STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155830	A. BUILDING 00 B. WING	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON'S CROSSING HEALTH CAMPUS	395 8TH AVENUE TERRE HAUTE, IN 47804

(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 Complaint IN00416356. Complaint IN00416356 - Federal/state deficiencies related to the allegations are cited at F689. Survey date: September 6, 2023 Facility number: 013335 Provider number: 155830 AIM number: 201290670 Census Bed Type: SNF/NF: 11 SNF: 37 Total: 48 Census Payor Type: Medicare: 22 Medicaid: 11 Other: 15 Total: 48 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on September 13, 2023.	F 0000	The submission of this plan of correction does not indicate an admission by Harrison's Crossing Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Harrison's Crossing Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Corrections to be completed by 9/27/23	
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
Sean Medsker	Executive Director	10/05/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155830	A. BUILDING 00 B. WING	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON'S CROSSING HEALTH CAMPUS	395 8TH AVENUE TERRE HAUTE, IN 47804

(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
	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure person-centered fall interventions were in place for a resident, (Resident B) who had a history of falls, which resulted in actual harm when he fell out of bed and sustained multiple rib fractures and hospitalization. The facility failed to ensure a resident, (Resident C) who had a history of falls, also received person-centered interventions as outlined in her plan of care for 2 of 3 residents reviewed for falls. Findings include: 1. On 9/6/23 at 11:32 a.m., a comprehensive record review was completed for Resident B. He was a long-term care resident who received Hospice services. He had diagnoses which included, but were not limited to, Parkinson's disease (a degenerative cognitive disease which affects the body's ability to control muscle movement), hemiplegia (paralyzed on one side of the body), COPD (chronic obstructive pulmonary disease), neurocognitive disorder with Lewy bodies (a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain), psychotic disorder, tremors, history of pulmonary embolism, and anxiety. Resident B had a comprehensive care plan, dated 3/17/22, which indicated he was at risk for falling related to decreased mobility and weakness. The goal of the care plan was to ensure Resident B would remain free from falls with major injury, and on 1/19/23 the IDT intervention for bolsters to the mattress was added.	F 0689	The submission of this plan of correction does not indicate an admission by Harrison's Crossing Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Harrison's Crossing Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Corrections to be completed by 9/27/23 F689: Accidents and Hazards 1 Resident B was affected by the alleged deficient practice. Resident no longer resides at the facility. Resident C was not affected by the alleged deficient practice. 2 All residents that have had a fall have the potential to be	09/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155830	A. BUILDING 00 B. WING	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON'S CROSSING HEALTH CAMPUS	395 8TH AVENUE TERRE HAUTE, IN 47804

(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
	A progress note, dated 6/16/23 at 9:44 p.m., indicated Resident B wanted to get up for breakfast and turned himself and rolled out of bed. He was assessed with no injury noted. His fall was unwitnessed. The IDT (Interdisciplinary Team) met to evaluate Resident B's fall. An intervention was added to place bolsters (support) to the sides of his bed to help serve as bed boundaries. A nursing progress note, dated 8/13/23 at 10:16 a.m., indicated Resident B rolled out of bed. He complained of neck and back pain and was sent to the emergency room. During an interview, on 9/6/23 at 2:28 p.m., Certified Nursing Aide (CNA) 7 indicated Resident B had been upset on 8/13/23 and yelled out. She went to provide him with perineal care. During her resident care with him, she noticed the "patch" (a dressing to cover wounds) came off his bottom. CNA 7 centered him on his bed which she had raised to waist height to provide care. She left the room to get the nurse, and when she returned, Resident B was found on the floor, as he must have rolled out of bed. CNA 7 called for help and Licensed Practical Nurse (LPN) 5 came to assist. CNA 7 indicated Resident B used a bariatric (wide) bed with quarter grab bars, but no bolsters had been added to the mattress. During an interview, on 9/6/23 at 2:48 p.m., a Registered Nurse (RN) indicated upon review of Resident B's records she did not find a record of bolsters being ordered, received, or added to his mattress. During an interview, on 9/6/23 at 3:00 p.m., LPN 5 indicated Resident B rolled out of his bed a		affected. Existing resident falls have been reviewed for implementation of appropriate fall interventions. Nurses to be educated on implementation of appropriate immediate interventions at the time of the fall. Interdisciplinary team educated on appropriate long-term intervention placement is in place that is related to the root cause of the fall. 3 The Director of Health Services (DHS) or designee, will audit 5 falls, if available, appropriate intervention is implemented and in place. Audit will occur weekly x 4 weeks, every other week x 2 months, and monthly x 3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155830	A. BUILDING 00 B. WING	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON'S CROSSING HEALTH CAMPUS	395 8TH AVENUE TERRE HAUTE, IN 47804

(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
	second time, and there were no bolsters on his bed. On 8/14/23 at 12:25 p.m., the facility reported Resident B sustained multiple fractures of his right 4th, 5th and 6th ribs, and a subtle nondisplaced fracture at the base of the 7th rib. A nursing progress note, dated 8/25/23 at 12:42 p.m., indicated Resident B passed away at a local hospital. 2. On 9/6/23 at 11:12 a.m., Resident C was observed with her eyes closed with her upper body on her bed and her feet were resting on the floor. She was observed lying on a regular mattress without bolsters. On 9/6/23 at 2:30 p.m., Resident C was observed with her eyes closed in the same position observed in at 11:12 a.m. Resident C had a regular mattress without bolsters on it. She was a long-term care resident who received Hospice services. She had diagnoses which included, but were not limited to, acute respiratory failure, pericardial effusion (fluid around the heart), neuropathy (nerve pain), dementia, heart failure, hyperlipidemia (high cholesterol), hypothyroidism, muscle weakness, altered mental status, and history of falls. A care plan, dated 4/25/22, indicated resident was at risk for falling related to decreased mobility, weakness, and cognitive status, which included a goal for Resident C would remain safe from falls with major injury. An intervention on the care plan indicated for her to have a mattress with bolsters. An event, dated 6/22/23, indicated Resident C was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155830	A. BUILDING 00 B. WING	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON'S CROSSING HEALTH CAMPUS	395 8TH AVENUE TERRE HAUTE, IN 47804

(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
	found on the floor next to her bed. No injury was observed. IDT added an intervention to have hospice order a mattress with bolsters. An event, dated 7/25/23, indicated Resident C had a fall on 7/25/23 at 3:44 p.m. She was found on the floor in her room. No injury was observed. On 7/26/23 at 9:39 a.m., IDT added an intervention to provide "meaningful" activity prior to meals. A nursing note, dated 8/19/23 at 2:26 p.m., indicated the resident was found on the floor in her room. There was no injury observed. A fall event, dated 8/19/23, indicated IDT to request hospice send a mattress with bolsters. On 9/6/23 at 12:32 p.m., the Executive Director (ED) provided a copy of current facility policy titled, "Fall Management Program Guidelines," dated 3/16/22. The policy indicated "...Trilogy Health Services (THS) strives to maintain a hazard free environment, mitigate fall risk factors, and implement preventative measures. THS recognizes even the most vigilant efforts may not prevent all falls and injuries. In the cases, intensive efforts will be directed toward minimizing or preventing injury...." On 9/6/23 at 12:32 p.m., the ED provided a copy a current facility policy titled, "Guidelines for Neurological Checks," dated 12/31/22. The policy indicated "...Residents having a fall should be evaluated for injury and neuro checks for 24 hours should be completed within the fall event form...." This Federal tag relates to Complaint IN00416356. 3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155830	A. BUILDING 00 B. WING	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON'S CROSSING HEALTH CAMPUS	395 8TH AVENUE TERRE HAUTE, IN 47804

(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