urinalysis, she would document the order and the conversation with the doctor, however sometimes that didn't happen. She could not see any reason why the urinalysis was ordered or any monitoring of the resident for infection after it was obtained. During an interview on 11/6/23 at 1:22 p.m., the RDCO indicated when the resident had the urinalysis they needed to put in a nurse's note, documenting they'd received the order, which would of course include the assessment and a nurse's note after they got the results indicating if they got new orders or not. The most current Clinical Documentation Standards policy included, but was not limited to, "... b. The nurse is expected to: i. Document accurately and truthfully to the best of his/her knowledge, what is heard or seen during assessments or encounters that concern the resident... iv. Document the status of the resident including changes..." The most current Notification of Change in Condition policy included, but was not limited to, "... Notifications: The attending practitioner is promptly notified of significant changes in condition, and the medical record must reflect the notification, response, and interventions implemented to address the resident's condition..." This Federal tag related to IN00420198.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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 0691 SS=D Bldg. 00	3.1-41(a)(2) 483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, record review, and interview, the facility failed to ensure appropriate colostomy care and interventions to prevent skin breakdown surrounding a colostomy stoma were implemented for 1 of 3 residents reviewed for colostomy care. (Resident 35) Findings include: The record for Resident 35 was reviewed on 11/3/23 at 11:00 a.m. The diagnoses included, but were not limited to, colostomy status, colostomy complication, and need for assistance with personal care. The care plan, initiated on 4/22/22 and last revised on 8/17/22, indicated the resident had an alteration in bowel elimination related to a need for a colostomy and history of colon cancer. The interventions included, but were not limited to, educate the resident on ostomy care, management of ostomy site, signs and symptoms of infection, skin integrity complications and diet, encourage the resident to express feeling regarding body image due to ostomy, provide emotional support as needed, monitor bowel movements, and provide assistance with ostomy care as needed.	F 0691	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Resident 35 was not harmed by the alleged deficient practice. Resident 35's care plan was reviewed and updated with appropriate colostomy care interventions. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who require colostomy care could be affected by the deficient practice. An audit was completed of all residents receiving colostomy care to ensure appropriate colostomy care interventions are in place. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DON/Designee held an	12/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	The Skin Wound note, dated 11/9/22 at 9:18 a.m., indicated the resident had no open wounds. The Wound NP (Nurse Practitioner) indicated to keep the resident's skin clean and dry and apply barrier cream as needed to prevent skin breakdown. The SBAR (Situation Background Assessment and Recommendation) note, dated 11/15/22 at 9:52 a.m., indicated the resident's ostomy site was leaking frequently. The nurse's note, dated 11/15/22 at 10:24 p.m., indicated the resident's ostomy site was leaking frequently. The Physician's note, dated 11/30/22 at 4:06 p.m., indicated the resident had complaints of pain in her abdomen near her fistula, which was aggravated by frequent colostomy bag changes. The plan was to increase the resident's pain medication. The Physician's note, dated 12/16/22 at 5:40 p.m., indicated the ED (Executive Director) of the building had called and stated the resident was panicked and in a lot of anxiety over her fistula and how frequently it was leaking and difficult to clean. The resident had an open wound of her fistula with erythema around the fistula site and irritation from the bag and stool. The plan was to increase the resident's anxiety medication and keep the skin as dry as possible and apply stoma powder as needed. The nurse's note, dated 12/17/23 at 2:45 a.m., indicated the resident had red tinged excoriation under and around the colostomy as well as in her abdominal folds and both thighs. The areas were cleansed, and the facility barrier cream was		in-service for all nurses to provide education and expectations as it relates to the “Colostomy Appliance Bag Change” policy and procedures including appropriate resident-centered colostomy care interventions. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Designee will audit 5 residents a week x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week x 4 weeks for no less than 3 months and compliance is maintained to ensure appropriate colostomy care interventions are in place. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	applied. The nurse's note, dated 1/1/23 at 5:06 p.m., indicated the nurse was in to see the resident related to her colostomy bag leaking. The bag had been changed at 12:00 p.m. The resident's skin was very excoriated, and the seal was very tight through the rest of the bag. The bag was leaking on the right side about a half of an inch area. The resident's skin was very excoriated and bleeding the day prior with the second bag change. The nurse asked the resident to wait a few hours before changing the bag related to her skin being so excoriated and sore, to not cause a skin issue with tearing and bleeding. The resident was cleaned up and a clean towel was placed over the colostomy site. The Skin Wound note, dated 1/2/23 at 12:29 p.m., indicated the resident had moisture associated skin damage (MASD) to the right side of her abdomen and groin related to her colostomy bag leaking. The nurse explained the importance of notifying staff of when the bag was leaking so it could be changed. Treatment orders were in place, the family and NP were aware. Staff would continue to monitor. The Skin Wound note, dated 1/11/23 at 11:53 a.m., indicated the resident was seen for a complete skin and wound evaluation related to readmission to the facility. She had chronic excoriation to the surrounding skin of her colostomy. The wound plan of care indicated to continue current treatments in place for abdominal skin and facility staff to manage stoma and surrounding skin. The Physician's note, dated 1/11/23 at 5:30 p.m., indicated the resident was readmitted from the hospital due to a concern for a possible hip			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	reinfection. While in the hospital she was also treated for cellulitis around her fistula with antibiotics. The nurse's note, dated 1/22/23 at 8:27 p.m., indicated the nurse went to help the resident with changing her colostomy bag. Her skin was tender and red around the stoma site. The nurse cleansed the area, patted it dry, and applied a thin layer of skin prep around the area and applied a new colostomy bag. The nurse applied tape around the edges of the colostomy bag to aide in not having another leak. The nurse's note, dated 1/31/23 at 11:56 p.m., indicated the resident's surrounding skin was very excoriated and had some bleeding. The nurse's note, dated 2/2/23 at 12:37 a.m., indicated the resident was experiencing pain with changing her colostomy bag. The nurse cleansed the area with cool washcloths per resident's request, patted the area dry, applied skin prep and a new colostomy bag. The resident was resting with no leaks. The Skin Wound note, dated 2/16/23 at 8:18 p.m., indicated the facility staff were managing the stoma site and surrounding skin. Increased moisture at the wound site could promote poor prognosis of wound healing. The Wound NP indicated to keep the wound site covered and avoid contamination with feces at all times. The Restorative note, dated 3/3/23 at 2:31 p.m., indicated the resident had not completed her program that week due to her bag needing changed or wanting to go to activities. The Restorative note, dated 3/6/23 at 3:20 p.m.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	indicated the resident refused her restorative program twice due to needing her bag to be changed each time. The Restorative note, dated 3/8/23 at 3:48 p.m., indicated the resident refused her program again due to needing her bag changed. The Restorative note, dated 4/7/23 at 2:28 p.m. indicated the resident would complete her program most days, but some days she was refusing due to needing her bag changed. The nurse's note, dated 4/25/23 at 10:36 p.m., indicated the resident complained of severe pain with a burning, red, irritated area around the stoma and ostomy discomfort. The ostomy bag was leaking. Her bag was changed, and she stated it felt much better. The nurse's note, dated 5/9/23 at 11:14 a.m., indicated the resident's dressing to her colostomy bag dressing was changed. The stoma was beefy red with no signs of infection. The stool was very loose, and she was given Imodium, which was somewhat effective. She had excoriation to her outer right abdominal area. The nurse's note, dated 5/26/23 at 11:09 p.m., indicated the resident's colostomy bag was changed. It was difficult to adhere to her excoriated skin. The nurse's note, dated 5/28/23 at 11:22 a.m., indicated the resident had run out of her colostomy bags. Nurses were using abdominal pads, paper and adhesive tape, adhesive skin prep, and mepilex to cover up the stoma. The dressing would leak five minutes after every change and even with reinforcement. She needed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	further examination. The nurse's note, dated 5/30/23 at 10:25 p.m., indicated the resident's colostomy bag was changed. She had increased redness, excoriation, and pain. She was tearful during the treatment. ' The Physician's note, dated 10/3/23 at 1:00 a.m., indicated the staff had informed the NP the resident's greater part of her abdomen was very excoriated and the nurse was concerned for cellulitis. She had not had a colostomy bag on for several hours due to her skin and stool was continuously draining. Her lower abdomen was very excoriated, taut around the stoma, and there were a few bleeding areas. The ostomy was currently off, and towels were laid on the stomach to soak up the feces draining. The nurse reported the resident would pick at the ostomy dressing. The skin below the ostomy was taut and shiny. The NP instructed to keep the area clean and dry and have the wound nurse evaluate for recommendations on ostomy care. Orders for florastor twice daily, doxycycline twice daily for seven days, flagyl three times daily for five days, and ceftriaxone 1 gram every 24 hours for 5 days were given for cellulitis. The Physician's note, dated 10/11/23 at 1:00 a.m., indicated the resident's abdomen showed improvement. She was lying in bed with no ostomy bag over the stoma. She was using towels to soak up the stool. The NP encouraged the resident to stop using the towels and use colostomy bags to keep stool off of her skin and keep her skin as clean and dry as possible. The Physician's note, dated 10/16/23 at 1:00 a.m., indicated the resident's abdomen was becoming more irritated again. Staff were not placing an			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	ostomy bag on her and stool was continuously being left on the abdomen. The NP educated the resident on the importance of using the ostomy bag versus laying towels on the abdomen and educated her not to pick at the dressings once they were placed. Staff were to ensure the ostomy was in place each shift. The site was to be washed with soap and water at bedtime daily. The resident was educated to leave the ostomy in place once it was on otherwise the abdomen might never heal appropriately. The record lacked documentation of any plan of care to address the resident's picking at the colostomy bag, noncompliance with colostomy care, continuous colostomy bag changes which contributed to her skin breakdown, or her continued issues with being out of colostomy supplies. During an observation on 11/1/23 at 9:18 a.m., Resident 35 was resting abed. Her sheets were stained with brown matter, which appeared to be stool. She indicated her colostomy bag leaked and it probably got on her blanket. During an interview on 11/6/23 at 9:21 a.m., the NP indicated she visited the resident a lot, but had not gotten a clear, full story yet. Her skin was really irritated, there were times she did not want to wear a bag and would just lay towels around it. Staff told her the resident would pick at it, but the resident told her staff didn't want to put it on her. She was not aware of any issues with them not having supplies for the resident until she was told about it the week prior. They used an abdominal pad and tap until supplies arrived. She wanted it cleaned once a day, of an evening, the ostomy bag to be placed, and wanted to make sure staff were checking it to make sure it was on and not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	leaking. She couldn't guarantee the resident was not picking at it. The towels kept the stool right on the skin. It just sat there. At least the bag itself kept it up off the skin. If she was picking at it they should probably be documenting that. She was not aware of any interventions to not pick at the bag aside from talking with her. If it leaked, they should be replacing the whole thing. During an interview on 11/6/23 at 12:56 p.m., LPN 8 indicated she felt so bad for Resident 35. They were out of her colostomy bags, and they still had not come in yet. She ran out of her bags a lot and they were having to wait to get them in. She did not know why they ran out. The resident would sit there and pick at the bag and make staff change it, but regardless, even if they had to change it ten times daily, she should not be running out. She did not understand using the towels. The resident's excoriation was awful. It was starting to look better, but the skin surrounding the ostomy was red. It had bled before. When towels were used, she had no doubt there was fecal matter staying on the skin. The bags running out had been an issue for a year. The Interdisciplinary team knew there was an issue, but she didn't believe anything was being done. During an interview on 11/6/23 at 1:31 p.m., the DON indicated they were going through so many supplies with the resident due to the way she handled her ostomy. When the resident emptied it herself, she would unhook the bottom portion of the bag, then wanted it taken off and replaced. It was happening several times daily. They were drastically exceeding the maximum amount that was ordered. There were also times she did not want it on. Most of the time she wouldn't even allow them to do the abdominal pads. She would			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	pick and pull at the dressing. During an interview on 11/6/23 at 1:33 p.m., the Executive Director indicated the resident had an issue further back with running out of her colostomy supplies and he had the central supply person just start ordering the maximum amount they could with every order. She had trouble with her bag since before he'd started as the ED. The Colostomy Appliance Bag Change Policy included but was not limited to, "... Policy... It is the policy of this facility to promote resident centered care to maintain the proper function of the colostomy and provide a comfortable and hygienic environment..." 3.1-47(a)(3)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure appropriate orders and monitoring were in place for respiratory care for 1 of 3 resident's reviewed for respiratory care. (Resident C) Findings include:	F 0695	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Resident C was not harmed by the alleged deficient practice. Resident C was part of a confidential survey and therefore	12/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	During an observation on 11/1/23 at 8:45 a.m., Resident 20 was lying abed with oxygen (O2) in place at 3 liters per minute (lpm) via nasal cannula. During an observation on 11/2/23 at 12:43 p.m., Resident 20 was lying abed with oxygen (O2) in place at 3 lpm via nasal cannula. The record for Resident 20 was reviewed on 11/2/23 at 1:00 p.m. The diagnoses included, but were not limited to, acute and chronic respiratory failure, pneumonia, and chronic obstructive pulmonary disease (COPD). The care plan, initiated on 10/6/20 and last revised on 7/8/21, indicated the resident had oxygen therapy related to COPD. The interventions included, but were not limited to, monitor for signs and symptoms of respiratory distress and report to the physician as needed, monitor pulse oximetry every shift and as needed, oxygen per physician order with humidification, and O2 at 3 lpm via nasal cannula for hypoxia and COPD. The physician's note, dated 10/13/23 at 6:48 p.m., indicated the nurse called reporting the patient had altered mental status and was "all slumped over." The resident was twitching and had foaming secretions coming out of her mouth. She was cool and clammy. Her blood pressure was 242/84 mmHg (millimeters of mercury), her respirations were 24 breaths per minute, her heart rate was 100 beats per minute, and her oxygen was 82% on 3 lpm. The resident was a DNR, so the physician instructed the nurse to contact the family and see what they preferred to be done for her. If they wanted the resident to go to the ER (Emergency Room) or stay in the facility. The physician's note, dated 10/13/23 at 6:56 p.m.,		not identified. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who require oxygen therapy could be affected by the deficient practice. An audit was completed of all residents receiving oxygen therapy to ensure appropriate oxygen and monitoring orders are in place. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DON/Designee held an in-service for all nurses to provide education and expectations as it relates to the “Physicians Orders” policy and procedures including oxygen therapy and monitoring orders. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Designee will audit 5 residents a week x 4 weeks, then 3 residents a week for week x 4 weeks, then 1 resident a week x 4 weeks for no less than 3 months and compliance is maintained to ensure appropriate oxygen therapy orders and monitoring is in place. The DON/Designee will present the results of these audits monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	indicated the resident's family requested to send the resident to the ER. The nurse's note, dated 10/13/23 at 7:27 p.m., indicated the resident was taken to the ER via EMS (emergency medical services) and report was called. The nurse's note, dated 10/13/23 at 7:30 p.m., indicated two CNA's (Certified Nurse Aides) had asked the nurse to look at the resident. She was quiet, with her eyes closed, and had not eaten her supper. Her nasal cannula was in place with oxygen set at 3 lpm. The resident roused to her name and opened her eyes. She then rolled her eyes and closed them. The physician was contacted and indicated to ask the family what they wanted. The family was contacted and requested to send the resident to the ER. The physician was contacted again and agreed to send her out. EMS was called. She was taken to the ER via EMS. The nurse's note, dated 10/16/23 at 10:52 a.m., indicated the resident was admitted to the hospital with a UTI (urinary tract infection), sepsis, and pneumonia. The nurse's note, dated 10/17/23 at 5:15 p.m., indicated the resident arrived to the facility at 4:10 p.m. via EMS. The Facility Notification of Resident Benefit Change, dated 10/18/23, indicated the resident was admitted to hospice services. The ancillary services to be included in the resident's hospice benefit included oxygen. The record lacked documentation of any current orders to administer oxygen or monitor the		to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	resident's respirations or blood oxygen saturation. The last documented vitals for respirations for the resident was a value of 18 breaths per minute on 10/20/23 and for oxygen saturation was a value of 96% on oxygen via a nasal cannula on 10/20/23. The record lacked documentation of any further blood oxygen saturation or respirations monitoring after 10/20/23. During an interview on 11/6/23 at 12:43 p.m., LPN (Licensed Practical Nurse) 8 indicated the resident did use oxygen. She thought she used 2 lpm. They typically had orders for oxygen use. She reviewed the resident's record and indicated she could not locate any orders for oxygen. She wore oxygen before she ever went out and she should have orders in there. They should also have orders to obtain her oxygen saturation and her pulse at least once a shift with her history. She could not locate any orders for oxygen monitoring. She felt like it had definitely been missed. During an interview on 11/6/23 at 1:27 p.m., the DON (Director of Nursing) indicated the resident's hospice documents indicated she was on oxygen, but not what the orders were. Her orders should have been figured out when she came back from the hospital. During an interview on 11/8/23 at 10:43 a.m., the DON indicated the resident now had orders input to monitor a full set of vitals on her daily. They were not in place prior and should have been. They monitored vitals anytime a resident was on oxygen. The most current Medication Administration			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	policy included, but was not limited to, "... General Procedures: a. Administer medication only as prescribed by the provider... " The most current Physician Orders policy included, but was not limited to, "... II. Taking the order... f. Place orders in electronic Medical Record... ii. The MAR/TAR [Medication Administration Record/Treatment Administration Record] should automatically be updated with new orders if a schedule has been assigned..." This Federal tag related to IN00420198 3.1-47(a)(6)			
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to schedule 8-hour consecutive RN coverage for 8 of 8 months reviewed. (April, May, June, July, August, September, October, and November 2023). This had the potential to affect all 73 residents currently residing in the facility.	F 0727	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** No residents were harmed by the alleged deficient practice.	12/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	Findings include: The review of the April to November 2023 Licensed Nursing schedule indicated the following days were short of 8 hours consecutive RN coverage: April: Sunday 4/2 = No RN coverage scheduled Sunday 4/9 = No RN coverage scheduled Sunday 4/23 = No RN coverage scheduled Saturday 4/29 = only 6.5-hours RN coverage scheduled Sunday 4/30 = only 6.5-hours RN coverage scheduled May: Sunday 5/7 = No RN coverage scheduled Sunday 5/14 = No RN coverage scheduled Saturday 5/20 = No RN coverage scheduled Sunday 5/21 = No RN coverage scheduled Sunday 5/28 = No RN coverage scheduled June: Sunday 6/4 = No RN coverage scheduled Sunday 6/11 = No RN coverage scheduled Sunday 6/25 = No RN coverage scheduled July: Saturday 7/1 = only 6.5-hours RN coverage scheduled Sunday 7/2 = No RN coverage scheduled Saturday 7/8 = only 6.5-hours RN coverage scheduled Sunday 7/9 = No RN coverage scheduled Saturday 7/15 = only 6.5-hours RN coverage scheduled Sunday 7/16 = only 6.5-hours RN coverage scheduled		**STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents residing in the facility could be affected by the deficient practice. All residents were reviewed to ensure they had not been impacted in any way by the deficient practice. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The RDCO educated the ED/DON on expectations related to the RN staffing regulations and procedures including scheduling 8-hour consecutive RN coverage, 7 days a week The ED/Designee held an in-service for all nurse managers and staff scheduler to provide education and expectations as it relates to the RN staffing regulations and procedures including scheduling 8-hour consecutive RN coverage, 7 days a week. RN coverage will be monitored in the facility daily staffing meetings. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The ED/Designee will audit RN staffing daily for no less than 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	Saturday 7/22 = only 6.5-hours RN coverage scheduled Sunday 7/23 = only 6.5-hours RN coverage scheduled Sunday 7/29 = only 6.5-hours RN coverage scheduled Sunday 7/30 = No RN coverage scheduled August: Sunday 8/6 = No RN coverage scheduled Saturday 8/12 = only 6.5-hours RN coverage scheduled Sunday 8/13 = only 6.5-hours RN coverage scheduled Sunday 8/20 = No RN coverage scheduled Saturday 8/26 = only 6.5-hours RN coverage scheduled Sunday 8/27 = No RN coverage scheduled September: Sunday 9/24 = No RN coverage scheduled October: Saturday 10/7 = only 6.5-hours RN coverage scheduled November: Saturday 11/4 = No RN coverage scheduled Sunday 11/5 = No RN coverage scheduled The review of the Quality Assessment and Performance Improvement (QAPI) indicated the facility identified staffing challenges due to the lack of staff related to RN coverage for 8 consecutive hours in 5/23. During an interview on 11/2/23 at 11:00 a.m., the Executive Director indicated that management was aware of the RN shortage. In May they added it to QAPI and reviewed the staffing weekly.		months and compliance is maintained to ensure 8-hour consecutive RN coverage is scheduled 7 days a week. The ED/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	During an interview on 11/8/23 at 8:30 a.m., LPN (Licensed Practical Nurse) 9 indicated there wasn't always RN coverage on the weekends. Management would come in if there was a call-in and they were unable to replace them but that wasn't a guarantee that would happen. During an interview on 11/8/23 at 11:00 a.m., the Executive Director indicated the DON during the period where the facility was short of RN's did not cover for the shortage. They also had interim DONs until the current DON was hired and she had been at the facility about a month. They had the capability of borrowing from a sister facility. Due to the nursing shortage, it had been a challenge. They did not use agency nurses. During an interview on 11/8/23 at 11:29 a.m., the Executive Director indicated the management team had two RNs on staff for the time period from April to the current date. The most current Facility Assessment Tool policy, included, but was not limited to, "...The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required..." 3.1-17(b)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on record review and interview, the facility failed to provide medically-related social services when residents experienced the loss of independent mobility via a power chair, weight issues, the change in family dynamics, missing money and a desire to be discharged to the community despite medical obstacles for 2 of 34 residents reviewed for Social Services. (Residents 51 and 59) Findings include: 1. During an interview on 11/2/23 at 10:23 a.m., with Resident 51 she indicated she was upset because the facility took away her personal power chair due to her weight exceeding the weight limits of the chair. She indicated she was the type who got out of bed every day and was independent in mobility around the facility in her chair. The facility gave her a manual wheelchair to use, but indicated that it was uncomfortable to use and the brakes did not work when she pushed it; the wheels went the opposite way; and since her fingers did not all work, they got stuck in the spokes. The facility did give her a loaner power chair, which worked initially, but due to battery issues with it, it would not hold a charge. The only other solution anyone gave her was to lose enough weight so she could then have her own chair back. Because she was unable to get out of bed, she was not able to participate in the Halloween event where residents passed out candy to the children. This really upset her. She	F 0745	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Residents 51 and 59 were not harmed by the alleged deficient practice. A psycho-social assessment was completed for both residents. Residents' care plans were reviewed and updated with appropriate social service interventions. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Residents who have experienced recent loss of independent mobility, weight issues, changes in family dynamics, missing money, or desire to be discharged to the community despite medical obstacles could be affected by the deficient practice. An audit was completed of all residents who have experienced recent loss of independent mobility, weight issues, changes in family dynamics, missing money, or desire to be discharged to the community despite medical obstacles was completed to	12/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	had been in the facility for two years and thought her last care plan meeting was maybe a year ago. The day she was finally able to get out of bed and up into her power chair after recuperating from surgery, the Social Worker came and told her there was going to be a care plan meeting. The meeting only dealt with her weight and never discussed any other issues, such as her desire to discharge from the facility. She could not remember having any other meetings after this one. She did not feel like this was a true care plan meeting. She also voiced that it was her goal to try to get a wheelchair accessible apartment and try to get someone who came in and out to do certain things she needed. During a second meeting with Resident 51 on 11/6/23 at 9:03 a.m., the resident indicated that the meeting the Social Worker called a "care plan meeting" was really only nursing, therapy and Social Services talking about her weight issues and how she was too fat to fit into her personal power chair anymore which they were then taking away from her because she was deemed "unsafe." They gave her a manual wheelchair to use and told her she would have to lose a significant amount of weight in order to regain use of her power chair. The manual wheelchair they gave her did not work properly, and the loaner power chair they also gave her had battery issues and would not hold a charge. She was no longer able to get out of bed and into the power chair to independently move about the facility and that the loss of what independence she had was difficult. She had been mentioning to the Social Worker that she wanted to leave the facility and move into an accessible apartment to have her family member come live with her. The resident indicated she was upset she had already lost the first couple years of his life due to her accident		ensure appropriate social service interventions are in place. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The ED/Designee held an in-service with the social service designee to provide education and expectations as it relates to the Social Service designee job description and expectations including duties involved in resident advocacy, performance of social and psychosocial functions, and maintaining proper documentation. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The ED/Designee will audit 5 residents a week x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week x 4 weeks for no less than 3 months, and compliance is maintained to ensure appropriate social services interventions and care plans are in place. The ED/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	and did not want to miss anymore. The record for Resident 51 was reviewed on 11/3/23 at 12:40 p.m. The diagnoses included, but were not limited to, personal history of traumatic brain injury, unspecified intracranial injury with loss of consciousness of unspecified duration, morbid obesity, paraplegia unspecified and adjustment disorder with mixed anxiety and depressed mood. The Quarterly Minimum Data Set (MDS) assessments, dated 2/22/23, 3/6/23, 6/15/23, 9/15/23 and 9/22/23, and the Annual MDS assessment, dated 5/19/23, all indicated the resident was alert and oriented; required extensive assist of 2 staff for bed mobility and transfers; had bilateral impairments in functional range of motion in lower extremities; and was supervision only with set up assist for locomotion on/off the unit via wheelchair. There was no active discharge plans and that the resident did not want to be asked about returning to the community. A care plan, dated 8/15/23, indicated the resident had a mood problem of depression. The goal was for the resident to not experience any increase in signs and symptoms of mood disturbance. Approaches included, but were not limited to, encourage resident to express feelings; and encourage to maintain as much independence and control in decision making as possible. A care plan, dated 8/15/23, indicated the resident had no plans for discharge secondary to the need for assistance with care. The goal was for the resident to participate in her care decisions for her long term stay. Approaches included, but were not limited to, monitor for signs and symptoms of anxiety, distress, withdrawal or depression		ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	relating to not returning to her previous home environment, and provide visits for support and observe for any concerns. The Social Service notes, dated 6/7/23 at 9:00 a.m. and 6/9/23 at 1:42 p.m., only addressed the resident asking other resident family members to buy her food. A Psychotherapist counseling session note, dated 7/13/23, indicated the therapist helped the resident to process her stress and frustration regarding not being able to use her wheelchair until she loses weight and not being weighed regularly. A Psychiatric note, dated 8/23/23, indicated the resident was being seen for management of chronic illness and diagnosis of major depressive disorder. When asked how she was doing, the resident reported that her mood was not too bad, but had anxiety due to being stuck in her room. She indicated she was trying to lose weight so she can get her power chair back as she was used to being up daily. The Assessment Plan was: Zoloft was recently increased for her mood with anxiety over being in facility and losing her power chair. Allow time for increase in medication. The Nurse Practitioner's (NP) note, dated 9/11/23 at 12:16 p.m., indicated the resident was sad about not having her motorized scooter and missed being out of bed and independent with being able to move herself around the facility and sitting outside. She indicated the resident reported requesting assistance to find an apartment with caregivers. During an interview on 11/6/23 at 8:30 a.m., the Executive Director (ED) indicated The Social			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	Worker was responsible for sending out care plan letters to the residents and families and took the notes. Everyone was responsible for making their own changes to the care plans as needed. During an interview with the Social Worker on 11/8/23 at 9:55 a.m., she indicated therapy had made the request in September for the IDT (Interdisciplinary Team) to meet with the resident to discuss her weight and since she no longer fit into her wheelchair, they were going to remove her power chair from her use. They deemed the resident unsafe due to almost falling forward out of the chair. She had made arrangements for psychiatric services and a psychotherapist to see the resident to deal with any issues she was having over the loss of her chair. She had this discussion before about her wanting to go home but she brought it up again recently about 2 weeks ago. She informed the resident she would have to have 24 hour caregivers and would not even be appropriate for Assisted Living. She called the resident's family member and POA (Power of Attorney) about it and left a message but had not heard back from her. This all came about going home again due to the resident's family member now living with another family member. She usually made notes whenever she talked to a resident, staff or family member, but sometimes it did fall by the wayside. The record lacked documentation by Social Services, which addressed the resident's shame over her weight and not being able to use her power chair due to it; loss of family contact; and her desire to return to the community. 2. During an interview with Resident 59 on 11/1/23 at 11:01 a.m., he indicated he had been voicing a desire to leave this facility and return to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	community once his health conditions were resolved. The resident also voiced he had a couple of dollars missing and reported it to the ED. During a second interview with the resident on 11/8/23 at 9:10 a.m., the resident indicated it was his intention all along to go home and still wanted to, as that was the reason for his coming to the facility on 2/1/23 and doing therapy so he could get strong enough to go home. The record for Resident 59 was reviewed on 11/6/23 at 3:20 p.m. The diagnoses included, but were not limited to, immobility syndrome (paraplegic), muscle weakness, diabetes mellitus due to underlying condition with unspecified complications, other symptoms and signs involving the musculoskeletal system, and .muscle wasting and atrophy. The Quarterly MDS assessments, dated 3/14/23, 6/7/23 and 9/7/23, indicated the resident was alert and oriented; and required extensive to total assist for bed mobility and transfers. The Quarterly MDS assessment, dated 3/14/23, indicated active discharge planning was occurring for the resident to return to the community. A care plan, dated 3/14/23, indicated the resident desired to return to the community. No further updates or changes had been made to this care plan since being initiated on 3/14/23. The Quarterly MDS assessments, dated 6/7/23 and 9/7/23, indicated there was no active discharge planning occurring and the resident was not going to be returning to the community.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	The Social Work, Physician/NP (Nurse Practitioner), and therapy notes between 2/1/23 and 2/23/23 initially indicated the resident planned to return home after the completion of therapy. The Social Work notes, dated 2/28/23, 6/7/23 and 9/12/23 subsequently indicated the plan was for the resident to remain long term in the facility. During an interview with the Social Worker on 11/8/23 at 9:15 a.m., she indicated the resident no longer had a home to be discharged to nor would any Assisted Living facility accept him due to the amount of care he needed. She indicated the resident's family member was very involved in the resident's care and helped the resident make a decision to remain in the facility long term. She was not aware he was now talking about going home again. On 9/26/23, a Reportable to State was made regarding the loss of $3.00 by the resident who identified a specific aide as having taken the money. An investigation was conducted with the said staff member suspended. Police were contacted and the resident was given a lockbox and instructed on how to use it. The Preventative Measures were for the resident to be monitored for changes in psychosocial well being and care plans reviewed and updated as appropriate by Social Services. A Social Work note, dated 9/27/23 at 7:31 a.m., indicated the resident was given a lock box and educated on how to use it, key placement, and what specifically to keep in the box. The record lacked documentation by Social Services to monitor the resident's psychosocial well being after the loss of the money per the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	Preventive Measures Taken in the 9/26/23 Reportable to State. Care plans were also not updated to reflect his mood regarding the loss of money. On 11/6/23 at 10:12 a.m., the Regional Director of Clinical Operations (RDCO) presented a copy of the Social Worker's Job Description signed on 4/3/22. The Job Description included, but was not limited to, "Purpose/Belief Statement: The position of Social Services Director provides planning, assessing, coordinating and implementation of services to enhance each resident's social and psychosocial well being and assure that care standards are met and the highest degree of quality care is provided at all times...Job Duties and Responsibilities: PERFORM ALL DUTIES INVOLVED IN RESIDENT ADVOCACY:...Participates in quarterly care conferences and attends any other meetings, re: resident care planning and or center policymaking that affects the caring community concept. Reports all grievances and complaints an makes necessary oral or written reports to the Administrator/designee. Serves as the resident advocate at all times working in harmony with all direct care giving staff to assure that the resident's needs are being met at all times...Is aware of any changes in a resident's condition and report immediately to the charge nurse. Identify and consider information that would: 1. Helps to solve the problems of residents to better meet their needs. 2. Determine the proper approach to an issue in question. 3. Assist in identifying and correcting problem areas. 4. Improves the quality of activities and or services and increase the opportunities and choices for the resident...RESPONSIBLE FOR THE PERFORMANCE OF ALL SOCIAL AND PSYCHOSOCIAL FUNCTIONS:...Responsible for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	the establishment of psychosocial goals to be included in the resident's plan of care in conjunction with nursing and other departments...MAINTAIN PROPER DOCUMENTATION AND PERFORM GENERAL DUTIES: Prepares, evaluates and charts social services documentation on each resident according to State and federal regulations...Documents...discharge plan, progress notes and other assessments as indicated per center..." 3.1 - 34(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, record review and interview, the facility failed to ensure accurate documentation in the Controlled Drug Administration Record sheets of the administered narcotics for 3 of 45 residents receiving narcotics in 2 of 6 medication carts. (Residents 64, 59, and 60) Findings include: 1. During an observation on 11/2/23 at 12:38 p.m., of the 100 Hall Medication Cart 1 with LPN (Licensed Practical Nurse) 4, the following concern was observed: - Resident 64's lorazepam 0.5 mg (milligrams) Controlled Drug Administration Record sheet, indicated the resident had a count of 2 tablets left. The last dose signed out on the sheet was on 11/2/23 at 8:36 a.m., by LPN 4. There was 1 tablet of the medication on the card. During an interview on 11/2/23 at 12:40 p.m., LPN 4 indicated he had just given the medication. The record for Resident 64 was reviewed on 11/6/23 at 2:10 p.m. The diagnoses included, but was not limited to, anxiety disorder. The care plan, dated 8/4/23 and last revised	F 0755	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Residents 64, 59, and 60 were not harmed by the alleged deficient practice. LPN 4 was educated on the "Medication Administration" policy and procedures. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who receive narcotics could be affected by the deficient practice. All residents currently receiving a narcotic were reviewed. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DON/Designee held an in-service for all nurses to provide education and expectations as it relates to the "Medication Administration" policy and procedures.	12/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	8/16/23, indicated the resident used anti-anxiety medication related to anxiety disorder. The interventions, dated 8/4/23, included, but were not limited to, provide anti-anxiety medication per medical provider's orders. The physician's orders, dated 10/26/23, indicated to administer the 0.5 mg lorazepam tablet every 4 hours as needed for anxiety. The resident's MAR (Medication Administration Record) indicated the last dose of the medication was administered on 11/2/23 at 8:36 a.m., by LPN 4. 2. During an observation on 11/2/23 at 12:46 p.m., of the 100 Hall Medication Cart 2 with LPN 4, the following concerns were observed: - Resident 59's hydrocodone-APAP (acetaminophen) 5-325 mg Controlled Drug Administration sheet indicated the resident had a count of 8 tablets left. The last dose signed out on the sheet was on 11/2/23 at 5:00 a.m., by LPN 5. There were 7 tablets of the medication on the card. The record for Resident 59 was reviewed on 11/6/23 at 2:14 p.m. The diagnoses included, but were not limited to, immobility syndrome (paraplegia), muscle wasting and atrophy, enterocolitis due to clostridium difficile, bacterial intestinal infection, and pain the right leg. The care plan, dated 3/4/23 and last revised 3/14/23, indicated the resident had complaints of acute/chronic pain related to chronic pain syndrome. The interventions, dated 3/4/23, included, but was not limited to, provide medication per orders, monitor for signs and symptoms of side effects and to evaluate for		**STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Designee will observe 5 residents' medication administrations a week x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week x 4 weeks for no less than 3 months, and compliance is maintained to ensure narcotics are signed out appropriately at time pulled. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	effectiveness of the medication. The physician's orders, dated 10/25/23, indicated to administer the 5-325 mg hydrocodone-APAP every 6 hours for pain. Resident 59's MAR indicated on 11/1/23 at 11:52 a.m., the resident received the hydrocodone-APAP by LPN 4, which was 4.5 hour after the previous dose had ben administered on 11/1/23 at 4:31 p.m. Resident 59's MAR indicated the last dose of the medication was administered on 11/2/23 at 12:00 p.m., by LPN 4. The next dose was given on 11/2/23 at 4:30 p.m., 4.5 hours after the previous dose was administered. Resident 59's MAR indicated on 11/2/23 at 12:59 a.m. the resident received the hydrocodone-APAP by LPN 5, which was 4 hours after the previous dose had been administered on 11/2/23 at 5:00 a.m. 3. Resident 60's hydrocodone-APAP 5-325 mg Controlled Drug Administration sheet indicated the resident had a count of 52 tablets left. The last dose signed out on the sheet was on 11/2/23 at 8:29 a.m., by LPN 4. There were 51 tablets of the medication on the card. The record for Resident 60 was reviewed on 11/6/23 at 2:17 p.m. The diagnoses included, but were not limited to, metabolic encephalopathy, peripheral vascular disease, and chronic pain syndrome. The care plan, dated 2/24/23 and last revised 3/14/23, indicated the resident had complaints of acute/chronic pain related to chronic pain syndrome and peripheral vascular disease. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	interventions, dated 2/24/23, included, but was not limited to, Provide medication per orders. Monitor for signs and symptoms of side effects and to evaluate for effectiveness of the medication. The physician's orders, dated 10/19/23, indicated to administer 5-325 mg hydrocodone-APAP three times a day (every 8 hours) for pain. Resident 60's MAR indicated on 11/1/23 at 10:10 a.m., the resident received the hydrocodone-APAP by LPN 4, which was 3 hours after the previous dose had been administered on 11/1/23 at 12:57 p.m. Resident 60's MAR indicated on 11/2/23 at 12:02 p.m., the resident received the hydrocodone-APAP by LPN 4, which was 3.5 hours after the previous dose had been administered on 11/2/23 at 8:29 a.m. During an interview on 11/2/23 at 12:48 p.m., LPN 4 indicated the facility policy was to sign the narcotic out when he administered them, but he signed them out when he finished documenting resident assessments. During an interview on 11/2/23 at 1:18 p.m., the Regional Director of Clinical Operations indicated the nurses should sign out narcotic medications when they were pulled. The nursing staff had just been educated on signing out narcotics. During an interview on 11/8/23 at 8:32 a.m., the DON indicated the nurse could not administer narcotics at 3 or 4 hours if the order was for every 6 hours. They should administer routine 8 hour narcotics at 8 hours, unless there was an order from the NP to do so.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	During an interview on 11/8/23 at 9:00 a.m., LPN 4 indicated everyone on the 100 Hall had orders for PRN medications every 6 hours. The routine narcotic orders had the 1-hour window, but he had not heard of any order from the NP to give the narcotics earlier than ordered. The current Medication Administration policy, included, but were not limited to, " ... dd. Medication will be charted when given. ee. Narcotics will be signed out when given. ff. Medications will be administered within the time frame of one hour before up to one hour after time ordered ..." 3.1-25(b)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure appropriate infection control practices for Enhanced Barrier Protocol (EBP) were followed for 1 of 3 residents reviewed for infection control. (Resident 16) Findings include: During an observation on 11/1/23 at 12:22 p.m., Resident 16's door had a sign on the outside that indicated she was in Enhanced Barrier Precautions and staff were to don a gown and gloves for high-contact resident activities, including dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or toileting, device care or use, and wound care for any skin opening requiring a dressing. Upon entering the room, CNA (Certified Nurse Aide) 10 was observed to be coming away from the resident's bed with a graduated cylinder nearly full of brown liquid stool. A strong odor of stool was present. CNA 10 was not wearing a gown. She proceeded to empty the stool into the toilet. CNA 11 was in the room with Resident, providing direct care for the resident's colostomy and was sealing the bag. She was not wearing a gown. CNA 11 indicated she had just finished emptying the resident's colostomy and was about to change her and strip her bed. There was a hanger on the wall in the resident's room with two empty boxes	F 0880	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Resident 16 was not harmed by the alleged deficient practice. The Wound nurse and CNAs 10 and 11 were educated on the "Enhanced Barrier Precautions" policy and procedures including the appropriate use of PPE. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who require enhanced barrier precautions could be affected by the deficient practice. An audit was completed of all residents requiring enhanced barrier perceptions to ensure appropriate signage is in place, supplies are available, and that staff understand enhanced barrier perception PPE requirements. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice**	12/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	of gloves and fully stocked with gowns. On 11/1/23 at 12:24 p.m., the Wound Nurse entered the room. She indicated she just needed to look at the resident's wound as they were changing her. She walked over to the bed and observed the resident's wound. She did not don a gown or correct the CNA's not wearing gowns. During an interview on 11/1/23 at 12:28 p.m., CNA 1 indicated the gowns had been there for a while as she and CNA 10 continued to change the resident's sheets after applying cream to her groin and a clean brief. At no point did either CNA don a gown. During an interview on 11/1/23 at 12:32 p.m., CNA 11 indicated the gowns had been in the room from back when they had COVID. They didn't ever wear the gowns. She was not aware of what Enhanced Barrier Precautions were. She did not know how long the sign had been on the door. No one had ever told her they needed to wear PPE with the ostomy care. During an interview on 11/1/23 at 12:33 p.m., CNA 10 indicated they put the gowns in the COVID rooms sometimes and they got left there. She initially indicated she was not aware of what Enhanced Barrier Precautions. Upon viewing the sign on the resident's door, she indicated she did recall what it was. It was for when someone had a treatment, colostomy or wounds, they had to put the PPE on. When they went in she didn't realize they were going to do colostomy care or wounds. She didn't know why she didn't put a gown on, she stated, "... It should have been a no-brainer... I believe when they first put the signs up they told us but we need to do some more inservices."		**does not recur:** The DON/Designee held an in-service for all nurses and CNAs to provide education and expectations as it relates to the “Enhanced Barrier Precautions” policy and procedures including the appropriate use of PPE. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Designee will observe 5 staff a week x 4 weeks, then 3 staff a week x 4 weeks, then 1 staff member a week x 4 weeks for no less than 3 months, and compliance is maintained to ensure PPE compliance in relation to Enhanced Barrier Precautions. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	The record for Resident 16 was reviewed on 11/1/23 at 1:00 p.m. The diagnoses included, but were not limited to, personal history of urinary tract infections, acute transverse myelitis in demyelinating disease of central nervous system, and neuromuscular dysfunction of bladder. The care plan, dated 11/1/23, indicated the resident required enhanced barrier precautions related to a history of MDRO multi-drug resistant organisms. The physician's order, dated 11/1/23, indicated the resident was on Enhanced Barrier Precautions when bathing, dressing, showering, transferring, personal hygiene, changing linens, toileting, and perineal care to a resident with a history of or colonized MDRO (methicillin drug resistant organism) for a history of ESBL (extended spectrum beta-lactamase). The most current Enhanced Barrier Precautions policy, included, but was not limited to, "... Procedure... Ensure PPE is available for staff at the entrance of the resident room... Gloves and gowns are required when providing care for the resident, such as... providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use... Enhanced barrier precautions... All residents with... infection or colonization with a novel or targeted MDRO when contact precautions do not apply... PPE used for... high contact resident care activities... providing hygiene... changing briefs or assisting with toileting... required PPE... Gloves and gown prior to high contact care activity..." 3.1-18(b)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on record review and interview, the facility failed to ensure residents were offered pneumococcal vaccinations as recommended by the CDC (Centers for Disease Control) for 2 of 5 residents reviewed for pneumococcal immunizations. (Residents 35 and 9) Findings include: 1. The record for Resident 35 was reviewed on 11/6/23 at 8:30 a.m. The record indicated Resident 35 was 66 years old and had received a dose of PCV20 (pneumococcal polysaccharide vaccine) on 3/2/23, however had received no further doses. On 11/8/23 the facility provided a copy of the resident's most current vaccination status from CHIRP (Child and Hoosier Immunization Registry Program), which indicated the resident had received no doses of PCV20, and only one dose of PCV13 on 11/6/2015.	F 0883	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Residents 35 and 9 were not harmed by the alleged deficient practice. Both residents were offered and provided the appropriate pneumococcal vaccine if indicated. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents could be affected by the deficient practice. An audit of all residents was completed to ensure appropriate pneumococcal vaccine has been offered and provided if indicated.	12/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	The record lacked documentation of any offer for the resident to receive the recommended second dose of either PCV20 or PPSV23 (pneumococcal polysaccharide vaccine) after one year as recommended by the current CDC (Centers for Disease Control) guidance. 2. The record for Resident 9 was reviewed on 11/6/23 at 8:40 a.m. The record indicated Resident 9 was 56 years old and had received one dose of PCV13 on 10/21/2014. The record lacked documentation of any offer for the resident to receive the recommended second dose of either PCV20 after one year as recommended by the current CDC guidance. During an interview on 11/8/23 at 11:38 a.m., the Director of Nursing indicated for Resident 35, the information that the resident had received the PCV23 was incorrect documentation. She had only received the PCV13. Resident 9 had received the PCV13 in 2014. Neither resident had been offered the follow up vaccination prior to 11/8/23 though they were both due for a second dose. It was something that was normally kept and recorded by the Infection Preventionist and they followed up on it. During an interview on 11/8/23 at 11:52 a.m., the Infection Preventionist indicated when a resident came in he would look on CHIRP and see what they were due for. He had been the Infection Preventionist for a year. He was aware they had residents that were not up to date. He talked to a staff member that was over him and they made a spreadsheet and they were trying to catch that up. They did that a couple months ago. They had identified who all was not up to date a couple of months prior. Right now they had just identified		**STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DON/Designee held an in-service for all nurses to provide education and expectations as it relates to the "Resident Pneumococcal Vaccines" policy and procedures including offering appropriate pneumococcal vaccine according to CDC guidance. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Designee will audit 5 residents' pneumococcal vaccine eligibility a week x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week x 4 weeks for no less than 3 months, and compliance is maintained to ensure appropriate pneumococcal vaccine has been offered and provided if indicated. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	who needed updated. They had not yet obtained the consents, provided education or ordered the vaccination; The most current Resident Pneumococcal Vaccines policy, included, but was not limited to, "... Procedure... B. Residents in the facility will be offered the pneumococcal vaccine unless medically contraindicated or the resident has already been immunized..." Guidance for Pneumococcal Vaccine Timing for Adults was obtained from the CDC's website on 11/8/23. The guidance included, but was not limited to, "... Make sure your patients are up to date with pneumococcal vaccination... Adults greater than 65 years old Complete pneumococcal vaccine schedules... Prior vaccines... PPSV23 only... Option A... PCV20... Option B... PCV15... PCV13 Only... Option A... PCV20... Option B... PPSV23..." 3.1-13(a)			
F 0908 SS=D Bldg. 00	483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. Based on record review and interview, the facility failed to ensure an electric wheelchair loaned to a resident by the facility was maintained in safe operating condition for 1 of 2 resident reviewed for patient equipment. (Resident 51) Findings include: During an interview with Resident 51 on 11/2/23 at 10:10 a.m., she indicated her personal electric	F 0908	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Resident 51 was not harmed by the alleged deficient practice. Resident 51's power chair received new batteries and was observed to be in working	12/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	wheelchair was removed due to her being over the weight limit of the chair. She was given a donated wheelchair from the facility to use until she lost sufficient weight, to use hers again. She indicated it was an older model and had been only able to use it for 2 days since the battery would not keep a charge once it was removed from the plug despite it initially indicating it was charging and then fully charged. The record for Resident 51 was reviewed on 11/3/23 at 12:40 p.m. The diagnoses included, but were not limited to, personal history of traumatic brain injury, unspecified intracranial injury with loss of consciousness of unspecified duration, morbid obesity, paraplegia unspecified and adjustment disorder with mixed anxiety and depressed mood. The Nurse Practitioner's (NP) note, dated 9/11/23 at 12:16 p.m., indicated the resident was sad about not having her motorized scooter and missed being out of bed and independent with being able to move herself around the facility and sitting outside. During an interview with LPN (Licensed Practical Nurse) 14 on 11/6/23 at 9:18 a.m., she indicated the resident had not been up in the electric wheelchair, the facility loaned her, due to the battery not working. It would not hold a charge and that the Maintenance Director was aware and was supposed to be waiting on a new battery. During an interview with CNA (Certified Nurse Aide) 15 and CNA 11 on 11/6/23 at 12:45 p.m., they indicated it had been a couple weeks that the wheelchair was not working due to the battery. During an interview with the Executive Director on		order with no further concerns. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Residents who utilize an electric wheelchair loaned by the facility could be affected by the alleged deficient practice. An audit was completed of all residents who utilize an electric wheelchair loaned by the facility to ensure the electric wheelchair is in working order. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The ED/Designee held an in-service the Maintenance Director to provide education and expectations as it relates to the upkeep of facility-loaned electric wheelchairs and timely repair. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The ED/Designee will audit 5 residents a week x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week x 4 weeks for no less than 3 months, and compliance is maintained to ensure any facility loaned electric wheelchairs are in working order. The ED/Designee will present the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155657	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON HEALTHCARE CENTER	150 BEECHMONT DR 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
	11/6/23 at 12:50 p.m., he indicated the loner chair was working up until recently, maybe until the Halloween event held last week, when she could not get up out of bed, as the chair would not hold a charge. He had ordered batteries today and got them used from one of their sister facilities, but it was going to take awhile for them to charge. The Director of Nursing (DON) was supposed to be looking into buying a battery locally. During an interview with the Maintenance Director on 11/6/23 at 1:55 p.m., he indicated he spoke to the resident last Tuesday, he thought (10/31/23), and plugged the wheelchair into the wall and it was taking a charge although it was slow. He told her he would check with her again and for her to let him know if it was still a problem. He did go back the next day and it only had a quarter charge on the battery. He was not supposed to be working on residents' own personal wheelchair, but did not know the chair was not personally hers and was a loner, which belonged to the facility. He could not order a battery on his own as it cost about $350.00 and he would have to have the Executive Director's approval first to do so. The Executive Director came to him only this morning about ordering a new battery. 3.1-19(bb)		results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	