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	09/19/2023

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 the Investigation of Complaints IN00416980 and IN00417434. Complaint IN00416980 - No deficiencies related to the allegation are cited. Complaint IN00417434 - Federal/State deficiency related to the allegations is cited at F689. Survey date: September 19, 2023. Facility number: 010597 Provider number: 155657 AIM number: 200204440 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type: Medicare: 13 Medicaid: 45 Other: 24 Total: 82 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on September 26, 2023.	F 0000		
F 0689 SS=G 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			

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

Brandon Jensen | LNHA | 10/03/2023

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

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	§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 the safety of a resident during an assisted transfer, which resulted in the resident falling backwards and developing a subdural hematoma and laceration to the back of her head for 1 of 3 resident reviewed for falls. (Resident E) Findings include: The record for Resident E was reviewed on 9/19/23 at 12:15 p.m. The diagnoses included, but were not limited to, cervical disc disorder with myelopathy of the cervicothoracic region, cognitive communication deficit, need for assistance with personal care, muscle weakness, and obesity. The care plan, dated 11/4/22 and last revised on 8/23/23, indicated the resident was at risk for falls, gait and balance problems, medications, weakness with an actual fall on 8/23/23. The interventions, dated 8/23/23, included, but were not limited to, apply anti-tippers to the wheelchair and send the resident to the ER (emergency room) as needed per MD (medical doctor) order. The nurse's note, dated 8/23/23 at 1:29 p.m., indicated the resident was getting ready to be put back into her bed after dialysis. The aides reclined her wheelchair to position her for the full body lift transfer. The resident's wheelchair tipped backwards, and the resident slid out. She received a hematoma and a small laceration to the back of her head on the left side. The nurse practitioner was called and came to assess the resident. The nurse on the hall indicated the resident took	F 0689	**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 complaint survey conducted on September 19, 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** **STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Resident E was part of a confidential survey and not be identified. **STEP 2 Corrective action taken for those residents having the**	09/25/2023

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	Eliquis. The nurse practitioner gave an order to send the resident to the ER for evaluation. The nurse's note, dated 8/23/23 at 1:35 p.m., indicated at 12:15 p.m., the nurse was called to the resident's room by the CNA (Certified Nurse Aide). The resident was assessed by the nurse. There was no change in LOC (level of consciousness). Her legs were equal in length, with no turn in or turn out. There was no pain when her BLE (bilateral lower extremities) were assessed. Her pulses were equal and bilateral. The resident had hit her head on the floor. The resident sustained a 0.5 cm (centimeter) cut on her head with bleeding. The resident was assisted to bed. At 12:20 p.m., the NP was on site and assessed the resident. A new order was received to send the resident to a local hospital for evaluation and treatment. At 12:45 p.m., EMS (emergency medical service) was on site to transport the resident. The Skin Grid Non-Pressure assessment, dated 8/23/23 at 12:15 p.m., indicated the laceration to the back of the head measured 0.75 cm long. The nurse's note, dated 8/23/23 at 6:05 p.m., indicated the resident was transferred from a local hospital to another hospital to confirm her injury. The nurse practitioner and representative were notified. The CT (computerized tomography) scan results on 8/23/23 at 11:04 p.m., indicated the hematoma measured 5.8 mm (millimeters) in greatest thickness, which had decreased in size since the prior examination. The CT showed a SDH (subdural hematoma) with midline shift. The left midline shift measured 7.3 mm with effacement of the right lateral ventricle. The midline shift was 9.5		**potential to be affected by the same deficient practice:** All residents who require a mechanical lift transfer and high back wheelchairs could be affected by deficient practice. An audit of all residents who require a mechanical lift transfer was completed to ensure no equipment or transfer safety concerns. Any identified concerns were immediately addressed. **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 direct care to provide education and expectations as it relates to the " Mechanical Lifts and Transfer" policy and procedures to include steps for providing a safe mechanical lift transfers and checking all equipment prior to transfer. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Designee will audit 5 mechanical lift transfers a week x 4 weeks, then 3 mechanical lift transfers a week x 4 weeks, then 1 mechanical lift transfers a week x 4 weeks for no less than 3 months and compliance is	

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	mm on the prior examination. No fracture was observed. The resident complaint of a headache since the fall, which had not improved. The nurse's note, dated 8/27/23 at 5:18 p.m., indicated the resident arrived at the facility at 5:17 p.m., via transport on a stretcher. During an interview on 9/19/23 at 1:01 p.m., CNA (Certified Nurse Aide) 4 indicated two CNAs were using the lift to seat the resident in her wheelchair. They made sure she was positioned in the wheelchair correctly before seating her in it. The resident liked the wheelchair tilted back slightly when using the full body lift. The wheelchair tipped back. The wheelchair did not have anti-tippers at the time of the fall but did now. She was unsure why the chair didn't have anti-tippers before the fall. The resident was assisted down as best they could. The resident hit her head on the floor. There was a lot of blood. The nurse and the Unit Manager came into the room to assess the resident. She was then assisted into her bed. The resident was sent out to the hospital the same day. The anti-tippers made it better to transfer the resident now. During an interview on 9/19/23 at 1:09 p.m., CNA 3 indicated they were getting the resident up. The resident's weight shifted in the chair. The high back chair made her tip. Her chair was supposed to have a spreader bar (The Seating Dynamics Spreader Bar head support mount was width and depth adjustable and may also be used to position the head support off-center. The Spreader Bar provides tremendous flexibility in adjustment and unparalleled rigidity on it for easy storage) and it didn't latch properly for some reason. When her chair was inspected, it was found that the spreader bar was not latched and altered her		maintained to ensure safe mechanical lift transfers. 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.	

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	weight. The resident fell and busted her head. There was bleeding. They were going to get her vitals, but the nurse was called in and assessed the resident. She couldn't get the bleeding to stop. The resident hit her head on something, but she wasn't sure what. The high back chair was taller than the resident, but the resident had slid up the high back, above the top of the chair back. The resident was sent out to the hospital. The current Mechanical Lifts and Transfer policy, included, but was not limited to, " ... The use of mechanical lifts requires a competent and skilled user and requires the use of two (2) employees safely, for both resident and employees ...VIII. Transferring to a Wheelchair ...c. Move the wheelchair into position. d. Engage the rear wheel locks of the wheelchair to prevent movement of the wheelchair ..." This Federal tag relates to Complaint IN00417434 3.1-45(a)(1) 3.1-45(a)(2)			